BILLIONS SAVED IN TAXES WHILE MILLIONS UNDERSERVED—WHAT HAS HAPPENED TO CHARITABLE HOSPITALS?

I. INTRODUCTION

Recent studies suggest that forty-seven million Americans are without adequate health insurance.[1] It is therefore not surprising that tax-exempt hospitals[2] are under fire for an alleged failure to meet the demands of such a large segment of the American population.[3] Indeed, the issue of tax-exemption for hospitals has been the subject of discussion by scholars, policymakers, and economists for some time.[4] Lately, though, the attack on tax-exempt hospitals is proceeding on a number of fronts.[5] America's tax-exempt hospitals are being challenged by Congress,[6] the Internal Revenue Service,[7] state and local

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1. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 20 (2007), http://www.census. gov/prod/2007pubs/p60-233.pdf.

2. The terms "tax-exempt" and "nonprofit" are generally used interchangeably in this context and generally refer to the same type of hospital. *E.g.*, Brief for Am. Pub. Health Ass'n. as Amicus Curiae Supporting Petitioner, Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26 (1976) (No. 74-1110), 1975 WL 173685, at *3-*6. This type of hospital is distinguishable from government hospitals, which are not discussed. *Id.* at *13.

3. *See* Linda Moroney et al., *Tax-Exempt Hospitals Under Fire, Health Lawyer News*, HEALTH LAW NEWS, Sept. 2004, at 1, *available at* http://faculty.smu.edu/tmayo/hln_0409.pdf.

4. *See* PEARL RICHARDSON, CONG. BUDGET OFFICE, HEALTH CARE TRENDS AND THE TAX TREATMENT OF HEALTH CARE INSTITUTIONS (1994), http://www.cbo.gov/ftpdocs/48xx/doc4836/doc39.pdf.

5. *See* Barry F. Rosen & Christopher D. Scott, *Back to the Future—Are Tax-Exempt Hospitals Headed for the Good Old Days?*, 39 MD. B.J. 35, 38 (2006) (recommending remedial measures by hospitals to "reduce the momentum for unfavorable changes in the laws governing tax-exempt hospitals"); *see also* Harold L. Kaplan & Linda S. Moroney, *Hospitals Face New Financial Threat of Charity Care Legislation*, 25 AM. BANKR. INST. J. 28, 59 (2006) (predicting an inevitable change in federal and state legislation pertaining to tax-exempt hospitals).

6. *See* Kaplan & Moroney, *supra* note 5, at 29, 58; *see also* Letter from Charles E. Grassley, Ranking Member, Senate Comm. on Fin., to David M. Walker, Comptroller Gen., U.S. Gov't Accountability Office (Apr. 5, 2007), *available at* http://www.senate.gov/~finance/press/Gpress/2007/prg040507b.pdf (urging the GAO to "conduct additional work on uncompensated care and other community benefits provided by nonprofit hospitals"); *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before the S. Comm. on Fin.*, 109th Cong. (2006), *available at* http://finance.senate.gov/hearings/statements/091306cg.pdf [hereinafter *Hearing on Nonprofit Hospitals*] (statement of Sen. Grassley, Chairman, S. Comm. Fin.).

7. *See* I.R.S., FY 2006 EO IMPLEMENTING GUIDELINES 12 (2005), http://www.irs.gov/pub/irs-tege/fy_2006_implementing_guidelines.pdf; *see also* Kaplan & Moroney, *supra* note 5, at 59 (referring to I.R.S. questionnaire circulated to approximately 600 tax-exempt hospitals requesting information on charity care and community benefits conferred by the hospital); I.R.S., COMPLIANCE CHECK QUESTIONNAIRE, TAX EXEMPT HOSPITALS (2006), http://www.irs.gov/pub/irs-tege/eo_hospital_questionnaire_sample.pdf; I.R.S., HOSPITAL COMPLIANCE PROJECT, INTERIM REPORT (SUMMARY OF REPORTED DATA) (2007), http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf (summarizing results of 2006 compliance check questionnaire); I.R.S. 2008 FORM 990, SCHEDULE H, http://www.irs.gov/pub/irs-tege/f990rschh.pdf (increasing considerably the amount of disclosure required by nonprofit hospitals).

governments,[8] individual plaintiffs,[9] and consumer-oriented groups,[10] to name just a few.

According to some sources, tax-exempt hospitals save billions of dollars each year in federal, state, and local taxes by virtue of their tax-favored status.[11] Interested groups, including Congress and the uninsured public, among others, want an accounting for how these tax savings are being used to benefit the general public.[12]

While Part II of this Comment provides background information on exempt organization status, Part III focuses on the historical roots of hospital exemptions and how they have evolved to their present-day status. Hospitals do not qualify for exemption under the current legislative regime that encompasses charitable organizations, the gloss of history notwithstanding. This observation, when coupled with the attacks being launched at tax-exempt hospitals from various sectors, leads to one inescapable conclusion: something must give.

Over time, several alternatives have been suggested to resolve this dilemma.[13] Some state governments have either considered or already implemented corrective measures designed to address healthcare issues and their exacerbation with the

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8. *See, e.g.*, Supervisor of Assessments of Montgomery County v. Group Health Ass'n, Inc., 517 A. 2d 1076, 1076 (Md. 1986); *see also* Michael Bologna, *Cook County to Debate Options, Strategies for Stripping Hospitals' Tax-Exempt Status*, DAILY TAX REPORT (BNA) No. 216, at H-5 (Nov. 8, 2007) (predicting potential repercussions of report outlining significant property tax benefits reaped by nonprofit hospitals in Cook County, Illinois).

9. *See, e.g.*, Colomar v. Mercy Hosp., Inc., 242 F.R.D. 671, 673 (S.D. Fla. 2007) (alleging unfair pricing practices); Maldonado v. Ochsner, 237 F.R.D. 145 (E.D. La. 2006), *aff'd sub nom* Maldonado v. Ochsner Clinic Found., 493 F.3d 521 (5th Cir. 2007) (alleging abusive collection practices and violation of compact with state for exemption); McCoy v. E. Tex. Med. Ctr. Reg'l Healthcare Sys., 388 F. Supp. 2d 760, 764 (E.D. Tex. 2005) (same); Sabeta v. Baptist Hosp. of Miami, Inc., 410 F. Supp. 2d 1224 (S.D. Fla. 2005) (same).

10. *See* Anthony Wright, *Hospital Overcharging Legislation Passes California Senate Health Committee*, CAL. PROGRESS REPORT, June 30, 2006, *available at* http://www.californiaprogressreport.com/2006/06/hospital_overch.html (describing "mystery shopping" survey by California Healthcare Foundation to uncover deficiencies in disclosure of financial options to patients); *see also* Brooke Knudson, *Coalition Joins Growing Movement for Healthcare Reform*, HEALTHCARE WORLD, July 18, 2007, *available at* http://www.healthcare-world.com/content/view/572/31/ (describing consumer groups' efforts to bring healthcare to the uninsured).

11. John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y & L. 623, 624 (2006) (citing Nancy M. Kane & William H. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, 78 MILBANK Q. 185, 200 (2000)); *see also Hearing on Nonprofit Hospitals, supra* note 6.

12. *See Hearing on Nonprofit Hospitals, supra* note 6.

13. *See, e.g.*, Colombo, *supra* note 11, at 635-39 (2006) (discussing alternatives to the status quo).

deemed failure of hospitals to carry their share of the load.[14] But since most state and local hospital exemptions originate with the federal exemption,[15] the importance of federal legislation as a necessary ingredient to solidify the role of exempt hospitals in our nation's healthcare schema cannot be overstated. Part IV of this Comment advocates such legislation.

II. BACKGROUND

A. *Benefits of Exemption*

Tax-exempt hospitals derive substantial tax-related benefits relative to their for-profit counterparts.[16] For 1995, examining a sampling of approximately 2,800 tax-exempt hospitals, the estimated aggregate value of tax-savings attributable to the sample group was approximately $4.6 billion.[17] In addition to substantial tax dollars saved in federal taxes, tax-exempt hospitals also enjoy exemption from most forms of state and local taxation.[18] The estimated aggregate state income tax benefit in 1995 for the sample group was approximately $500 million.[19] Tax-exempt hospitals in the United States also realized approximately $1.7 billion dollars in tax savings from property tax exemptions.[20] For 2002, the total value of exemptions from

14. *See, e.g.*, Kaplan & Moroney, *supra* note 5, at 29 (describing new legislation in New York designed to assist low-income persons by restricting access to the state's indigent care pool to those hospitals who, among other things, provide free or discounted care to the uninsured); *see also* Colombo, *supra* note 11, at 627; Chris Rauber, *State Agency OKs Huge Sutter Health Bond Issue, with Conditions*, E. BAY BUS. TIMES, Mar. 30, 2007, *available at* http://sacramento.bizjournals.com/eastbay/stories/2007/03/26/daily59.html (discussing California's requirement of $8.5 million in donations to clinics and rural hospitals in exchange for tax-exempt bond approval); Thom Wilder, *In Changing Landscape, Nonprofit Hospitals Must Continually Justify Status, Attorney Says*, DAILY TAX REPORT (BNA), Apr. 26, 2007, No. 80, at G-2.

15. Rosen & Scott, *supra* note 5, at 35-36. *But see* Jack Burns, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, 29 J. CORP. L. 665, 674-76 (2004) (recognizing state court decisions that define their own charitable standards irrespective of federal status).

16. *See generally* William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-profit Hospitals* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 6435, 1998) (discussing tax-related benefits accruing to tax-exempt hospitals).

17. *See id.* at 26-27.

18. *See id.* at 28-30.

19. *See id.* at 26-27.

20. *See id.* at 30.

federal, state, and local taxes is estimated to be $12.6 billion for all tax-exempt hospitals.[21]

Tax-exempt hospitals are also eligible to issue tax-exempt bonds and receive tax-deductible contributions.[22] While the tax savings available for these activities do not accrue directly to the benefit of tax-exempt hospitals, their availability does potentially increase tax-exempt hospitals' access to capital. Accordingly, tax-exempt bond financing and the availability of a charitable deduction for contributions to tax-exempt hospitals can enhance the financial position of tax-exempt hospitals relative to for-profit hospitals.

As of 1995, it was estimated that the combination of tax-exempt bonds issued by exempt hospitals and charitable deductions cost the government in excess of $1.4 billion in annual revenues.[23] As of 2002, tax-exempt bonds and charitable contributions to tax-exempt hospitals cost the federal government approximately $3.6 billion.[24]

B. *Requirements for Exemption*

In the early days of our federal tax system, it was recognized that certain organizations, by virtue of their charitable activities, should be exempt from the burdens of taxation.[25] Internal Revenue Code § 501(c)(3), originally enacted in 1954,[26] and its precursor, § 101(6) of the Internal Revenue Code of 1939,[27] were established to provide exemption from the incidents of federal taxation for those organizations that were charitable in nature. Currently, the Internal Revenue Code ("I.R.C.") embraces two key principles that are intended to govern the determination of whether an organization is exempt from federal income taxes: (1) the entity must be organized as a nonprofit organization and (2)

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21. CONG. BUDGET OFFICE, PUB. NO. 2707, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 5 (2006), http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf [hereinafter CBO].

22. Gentry & Penrod, *supra* note 16, at 32-40.

23. *Id.* at 36-37, 40.

24. CBO, *supra* note 21, at 5.

25. *See* Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. 1379, 1476 n.1 (1991) (describing the history of the federal exemption for charitable purposes and tracing it to ancient Greek and Roman times); *see also* Helena G. Rubenstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381, 381-82 (1997) (recounting the history of America's tax-exemption and its 17th century English roots); *see also* discussion *infra* Part III.A (recounting tax exempt charitable hospitals from a historical perspective).

26. Internal Revenue Code of 1954, ch. 736, § 501(c)(3), 68A Stat. 3, 163 (1954).

27. Internal Revenue Code of 1939, ch. 2, § 101(6) 53 Stat. 1, 33 (1939) (replaced 1954).

the entity must meet certain operational requirements.[28] Some organizations, like churches and schools, are generally exempt by virtue of their specific inclusion in I.R.C. § 501(c)(3).[29] Organizations not specifically enumerated in I.R.C. § 501(c)(3) must presumably be "charitable" in nature in order for the organization to qualify as exempt.[30] Hospitals and healthcare activities, notably absent from the list of activities that are inherently exempt,[31] apparently fall into the "charitable" basket.

1. Organizational Requirements

In order to be recognized as exempt from federal income taxes, an entity must meet the organizational requirements of I.R.C. § 501(c)(3).[32] The organizational requirement is largely one of form. The entity's legal form must generally be that of a "[c]orporation[ ], . . . community chest, fund, or foundation."[33] Moreover, an entity's organizing documents must generally restrict the organization to performing charitable activities.[34] Also, the organizing documents may not expressly permit the organization to engage in activities that do not advance the charitable purposes of the organization.[35] The documents may also not authorize the organization to engage in political campaigning,[36] significant lobbying or legislative activities,[37] enrichment of the organization's "members or shareholders,"[38] or activities of a non-charitable nature generally undertaken for profit.[39]

2. Operational Requirements

The operational requirements of I.R.C. § 501(c)(3) are more substantive in nature because they look more to the actual or proposed operations of the organization, apart from the

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28. *See* I.R.C. § 501(c)(3) (2000).

29. *Id.* ("Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific testing for public safety, literary, or educational purposes, or to foster national or international amateur sport competition . . . [or] the prevention of cruelty to children or animals.").

30. *See id.*

31. *See id.*

32. *Id.*

33. *Id.*

34. Treas. Reg. § 1.501(c)(3)-1(b)(1)(i)(a) (1959).

35. *Id.* § 1.501(c)(3)-1(b)(1)(i)(b).

36. *Id.* § 1.501(c)(3)-1(b)(3)(ii).

37. *Id.* § 1.501(c)(3)-1(b)(3)(i).

38. *Id.* § 1.501(c)(3)-1(b)(4).

39. *Id.* § 1.501(c)(3)-1(b)(1)(iii).

organizing documents.[40] In general, an organization must behave as a charitable organization in order to meet the operating requirements of I.R.C. § 501(c)(3).[41] Case law has developed over the years to limit the availability of exemption for organizations that do not operate for charitable purposes.[42] This Comment is limited to addressing only those operational issues of particular relevance to the exemption for hospitals.

a. Presence of a Nonexempt Purpose

While the language of I.R.C. § 501(c)(3) suggests that organizations must operate "exclusively" for one or more exempt purposes,[43] this provision has not been read by the courts to apply literally.[44] Rather, the courts have replaced the literal exclusivity requirement with a slightly more liberal standard—the presence of a single *substantial* non-exempt purpose will cause an organization to fail the operational test of I.R.C. § 501(c)(3), thereby precluding exemption.[45] The non-exempt purpose doctrine is all-encompassing in that it captures numerous aspects of an organization's activities, from business and commercial activities[46] to political activity.[47] Presumably, an organization whose purposes include earning profits has a substantial non-exempt purpose that should prohibit exemption.

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40. *See* Truth Tabernacle Church, Inc. v. Comm'r, 57 T.C.M. (CCH) 1386, 1389 (1989) (concluding that the taxpayer met the operational requirements in spite of the fact that its organizing documents were imprecise in that regard); *see also* Redlands Surgical Servs. v. Comm'r, 113 T.C. 47, 71 (1999), *aff'd*, 242 F.3d 904 (9th Cir. 2001) (emphasizing the importance of an organization's "actual purposes the organization advance[d] . . . rather than [its] statement of purpose").

41. *Truth Tabernacle Church*, 57 T.C.M. (CCH) at 1388.

42. *See, e.g.*, Better Bus. Bureau of Wash., D.C. v. United States, 326 U.S. 279, 283 (1945) (holding that promotion of an ethical and profitable business community was a substantial non-exempt purpose that nullified the organization's exemption qualification); United States v. Cmty. Servs., 189 F.2d 421, 424-25 (4th Cir. 1951) (holding that an organization operated for commercial purposes does not meet the operating requirements for tax-exemption); New Dynamics Found. v. United States, 70 Fed. Cl. 782, 802 (2006) (finding that the organization's operations were not exclusively for exempt purposes).

43. I.R.C. § 501(c)(3).

44. *New Dynamics Found.*, 70 Fed. Cl. at 799.

45. Easter House v. United States, 12 Cl. Ct. 476, 483 (1987), *aff'd*, No. 87-1519, 1988 WL 25416 (Fed. Cir. Mar. 28, 1988).

46. *Comty. Servs.*, 189 F.2d at 424; Fides Publ'r Ass'n v. United States, 263 F. Supp. 924, 935 (N.D. Ind. 1967).

47. Fund for Study of Econ. Growth and Tax Reform v. I.R.S., 997 F. Supp. 15, 21 (D.C. Cir. 1998) (finding taxpayer that "supported a one-sided political agenda and did not 'operate exclusively' for non-exempt purposes").

b. Commerciality Doctrine

Created by the courts,[48] the "Commerciality Doctrine" is applied to the provision of goods and services by an exempt organization to determine if the exempt organization's provision of such goods and services is distinguishable from that of its for-profit equivalent.[49] The focus of this type of inquiry is not on the status of the organization providing the good or service, but rather the good or service itself as well as the manner in which it is provided.[50]

Like the non-exempt purpose test, the Commerciality Doctrine can be used by the government to deny tax-exempt status to organizations.[51] Application of the Commerciality Doctrine is extraordinarily complicated by its dependence on facts and circumstances.[52] The determination of whether an activity is conducted in such a way as to suggest a non-exempt for-profit commercial venture, as opposed to an exempt charitable activity, is dependent upon a number of factors. The factors include, but are not limited to: the profitable nature of the activity,[53] the magnitude of the activity in relation to the organization's other exempt activities,[54] how the activity supports or furthers the exempt purpose(s) of the organization,[55] whether the activity is one that is ordinarily conducted by for-profit entities,[56] and the business and marketing practices employed in conducting the activity.[57] This broad array of factors has led to inconsistency in results.[58] Nonetheless, the Commerciality Doctrine remains a viable tool used by the I.R.S.

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48. Bradley Myers, *Revisiting the Commerciality Doctrine*, 10 J. AFFORDABLE HOUSING & CMTY DEV. L. 134, 134 (2001).

49. *Id.* at 138.

50. *See id.* at 134 (explaining the Doctrine's "focus is on the activity, not the motivation or actions of the performer of the activity").

51. *Id.* at 138.

52. *See* W. Marshall Sanders, *The Commerciality Doctrine is Alive and Well*, 16 TAX'N OF EXEMPTS 209, 210 (2005); *see also* B.S.W. Group, Inc. v. Comm'r, 70 T.C. 352, 358 (1978) (explaining how the Commerciality Doctrine is applied and naming several complex fact-specific factors to be considered).

53. *See* Scripture Press Found. v. United States, 285 F.2d 800, 803 (Ct. Cl. 1961) (suggesting that large profits are "at least some evidence indicative of a commercial character"); *B.S.W. Group, Inc.*, 70 T.C. at 358 ("[T]he existence and amount of annual or accumulated profits are relevant evidence of a forbidden predominant purpose.").

54. *See Scripture Press Found.*, 285 F.2d at 805-06.

55. *See, e.g.*, S.F. Infant Sch., Inc. v. Comm'r, 69 T.C. 957, 966 (1978) ("[P]roviding . . . custodial care [is] . . . a vehicle for or incidental to achieving [their] . . . only substantial purpose.").

56. *B.S.W. Group, Inc.*, 70 T.C. at 358.

57. Sanders, *supra* note 53, at 211.

58. *Id.* at 210-11.

and the courts to disqualify organizations as well as to subject earnings from certain activities to taxation.[59]

i. Origin of the Commerciality Doctrine

As early as 1924, the Supreme Court pondered the appropriateness of commercial activities conducted by exempt organizations.[60] Though the Court found in favor of the organization in *Trinidad*,[61] the facts presented caused the Court's analysis to fall short of approbating commercial ventures involving selling wares to the public or competing with other entities.[62] The *Trinidad* opinion is known for establishing what would later be known as the "Destination-of-Income Test"[63] (hereinafter referred to as the "Destination Test").

ii. Destination Test

The Destination Test was generally favorable to exempt organizations because it permitted organizations to engage in noncharitable activities to raise funding for charitable endeavors.[64] Despite the Court's discussion in *Trinidad v. Sagrada Orden de Predicadores* regarding the incidental nature of the non-charitable activities to the organization, the Destination Test that emerged from *Trinidad* represented the notion that the source of funding was irrelevant, so long as the net proceeds of the activity were used to further charitable purposes of the organization.[65] The Destination Test survived until 1954, when the appearance of I.R.C. § 502 shifted the focus of the inquiry to the charitable nature of the activities performed by the organization.[66]

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59. *See* Myers, *supra* note 49, at 134, 138-39.

60. *Id.* at 136 (interpreting the significance of Trinidad v. Sagrada Orden de Predicadores, 263 U.S. 578 (1924)).

61. *Trinidad*, 263 U.S. at 582.

62. *Id.* (recognizing the absence of a claim that the organization was selling its wares to the public or competing with others).

63. Fides Publishers Ass'n v. United States, 263 F. Supp. 924, 935 (N.D. Ind. 1967).

64. Myers, *supra* note 49, at 136 (discussing Roche's Beach, Inc. v. Comm'r, 96 F.2d 776 (2d Cir. 1938) (operation of public beach for profit) and C.F. Mueller Co. v. Comm'r, 190 F.2d 120 (3d Cir. 1950) (macaroni manufacturer)).

65. Myers, *supra* note 49, at 135; *Roche's Beach, Inc.*, 96 F.2d at 778 (interpreting *Trinidad* to say that an exempt "corporation may . . . conduct business activities for profit").

66. Internal Revenue Code of 1954, Pub. L. No. 83-591, 68A Stat. 3, 166 (1954) (under § 502, "[a]n organization operated for the primary purpose of carrying on a trade or business for profit shall not be exempt . . . on the ground that all of its profits are payable to one or more organizations exempt . . . from taxation").

While I.R.C. § 502 sounded the death knell for exempt organizations whose sole or primary activity was not inherently charitable,[67] § 402 of the Revenue Act of 1950[68] and its successor I.R.C. § 511[69] hampered the for-profit commercial activities of otherwise exempt organizations through imposition of an income tax on unrelated net business income ("UBIT").[70] Together, the purpose of these sections was to eliminate the competitive advantage being reaped by exempt organizations by virtue of their tax-exempt status and to put them on a more equal footing with their for-profit counterparts.[71]

The Destination Test, though thought to have arisen in the same context as the Commerciality Doctrine (the *Trinidad* case),[72] is inapposite to today's understanding of the Commerciality Doctrine. The existing Commerciality Doctrine makes irrelevant the destination of the earnings and profits of a venture, opting instead for an inquiry into the activities of the organization and whether those activities are conducted in a charitable manner, regardless of the fact that the net proceeds inure to charitable beneficiaries.[73] Notwithstanding the ultimate abandonment of the Destination Test, it is nonetheless important to an overall understanding of what is, as well as what is not, a charitable activity under today's accepted meanings.

iii. The Present Inquiry

Under present-day charitable analysis, the relevant inquiry focuses on the activities of the organization[74] irrespective of where the net proceeds or profits of an organization ultimately come to rest. Therefore, an organization that does not engage "primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3)" does not qualify for federal tax exemption.[75] In addition, entities asserting

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67. *See id.*; People's Educ. Camp Soc'y, Inc. v. Comm'r, 331 F.2d 923, 935 (2d Cir. 1964) ("Section 502 of the Code . . . denies exempt status to an entity primarily engaged in business.").

68. Revenue Act of 1950, Pub. L. No. 81-814, 64 Stat. 906, 948 (1950).

69. Internal Revenue Code of 1954, Pub. L. No. 83-591, 68A Stat. 3, 169 (1954).

70. *Id.*

71. *People's Educ. Camp Soc'y, Inc.*, 331 F.2d at 935 ("Congressional purpose . . . was to prevent organizations with tax exempt status from competing unfairly with ordinary, taxed business entities.").

72. Myers, *supra* note 49, at 136.

73. *Id.* at 138.

74. Treas. Reg. § 1.501(c)(3)-1(c)(1) (1959).

75. *Id.* § 1.501(c)(3)-1(a)(1).

exemption from federal taxes bear the burden of proving their entitlement to such exemption.[76]

Under this standard, it would appear that since they are not specified by name in I.R.C. § 501(c)(3), hospitals would be required to establish a charitable basis for their exemption.[77] On the contrary, the word "hospital" has become all but synonymous with charitable organization, regardless of the presence, or lack thereof, of any significant charitable pursuits by the hospital organization.[78]

C. *How Do Hospitals Qualify as Tax-Exempt?*

If organizations are required to behave charitably to sustain exemption,[79] how do hospitals whose behavior is less than charitable continue to qualify? If the presence of a single substantial nonexempt purpose bars exemption,[80] how does a hospital with a profit motive that trumps charitable care considerations qualify as exempt?[81] Why is it that the Commerciality Doctrine[82] is seemingly inapplicable to tax-exempt hospitals that occupy a field also populated by for-profit entities? Some critics note that there are few, if any, noticeable differences between the operations of tax-exempt hospitals as compared to for-profits.[83] If the UBIT was enacted to reduce the perceived incidence of unfair competition between tax-exempt entities and for-profits providing the same or similar services,[84] why should tax-exempt hospitals continue to reap benefits from exemption that are unavailable to for-profit hospitals? Commentators estimate that tax-exempt hospitals receive billions in tax subsidies each year.[85]

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76. IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188, 1193 (10th Cir. 2003).

77. *See* I.R.C. § 501(c)(3) (2000).

78. *See* Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 URB. LAW. 143, 166 (1994) (discussing results of a GAO report which estimated that in 1988 tax-exempt hospitals provided uncompensated care equal to 4.8 percent of revenues while for-profit hospitals provided uncompensated care which amounted to 5.2 percent of revenues for the same period).

79. *See* discussion, *supra* Part II.B.

80. *See* discussion *supra* Part II.B.2.a.

81. *See* Rosen & Scott, *supra* note 5, at 36 (discussing alternative means of maintaining exemption).

82. *See* discussion *supra* Part II.B.2.b.

83. Kaplan & Moroney, *supra* note 5, at 58 ("[T]he common assertion is that nonprofit and for-profit hospitals today are remarkably similar in their operations and practices.").

84. *See* discussion *supra* Part II.B.2.b.ii.

85. Colombo, *supra* note 11, at 624; *see also* Gentry & Penrod, *supra* note 16, at 31 (estimating the benefits of exemption from income and property taxes to be more than $6 billion).

Perhaps the history of the tax-exempt hospital in America justifies the origination of the exemption.[86] The current system, however, has little in common with its historical roots and instead reflects a gradual shift in the operation of tax-exempt hospitals away from charitable care and toward for-profit aggrandizement. The remainder of this Comment examines the hospital exemption, tracing the origins of tax-exempt hospitals in America to their current status, advancing an argument for why they should not be considered exempt under the existing legislative regime and recommending changes to the current structure.

III. TAX-EXEMPT HOSPITALS

A. *Historical Perspective*

According to some commentators, the rationale for tax exemption for most charitable organizations cannot be explained through a single theory.[87] For example, one theory suggests that organizations are tax-exempt because of their reliance on government and the "common-sense notion" that government should not tax itself.[88] Others suggest that exemptions for charitable organizations are rooted in our nation's history.[89] The following discussion will demonstrate that, at least for hospitals, the reasons are varied and derive from history, tax policy and social policy.

1. The Charitable Hospital

In the early days of America, hospitals were "asylum[s] for the indigent."[90] Accordingly, when considered in light of our nation's historical predilection to exempt activities designed to

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86. *See* discussion *infra* Part III.A.

87. Hall & Colombo, *supra* note 26, at 1476 n.3 (citing Harvey P. Dale, Rationales for Tax Exemption 2-3 (1988) (unpublished paper) *available at* http://archive.nyu.edu/handle/2451/23377).

88. *Id.* at 1476 n.3 (citing PETER SWORDS, CHARITABLE REAL PROPERTY TAX EXEMPTIONS IN NEW YORK STATE: MENACE OR MEASURE OF SOCIAL PROGRESS? (Colum. Univ. Press 1981)).

89. *See* Rubenstein, *supra* note 26, at 381-82 (discussing the origination of charitable organizations in America).

90. ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 17-51 (Basic Books 1989) (describing the history of healthcare in America and the transformation undertaken by hospitals in the late 19th and early 20th centuries from institutions to ease (though not necessarily treat) the suffering of the poor to "modern scientific" organizations whose specialized treatments would become symbols of social status for the wealthier classes that could afford them).

relieve the incidence of poverty from taxation,[91] it is understandable, if not obvious, why hospitals, as the sole purveyors of medical care for the poor, were initially recognized as tax-exempt entities. What is not so obvious is the continued exemption from federal and most state and local taxes, given the dramatic changes in hospital care and management over the last century.

a. Charitable Immunity

If the inclination towards exemption was derived from the original activities of hospitals, their continued exemption is no doubt owing, at least in part, to early approbation by the courts.[92] Early decisions tended to further entrench the notion that hospitals are inherently exempt from liabilities, be they tax or tort-based, that were assessed against the rest of society.[93]

One noteworthy example of the judicial preference for charitable organizations is the doctrine of charitable immunity, a judicially-created doctrine wherein hospitals could escape tort liability for negligent acts.[94] The doctrine was justified under several theories: trust fund theory,[95] exemption from the doctrine of respondeat superior,[96] implied immunity waiver,[97] and public policy.[98]

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91. Rubenstein, *supra* note 26, at 381-83.

92. STEVENS, *supra* note 90, at 41 (citing Sisters of Third Order of St. Francis v. Bd. of Review of Peoria County, 83 N.E. 272, 273-74 (Ill. 1907) for the proposition that "courts supported the principle of private benevolence as a public good, sui generis").

93. *See, e.g., Sisters of Third Order of St. Francis*, 83 N.E. at 273-74.

94. *See* Paul T. O'Neill, *Charitable Immunity: The Time to End Laissez-Faire Health Care in Massachusetts Has Come*, 82 MASS. L. REV. 223, 227 (1997) (describing the "logically inconsistent, legal fictions, erroneous misapplications . . . [and] poor excuses . . . [advanced to] depriv[e] a victim from just and needed compensation").

95. *Id.* (citing McDonald v. Mass. Gen. Hosp., 120 Mass. 432, 432 (1876) ("A corporation, established for the maintenance of a public charitable hospital, which has exercised due care in the selection of its agents, is not liable for injury to a patient caused by their negligence, nor for the unauthorized assumption of one of the hospital attendants to act as a surgeon.")).

96. *Id.* at 228 (citing Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("It is the settled rule that such a hospital is not liable for the negligence of its physicians and nurses in the treatment of patients.")).

97. *Id.* (citing Powers v. Mass. Homeopathic Hosp., 109 F. 294, 303-04 (1st Cir. 1901) ("One who accepts the benefit either of a public or of a private charity enters into a relation which exempts his benefactor from liability for the negligence of his servants in administering the charity.")).

98. David James Bush, *The Constitutionality of the Charitable Immunity and Liability Act of 1987*, 40 BAYLOR L. REV. 657, 659 (1988) ("[T]he work of charitable organizations should be encouraged and . . . donors to charities might be discouraged if their gifts were applied to the payment of tort claims.").

Though the theories for charitable immunity were legally distinct, courts regularly applied them interchangeably or in conjunction with one another.[99] Further, the myriad of exceptions and nuances involved in applying the various theories of charitable immunity precluded consistent application of the law and by 1940 the doctrine had fallen into disfavor with many academics and judges.[100] The other shoe finally dropped in 1942 when the Court of Appeals for the District of Columbia Circuit announced full abrogation of the charitable immunity doctrine.[101] In reaching its decision, the court in turn examined each of the theories for immunity and rejected all of them in favor of the well-accepted and underlying principle that persons injured through the negligent acts of others are entitled to just compensation.[102] This decision has been said to mark the end of the charitable immunity doctrine as many jurisdictions followed suit and fully abrogated the doctrine.[103] However, some jurisdictions opted for partial immunity and/or immunity based on a strictly narrowed construction.[104]

The notion of hospitals as purely benevolent had all but disappeared by the beginning of the twentieth century.[105] In view of this, it is interesting to observe that it would take almost a half century before American courts would begin to recognize the changed nature of hospitals. Hospitals were no longer the stewards of medical care for the poor.[106] They comprised a thriving industry, admired as much for its devotion to "modern scientific" techniques as for its contribution to defining and furthering the interests of the wealthier classes in America.[107]

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99. *See, e.g.*, Adams v. Univ. Hosp., 99 S.W. 453, 453-54 (Mo. App. 1907) (discussing absence of liability based on alternate theories of exemption from respondeat superior, implied immunity waiver, and public policy).

100. O'Neill, *supra* note 94, at 230.

101. President & Dirs. of Georgetown Coll. v. Hughes, 130 F.2d 810, 828 (D.C. Cir. 1942) ("[A] charity should respond as do private individuals, business corporations, and others, when it does good in the wrong way.").

102. *Id.* at 812 ("For negligent or tortious conduct liability is the rule. Immunity is the exception.").

103. O'Neill, *supra* note 94, at 230 (describing the *Georgetown* opinion as "remov[ing] the last cornerstone justifying charitable immunity"); *see also* Janet Fairchild, Annotation, *Tort Immunity of Nongovernmental Charities—Modern Status*, 25 A.L.R. 4th 517 (1983) (surveying jurisdictions).

104. Fairchild, *supra* note 103, § 6.

105. *See generally* STEVENS, *supra* note 90, at 30-39 (discussing the development of the "pay system" in American hospitals).

106. *Id.* at 17.

107. *See generally id.* at 30-46 (describing the role of hospitals in promoting scientific advancements as well as social superiority for the wealthier classes).

b. On the Tax Front

While the judiciary was struggling with the doctrine of charitable immunity, federal, state, and local governments were struggling to define the parameters of tax-exemption for charitable hospitals. Though, as previously discussed, hospitals were initially considered tax-exempt by virtue of their activities, the judiciary once again sustained the concept of exemption, this time in the tax arena.[108] The court did so in spite of the hospital's increasing abandonment of the charitable aspects of conducting hospital affairs in favor of the business and social rewards inherent therein.[109]

As the previous discussion illustrates, by the time of the enactment of I.R.C. § 501(c)(3)'s predecessor in 1939 (§ 101(6) of the Internal Revenue Code of 1939), hospitals were firmly entrenched through common-law doctrine as tax-exempt charitable entities. Yet no specific reference to hospitals was incorporated into § 101(6) of the Internal Revenue Code of 1939. Indeed, though the I.R.C. has changed numerous times over the years since its first enactment, hospitals have never been incorporated by specific reference into the tax code.[110]

B. *The Current Regulatory Regime*

It is curious that an exemption that provides billions of dollars in tax subsidies each year[111] is not the result of a statutory mandate.[112] As previously noted, there is no specific reference to hospitals in I.R.C. § 501(c)(3).[113] Likewise, the underlying regulations do no more than reiterate the I.R.C.'s inventory of organizations exempt by name.[114] Moreover, Treas. Reg. § 1.501(c)(3)-1(d)(2) defines the term "charitable" without reference to hospitals or to the provision or promotion of healthcare as a charitable activity.[115] While I.R.C. § 501(c)(3)

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108. *See, e.g.*, Sisters of Third Order of St. Francis v. Bd. of Review of Peoria County, 83 N.E. 272, 273 (Ill. 1907) (upholding exemption from property taxes despite the finding that only five percent of hospital's patients were charity cases).

109. *See id.* at 273-74.

110. *See* I.R.C. § 501(c)(3) (2000) (hospitals not enumerated).

111. *See* Gentry & Penrod, *supra* note 16, at 1.

112. *See* I.R.C. § 501(c)(3) (hospitals not enumerated); *see also* Charles Grassley, Ranking Member, Senate Comm. on Fin., Remarks at Roundtable on Nonprofit Hospitals (Oct. 30, 2007), http://www.senate.gov/~finance/press/Gpress/2007/prg103007.pdf ("Congress never changed the law regarding the duties of charity care for nonprofit hospitals—it was done by administrative fiat.").

113. *Id.*; *see also* Rubinstein, *supra* note 26, at 383.

114. *See* Treas. Reg. § 1.501(c)(3)-1 (1959).

115. *Id.* § 1.501(c)(3)-1(d)(2).

ostensibly remains the authorizing statutory provision, the authoritative guidance that defines a charitable hospital can be found in I.R.S. Revenue Rulings.[116]

I.R.S. Revenue Rulings, it has been said, are no more than the I.R.S.'s interpretation of a particular area of law.[117] Not created under the notice-and-comment procedures of 5 U.S.C. § 553,[118] recent U.S. Supreme Court decisions have indicated that I.R.S. Revenue Rulings are entitled to deference only to the extent they are persuasive.[119] Notwithstanding this, the I.R.S. Revenue Rulings that define what it is to be an exempt hospital have survived since their inception in 1956.[120]

1. Revenue Ruling 56-185

If today's tax-exempt hospitals owe any part of their tax-favored status to a history of providing relief from poverty through care of the indigent,[121] the legal theory behind why the exemption persists may be explained by the fact that "the promotion of health is considered to be a charitable purpose" according to the "general law of charity."[122] As previously noted, by early in the twentieth century, most hospitals ceased to define themselves with reference to acts they undertook in furtherance

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116. *See* Rev. Rul. 56-185, 1956-1 C.B. 202; Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 83-157, 1983-2 C.B. 94.

117. *See* Linda Galler, *Judicial Deference to Revenue Rulings: Reconciling Divergent Standards*, 56 OHIO ST. L.J. 1037, 1059 (1995) (discussing the Tax Court's attitude towards revenue rulings); *see also* Peracchi v. Comm'r, 143 F.3d 487, 492 n.13 (9th Cir. 1998) ("A revenue ruling is entitled to some deference as the stated litigating position of the agency which enforces the tax code, but not nearly as much as a regulation."); Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1216 (3d Cir. 1993) (accord).

118. *See* 5 U.S.C. § 553 (2000). For a discussion of the possible implications of not following the notice-and-comment procedures of 5 U.S.C. § 553, see Ryan C. Morris, *Substantially Deferring to Revenue Rulings After Mead*, 2005 B.Y.U.L. REV. 999, 1001-04 (2005) (describing the hierarchy of deference granted by the courts to pronouncements of administrative agencies as being determined with regard to the procedures involved in issuing the pronouncement).

119. *See* Morris, *supra* note 118, at 1004 (stating that the effect of *United States v. Mead*, 533 U.S. 218 (2001) and *Christensen v. Harris County*, 529 U.S. 576 (2000) was that "courts have become the real interpreters of tax law, and revenue rulings have become the IRS's hope, its aspiration."); *cf.* Chevron U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837, 842-43 (1984) (holding administrative agency interpretations of organic statute entitled to deference where the statute is unambiguous and the agency interpretation is reasonable).

120. Rev. Rul. 56-185 was modified (but not replaced) by Rev. Rul. 69-545 which was in turn "amplified" by Rev. Rul. 83-157.

121. *See* Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL. POL'Y & L. 251, 255-56 (1991).

122. Rev. Rul. 69-545, 1969-2 C.B. 117 (citing Restatement (Second) of Trusts § 368 and § 372 (1959)).

of charitable relief of the impoverished.[123] By this time, most hospitals were charging for their services when and where they could.[124]

Prior to 1956, there was no meaningful administrative guidance from the I.R.S. governing hospital exemptions under I.R.C. § 501(c)(3).[125] Case law during the first half of the twentieth century reflected the courts' efforts to rationalize the continued exemption of hospitals despite the transformation from institutions formed to ease the plight of the indigent, to thriving and profit-seeking enterprises.[126] The purpose of Revenue Ruling 56-185 was to set forth affirmative criteria under which hospitals could qualify as exempt.[127] Consequently, Revenue Ruling 56-185 alleviated some of the uncertainty surrounding hospital exemptions and ultimately reduced the litigation surrounding such exemptions.[128]

From a charitable-theory standpoint, Revenue Ruling 56-185 established a common-sense foundation for hospital exemptions that was consistent with traditional notions of what constitutes a charitable activity.[129] Revenue Ruling 56-185 presented two factual scenarios that were on opposite ends of a continuum; with an example of a perfect hospital with the best of all possible factors at one end and a prime example of exemption gone wrong at the other.[130] While there were several characteristics that made the one hospital exempt and the other not,[131] the requirement that a hospital "operate[] to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay" [132] most adequately reflects the charitable tenor of Revenue Ruling 56-185.

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123. *See* STEVENS, *supra* note 91, at 17.

124. *Id.* at 30; *see also* Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 319 (1991) ("[N]onprofit hospitals have increasingly taken on the appearance of business enterprises by serving mostly paying patients.").

125. *See* Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U. L.J. 1015, 1040 (1988).

126. *Id.* at 1038.

127. *See* Rev. Rul. 56-185, 1956-1 C.B. 202.

128. *See* Mancino, *supra* note 125, at 1040-42.

129. *See id.* at 1041.

130. *See* Rev. Rul. 56-185, 1956-1 C.B. 202.

131. Rev. Rul. 56-185, 1956-1 C.B. 202 discusses four basis requirements: (1) organization of the hospital as a nonprofit charitable organization, (2) operation to the extent of financial ability for those unable to pay, (3) open policy with regard to physicians and surgeons, and (4) prohibition against private inurement.

132. *Id.*

Revenue Ruling 56-185 was not without its critics. Determining if a hospital met the ruling's financial-ability test was a difficult proposition. Hospital administrators and the I.R.S. were often in disagreement about whether the hospital actually offered an appropriate level of charitable care.[133] As a result, a number of hospitals were ultimately unable to meet the charitable-care provisions of Revenue Ruling 56-185 and were in danger of losing their exemptions under the new regime.[134] However, 1959 witnessed the arrival of comprehensive revisions to the regulations supporting I.R.C. § 501(c)(3), which defined the term "charitable" with reference to its generally accepted legal meaning.[135] Though revision of the 1959 regulations would expand the charitable universe (at least for hospitals), the concept of promotion of healthcare as a charitable activity was not delineated in the original version of Treas. Reg. § 1.501(c)(3)-1, nor has it ever been added.[136] Promotion of healthcare as a charitable activity made its first official appearance in the administrative guidelines with the advent of Revenue Ruling 69-545.[137]

2. Revenue Ruling 69-545

Many tax-exempt hospitals already were struggling to comply with Revenue Ruling 56-185, when the advent of Medicare and Medicaid in 1965 made it even more difficult because a significant portion of their charitable care recipients were now covered by the government's insurance programs.[138] Revenue Ruling 69-545 was the I.R.S.'s attempt to address concerns by America's tax-exempt hospitals that Medicare and Medicaid would impede efforts to comply with Revenue Ruling 56-185.[139]

Revenue Ruling 69-545 marked the end of charity care as the "touchstone" for hospital exemptions.[140] It modified Revenue Ruling 56-185 to remove the requirement that a hospital provide

133. *See* Rubenstein, *supra* note 26, at 396.

134. Mancino, *supra* note 125, at 1041.

135. *Id.* at 1042 (discussing Treas. Reg. § 1.501(c)(3)-1 (1959)).

136. *See* Treas. Reg. § 1.501(c)(3)-1.

137. Rev. Rul. 69-545, 1969-2 C.B. 117 ("A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may [] qualify as organized and operated in furtherance of a charitable purpose.").

138. *See* Social Security Amendments Act of 1965, Pub. L. No. 89-97, 79 Stat. 290 (1965) (providing healthcare benefits to persons 65 and older); *see id.* at 343 (providing healthcare benefits to qualified persons with insufficient financial means to obtain necessary medical care); *see also* Rubenstein, *supra* note 26, at 396-397.

139. Rubenstein, *supra* note 26, at 397.

140. Colombo, *supra* note 11, at 625.

charity care to the extent of its financial abilities.[141] The ruling states that "promotion of health" is, according to the charitable law of trusts, an exempt activity in and of itself.[142] Based on this ruling, the I.R.S. determined that continued insistence on a requirement that exempt hospitals operate for the indigent to the extent of their financial ability was unwarranted.[143] In place of the "extent of financial ability" standard, Revenue Ruling 69-545 introduced the "community benefit" standard.[144] Under the community benefit standard, which is still in use, a hospital can maintain its exempt status by operating for the benefit of the community "as a whole."[145] According to Revenue Ruling 69-545, an exempt hospital's emergency room must offer emergency treatment for charity patients.[146] Otherwise, the hospital may limit its services to those community members that are willing and able to pay, so long as the benefited class "is not so small that its relief is not of benefit to the community."[147] However, even the emergency room treatment provision is without teeth. Medicare-participating hospitals that have emergency rooms, including for-profit hospitals, are required to treat all emergencies.[148] Therefore, requiring today's tax-exempt hospitals with emergency rooms to provide care without regard to a patient's ability to pay is a meaningless distinction between tax-exempt and for-profit hospitals.[149]

Just as its predecessor had done, Revenue Ruling 69-545 describes two separate fact patterns which attempt to illustrate the differences between what constitutes a tax-exempt hospital and what does not.[150] Like Revenue Ruling 56-185, Revenue Ruling 69-545's examples are at opposite ends of a continuum with insufficient clarification to guide organizations that reside somewhere in the middle.[151] This failure to provide meaningful

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141. Rev. Rul. 69-545.

142. Colombo, *supra* note 11, at 625.

143. Rev. Rul. 69-545.

144. *See* Colombo, *supra* note 11, at 625.

145. *See* Rev. Rul. 69-545 (stating that requirements for exemption established under Rev. Rul. 56-185 remain unchanged).

146. Colombo, *supra* note 11, at 626.

147. Rev. Rul. 69-545.

148. Rosen & Scott, *supra* note 5, at 36-37 (discussing the effects of Medicare and Medicaid programs on tax-exempt and for-profit hospitals).

149. *Id.* at 37.

150. Rev. Rul. 69-545, *see also* Rev. Rul. 56-185, 1956-1 C.B. 202.

151. Rev. Rul. 69-545, *see also* Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26, 49 (1976) (Brennan, J., concurring) ("[M]odif[ications to] . . . Revenue Ruling 56-185 . . . [are] at best ambiguous regarding its application or effect respecting nonprofit hospitals not within the factual and legal situation of Hospital A.").

standards has garnered criticism from even would-be supporters of the revised standards.[152] The ambiguities created an atmosphere of continual and ongoing disagreement about the minimum requirements for maintaining the exemption.[153]

a. Congressional Response

As previously pointed out, neither a per se hospital exemption nor a promotion of healthcare as an exempt activity are found in the I.R.C.[154] or the underlying regulations.[155] In 1969, prior to the issuance of Revenue Ruling 69-545, the House of Representatives launched an effort to incorporate a specific reference to hospitals into I.R.C. § 501(c)(3)'s list of organizations by way of the Tax Reform Act of 1969.[156] The Senate expressly rejected this provision in Senate Report No. 91-552, electing instead to "reexamine [the] matter in connection with pending legislation on Medicare and Medicaid."[157] Concerned that a per se exemption for hospitals would limit access to healthcare for low-income families ineligible for Medicaid, the Senate rejected the House provision on health policy grounds.[158] Consequently, the Senate version prevailed.[159]

As promised, the Senate once again raised the issue of hospital exemptions during Senate Finance Committee hearings held to discuss Medicare and Medicaid.[160] The Committee condemned Revenue Ruling 69-545 as harmful to overall health policy.[161] Ultimately, the Committee recommended its revocation and restoration of the standards that existed under Revenue

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152. *See* Colombo, *supra* note 11, at 626 (discussing the strictures of the community benefit standard).

153. Fox & Schaffer, *supra* note122, at 258-59 (discussing varied interpretations of Rev. Rul. 69-545).

154. *See* I.R.C. § 501(c)(3) (2000).

155. *See* Treas. Reg. § 1.501(c)(3)-1 (1959).

156. *See* H.R. REP. NO. 91-413 (1969), *as reprinted in* 1969 U.S.C.C.A.N. 1645, 1689 ("[H]ospitals otherwise meeting the requirements of [I.R.C. § 501(c)(3)] are exempt.").

157. S. REP. NO. 91-552 (1969), *as reprinted in* 1969 U.S.C.C.A.N. 2027, 2090 (deleting provision in spite of the fact that the House proposal would "conform[ ] the Code to the result reached by the 1969 ruling"); *see also* Fox & Schaffer, *supra* note 122, at 265 ("[T]he Senate Finance Committee deleted the change recommended by the House because it was [ ] redundant" in light of the I.R.S.'s recent issuance of Revenue Ruling 69-545).

158. Fox & Schaffer, *supra* note 122, at 264.

159. *See* Tax Reform Act of 1969, Pub. L. No. 91-172, 83 Stat. 487 (1969) (noting no changes to I.R.C. § 501(c)(3)); *see also* H.R. REP. NO. 91-782 (1969) (Conf. Rep.), *as reprinted in* 1969 U.S.C.C.A.N. 2392, 2404 (accepting Senate revisions).

160. Fox & Schaffer, *supra* note 122, at 266.

161. *Id.*

Ruling 56-185.[162] In spite of all this, Congress took no further action at the time to invalidate the ruling.[163]

b. Judicial Response

In the earliest case to examine the validity of Revenue Ruling 69-545, a group of indigents brought suit in the District of Columbia Circuit, requesting declaratory and injunctive relief with regard to the validity of Revenue Ruling 69-545 and actions taken by the I.R.S. in accordance with the ruling.[164] Alleging "injury in their opportunity and ability to receive hospital services in nonprofit hospitals,"[165] plaintiffs asked the court to find that the I.R.S. had acted unlawfully in approving tax exemptions for hospitals without regard to their provision of care for the indigent.[166] Plaintiffs further requested that the court prohibit the I.R.S. from granting exemption to hospitals in reliance on Revenue Ruling 69-545 and require that the I.R.S. withdraw the ruling and revoke the exemption of organizations not in compliance with the standards previously set forth for exemption.[167] After dedicating considerable discussion to the issue of standing,[168] the court ultimately held in favor of the plaintiffs, finding the I.R.S. had exceeded its authority in permitting hospitals to qualify as exempt without regard to the level of care made available to those unable to pay.[169] As a result, the I.R.S. was enjoined from granting tax-exempt status to hospitals and permitting charitable contribution deductions as otherwise permitted under I.R.C. § 170 unless and until the hospital had complied with Revenue Ruling 56-185.[170] The Court of Appeals for the District of Columbia, agreeing that plaintiffs had standing, reversed the district court's ruling, finding that the I.R.S.'s interpretation of I.R.C. § 501(c)(3) and the issuance of Revenue Ruling 69-545 were "not contrary to any express

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162. Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 46-47 (1995).

163. Fox & Schaffer, *supra* note 122, at 266 (suggesting reasons for the Committee's failure to act on perceived deficiencies of Revenue Ruling 69-545, such as "preoccup[ation] with . . . rising costs for Medicare and Medicaid").

164. *See* E. Ky. Welfare Rights Org. v. Shultz, 370 F. Supp. 325, 326-27 (D.D.C. 1973), *rev'd sub nom.* E. Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976).

165. *Simon*, 426 U.S. at 33 (citing complaint filed with the district court).

166. *Schultz*, 370 F. Supp at 326.

167. *Id.* at 326-27.

168. *Id.* at 329-34 (finding the plaintiffs had standing).

169. *Id.* at 338.

170. *Simon*, 426 U.S. at 35 n.13.

Congressional intent."[171] The case went to the Supreme Court of the United States which ultimately held the case to be nonjusticiable due to lack of standing by the respondents (plaintiffs in the original action).[172] In spite of this, the Court appears to accept the notion that Revenue Ruling 69-545 may have "encourag[ed] a hospital to provide fewer [medical] services to indigents."[173] Shortly thereafter, the Sixth Circuit in *Lugo v. Miller* unsurprisingly rejected a similar claim for the same reasons. [174]

Beyond *Simon* and *Lugo*, no attempts have been launched in the courts to directly challenge the validity of Revenue Ruling 69-545.[175] The Tax Court chose to adopt the reasoning of the District Columbia Circuit's opinion in *Simon* regarding the ruling's validity.[176] They did so in spite of the fact that *Simon* holds no precedential value for purposes of validating the ruling.[177] Moreover, in vacating the District of Columbia Circuit, the Supreme Court was careful not to discuss the merits of Revenue Ruling 69-545.[178] This, of course, leaves the $64,000 question unanswered: is Revenue Ruling 69-545 a proper exercise of I.R.S. authority?

The ambiguity concerning what Revenue Ruling 69-545 requires has added several layers of complexity to this question.[179] For example, the meaning of "community benefit standard" has been discussed and debated ad nauseam among legal commentators for more than thirty years.[180] The judicial response has not added any substantive clarification. Most courts have applied their own particular interpretation of

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171. *E. Ky. Welfare Rights Org.*, 506 F.2d at 1290.

172. *Simon*, 426 U.S. at 44-46.

173. *Id.* at 42 n.23.

174. Lugo v. Miller, 640 F.2d 823, 831 (6th Cir. 1981).

175. *See* Fox & Schaffer, *supra* note 122, at 251 (describing early judicial response to Rev. Rul. 69-545).

176. *See* Sound Health Ass'n v. Comm'r, 71 T.C. 158, 178-80 (1978) (citing E. Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (1974)).

177. *See Simon*, 426 U.S. at 44-46 (vacating lower court's decision on grounds of justiciability).

178. *Id.* at 35, 43 (discussing the lower courts' reasoning as to the validity of Rev. Rul. 69-545 without approval or condemnation).

179. Fox & Schaffer, *supra* note 122, at 258-59.

180. *Compare, e.g.*, J. David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 2 HEALTH MATRIX 35, 38 (1992) (arguing in favor of an interpretation of the community benefit concept as awarding tax-exemption to those organizations that are "governed and managed in a manner beneficial to the community"), *with* Jack Hanson, *Are We Getting Our Money's Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals*, 17 LOY. CONSUMER L. REV. 395, 397 (2005) ("Charity care is the most important among the community [ ] benefits that nonprofit hospitals are expected to provide . . . .").

Revenue Ruling 69-545,[181] and "no clear test has emerged to apply to nonprofit hospitals seeking tax exemptions."[182] Adding insult to injury, the I.R.S. has wavered in its interpretation and enforcement of Revenue Ruling 69-545 over the period since its promulgation.[183]

c. The Rubber Meets the Road

Revenue Ruling 69-545 is founded on the premise that the promotion of health is a per se charitable activity.[184] But this foundation is somewhat undermined by the I.R.S.'s stance in *Geisinger Health Plan v. Commissioner*.[185] In *Geisinger*, the I.R.S. contended that, despite the taxpayer HMO's promotion of healthcare, some additional "indicia of charity" is required to sustain exemption under I.R.C. § 501(c)(3).[186]

This statement belies the notion that the promotion of health is charitable in its own right. If an activity is deemed to be charitable in nature, it seems anomalous to require additional charitable characteristics to sustain exemption.[187] In point of fact, other inherently charitable organizations carry no similar burden. An exempt educational organization fulfills its charitable purpose by educating.[188] Likewise, a religious organization need only advance religion to fulfill its charitable purpose,[189] and so on. Of course, Congress or the I.R.S. could have opted for a more meaningful set of standards for determining exemption, but they have thus far declined to do so.

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181. *See, e.g.*, Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1219 (3d Cir. 1993) ("[T]he relevant inquiry . . . [is] whether [an organization] *primarily* benefit[s] the community . . . .") (emphasis added); St. David's Health Care Sys. v. United States, 349 F.3d 232, 236 n.4 (5th Cir. 2003) ("[A] hospital need not demonstrate every factor set forth in Revenue Ruling 69-545 in order to qualify for a tax exemption.").

182. *Geisinger Health Plan*, 985 F.2d at 1217.

183. *See* Fox & Schaffer, *supra* note 122, at 251, 273-74 (noting the absence of attention or enforcement by the I.R.S. for twenty years).

184. Rev. Rul. 69-545, 1969-2 C.B. 117, 118 ("A nonprofit organization whose purpose and activity are providing hospital care is promoting health and . . . qualif[ies] as organized and operated in furtherance of a charitable purpose."); *see also* Sound Health Ass'n v. Comm'r, 71 T.C. 158, 178 (1978) ("[T]he rendering of medical care is a charitable activity.").

185. 985 F.2d at 1216.

186. *Id.*

187. This is not to suggest, however, that the other strictures of I.R.C. § 501(c)(3) need not be met—they are universally applicable to all charitable entities. *See* I.R.C. § 501(c)(3) (2000).

188. *See* Treas. Reg. § 1.501(c)(3)-1(d)(3)(i) (1959) (defining "educational" as including "instruction or training of the individual . . . or . . . the public" to improve or develop competencies).

189. *Id.* § 1.501(c)(3)-1(d)(1)(i)(a).

To make matters worse, there is evidence to suggest that the I.R.S. may have relied on inaccurate information derived from self-serving statements in formulating the standards set forth in Revenue Ruling 69-545.[190] According to an examination into the history of the ruling, hospital-industry representatives convinced the I.R.S. in 1969 that the advent of Medicare and Medicaid had eliminated the need for free medical services.[191] Current circumstances suggest that nothing could be further from the truth and "[p]oor people shouldn't have to suffer because Treasury and I.R.S. got the facts wrong in 1969."[192]

The I.R.S.'s promulgation of Revenue Ruling 69-545 opened a Pandora's Box for healthcare in this country. Neither Congress nor the I.R.S. could have anticipated the untoward consequences that a tax ruling would engender in the area of health policy.[193] The I.R.S. was oblivious, at least in 1969, to the fact that they were making health policy in introducing what they thought to be a mere interpretation of tax law.[194] Commentators, however, suggest that this is precisely what happened[195] and the fallout has, at a minimum, contributed to instances of uncharitable conduct by tax-exempt hospitals in the delivery of healthcare services to indigent Americans.[196]

To be fair, it was unclear in 1969 what the recent implementation of Medicare and Medicaid would ultimately mean to healthcare in the United States.[197] Yet the obvious

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190. *See* Fox & Schaffer, *supra* note 121, at 259-62 (recounting the historical background of Rev. Rul. 69-545); *see also* Memorandum from the U. S. Senate Committee on Finance to Reporters and Editors (July 14, 2006), http://www.senate.gov/~finance/press/Gpress/2005/prg071406.pdf [hereinafter Memorandum] (statement of Sen. Grassley, Chairman, U.S. Senate Comm. on Fin.) ("[I]t is clear that the IRS and Treasury decision to change the rules regarding charity hospitals in 1969 was based on extremely inaccurate information.").

191. *See* Fox & Schaffer, *supra* note 121, at 262 (referring to the ruling author's assertion that "he accepted claims by hospital administrators that 'they couldn't find patients to whom to give free care'"); *see also* Memorandum, *supra* note 191 ("The IRS . . . listened to the lobbyists who hoodwinked the IRS and Treasury that inability to afford medical care was a problem of the past.").

192. Memorandum, *supra* note 191.

193. *See* Fox & Schaffer, *supra* note 121, at 266 (discussing the health policy implications of Rev. Rul. 69-545).

194. *Id.* at 253.

195. *See id.* at 260 (noting lack of coordination between the I.R.S. and the Department of Health, Education, and Welfare such that "the Service was acting as if it were the only agency in the executive branch").

196. *Id.* at 273; *see also* Merritt A. Dattel, Policy Comment, *A Game of Hide and Seek: A Critique of the Free Care System of Non-Profit Hospitals in Massachusetts*, 2 J. HEALTH & BIOMEDICAL L. 129, 130 (2006) (discussing the effects of denied access to healthcare services on indigents).

197. *See, e.g.*, Colombo, *supra* note 11, at 625 (describing issuance of Rev. Rul. 69-545 as the I.R.S.'s response to claims by the hospitals that "Medicare and Medicaid programs

inconsistency between the I.R.S.'s promulgation of Revenue Ruling 69-545 and Congress' deliberate rejection,[198] coupled with the subsequent (and continued) failure by Congress to codify,[199] seems to be a clear indicator that the I.R.S.'s action was taken without the appropriate political safeguards required of important policy decisions in this country.[200] The inconsistency is particularly obvious when viewed through the lens of hindsight and in consideration of the events currently unfolding. The past several decades are replete with hearings and investigations on the matter of hospital exemptions.[201] In spite of this, Congress remains reluctant to address this issue with affirmative legislation.[202]

While *Simon* and *Lugo* silenced would-be plaintiffs who would attempt to invalidate hospital exemptions on the basis of an improperly issued revenue ruling,[203] the silence was not to last.[204]

3. Revenue Ruling 83-157: The Last Nail

It has been suggested that Revenue Rulings 56-185 and 69-545 comprise the "entire body of law" governing hospital

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would eliminate demand for charity care"); *see also* James B. Simpson & Sarah D. Strum, *How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered*, 14 U. PUGET SOUND L. REV. 633, 653 (1991) (referring to a prevailing feeling in the medical community and government that Medicare and Medicaid would "do away with medical indigency").

198. *See* discussion *supra* Part III.B.2.a.

199. *See* I.R.C. § 501(c)(3) (2000).

200. *See* David Schoenbrod, *Separation of Powers and the Powers That Be: The Constitutional Purposes of the Delegation Doctrine*, 36 AM. U. L. REV. 355, 356 (1987) ("[T]he framers intended that the [A]rticle I legislative process would provide safeguards for public welfare and individual values . . . ."); *see also* Fox & Schaffer, *supra* note 121, at 255 ("[T]he Internal Revenue Service . . . act[ed] outside the normal channels of accountability for the health and welfare of Americans.").

201. *See* Crimm, *supra* note 163, at 38 n.141 (recounting the history of Congressional hearings discussing hospital exemptions from 1969 through 1993); *see also* Jamie Brashear et al., *Survey of Recent Developments in Health Law*, 39 IND. L. REV. 1051, 1072 (2006) (discussing 2004 and 2005 Congressional hearings on hospital exemptions).

202. *See* Memorandum, *supra* note 191 (seeking assurances from the Treasury and the I.R.S. that new guidance will be forthcoming); *see also Hearing on Nonprofit Hospitals*, *supra* note 6 (statement of Senator Grassley, Chairman, Senate Comm. on Fin.) (suggesting that the problem can be fixed without statutory changes); Elizabeth A. Grover, *Grassley Praises Catholic Hospital Group, Pans Another for Charity Care Accounting*, 223 Daily Tax Rep. (BNA), at G-13 (Nov. 20, 2006) (quoting GPO finance spokeswoman as saying that "[i]f [the I.R.S. and Treasury] put out better guidance . . . [Grassley] won't need to consider legislation"). *But see* Tax Exempt Hospitals Responsibility Act (TEHRA), H.R. 6420, 109th Cong. § 3 (2006) (proposing the adoption of minimum levels of charity care, imposition of excise taxes for infractions, and requirement of disclosure to patients regarding fees and admission policies).

203. *See* discussion *supra* Part III.B.2.b.

204. *See* discussion *infra* Part III.C.1.

exemptions.[205] But Revenue Ruling 83-157 is at least worthy of mention for its further retreat from the origins of hospital exemptions. Revenue Ruling 83-157 modified Revenue Ruling 69-545, eliminating the *absolute* requirement of an emergency room from the community benefit standard.[206]

C. *Today's Charitable Hospital: A Contradiction in Terms?*

Notwithstanding the faulty logic supporting the regulatory regime, tax-exempt hospitals are not under fire because of a failure by Congress or the I.R.S. to articulate proper standards for exemption. On the other hand, their inertia has no doubt contributed to the perceived misconduct for which tax-exempt hospitals are being criticized.[207] This is not to say that tax-exempt hospitals on the whole are not providing uncompensated care.[208] Most tax-exempt hospitals do provide some level of uncompensated care and many provide substantial amounts of uncompensated care.[209] But for-profit hospitals also provide uncompensated care and there is some indication that they provide as much as some tax-exempt hospitals.[210] Indeed, all hospitals with emergency care facilities are required to render emergency assistance to patients without regard to their ability to pay,[211] or be subjected to fines and damages for failure to do so.[212] The problem in this regard is not the charity care requirement, but rather the manner in which it is being applied.

Numerous news reports have detailed the stories of uninsured patients without any meaningful ability to pay who

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205. Mancino, *supra* note 125, at 1037.

206. Rev. Rul. 83-157, 1983-2 C.B. 94-95. *But see* James J. McGovern & T.J. Sullivan, *Managed Health Care: Does It Offer a Cure for the Nation's Health Care Ills?*, C653 A.L.I.-A.B.A. 233, 236 (1991) (emphasizing the narrow circumstances under which an emergency room providing uncompensated care is not required); *see also* IHC Health Plans v. Comm'r, 325 F.3d 1188, 1197 (10th Cir. 2003) (providing healthcare to the community for a fee insufficient by itself to meet community benefit standard).

207. *See* Fox & Schaffer, *supra* note 121, at 251-54.

208. Uncompensated care in this context includes charity care and bad debt. *See* CBO, *supra* note 21, at 2.

209. *See* Memorandum, *supra* note 191 ("Some charity hospitals are doing a little, some a lot, and some nothing.").

210. *See* CBO, *supra* note 21, at 8 (noting some research indicates that differences in uncompensated care provided by tax-exempt and for-profit hospitals is minimal); *see also* Letter from Mark W. Everson, Comm'r, I.R.S., to Charles E. Grassley, Chairman, Senate Comm. on Fin. (Mar. 30, 2005), http://www.senate.gov/~finance/hearings/other/Letter%20from%20Everson.pdf.

211. 42 U.S.C. § 1395dd(a) (2000) ("[T]he hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists.").

212. *Id.* § 1395dd(d).

have received less than charitable treatment from tax-exempt hospitals.[213] Patients are generally required to agree to pay before they are given treatment.[214] As a result, patients are effectively signing blank checks when they so agree because neither they nor the hospital have any idea at that point how much the bill is going to be. On leaving the hospital, even patients making reasonable attempts to meet their obligations may find themselves in an untenable situation. The payments to the hospital may not even cover the interest that the hospital tacks on to the amount due.[215] After years of paying the hospital more than they can afford, a patient may find to his dismay not only that the debt has not decreased, but that it has substantially increased.[216] But the patient keeps making payments because if he begins to miss payments, debt collectors acting on behalf of the hospital will begin hounding him.[217] At a minimum, the patient's credit rating will suffer. But the patient may also be subject to garnishment or liens.[218] In one surrealistic example, a hospital even tried to attach a lien to a body part.[219] What makes this situation even more disturbing is that an insured patient receiving identical services would be charged less.[220] The final insult comes after tax-exempt hospitals, having harassed patients incessantly for payment, finally make a business decision to write off the amount due. In doing so, the hospital includes this bad debt as part of its community benefit.[221] As

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213. *See generally* Beverly Cohen, *The Controversy over Hospital Charges to the Uninsured—No Heroes, No Villains*, 51 VILL. L. REV. 95, 98-103 (2006) (discussing a series of 2003 Wall Street Journal articles concerning hospital billing and collection practices); *see also* Fox & Schaffer, *supra* note, 122, at 273 ("[R]efus[al of] emergency care to patients unable to pay . . . had become so common as to be the stuff of newspaper stories . . . .").

214. *See* Maldonado v. Ochsner, 237 F.R.D. 145, 154 (E.D. La 2006) (alleging plaintiffs were required to sign a contract prior to services being rendered).

215. *See* Cohen, *supra* note 214, at 98.

216. *See, e.g.*, *id.* (citing Lucette Lagnado, *Twenty Years and Still Paying*, WALL ST. J., Mar. 13, 2003, at B1) (describing how an "$18,740 hospital bill had blossomed to nearly $55,000 after the addition of interest and fees").

217. *See, e.g.*, Carlson v. Long Island Jewish Med. Ctr., 378 F. Supp. 2d 128, 130 (E.D.N.Y. 2005) (alleging "unconscionable collection practices" by hospitals); *see also* Cohen, *supra* note 214, at 103-05 (citing "investigational reports" on hospital practices).

218. *See* Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 565-66 (2006) (discussing state lien statutes for medical services).

219. *See* Cohen, *supra* note 214, at 102-03 (citing Lucette Lagnado, *Medical Seizures: Hospitals Try Extreme Measures to Collect Their Overdue Debts*, WALL ST. J., Oct. 30, 2003, at A1) (referring to the Carle Foundation Hospital's execution of a "body attachment").

220. *See* Cohen, *supra* note 214, at 100-01.

221. *See* David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, 23 J. Corp. L. 741, 758 & n.61 (1998). *But see* Rev. Rul. 56-185, 1956-1 C.B. 202

unbelievable as it may seem, this situation illustrates the nonsensical and inequitable treatment that indigent, uninsured patients often endure at today's charitable hospitals.[222]

1. Enough Is Enough: Back to Court

Beginning in 2004, litigation surrounding hospital exemptions began anew.[223] Taking lessons from *Simon*, the plaintiffs in recent litigation did not seek to invalidate hospital exemptions by attacking the validity of Revenue Ruling 69-545, but rather approached the problem from a different angle.[224]

Brought in both federal and state court, many of these lawsuits proceeded on the theory that tax-exempt hospitals had breached their fiduciary duty to the public.[225] The complaints alleged that hospitals, exempt under I.R.C. § 501(c)(3), owed a duty to the public to act on its behalf.[226] According to the plaintiffs, tax-exempt hospitals violated the public trust through improper billing practices, aggressive debt collection efforts, and failure to provide charitable care.[227] At the present time, however, most of these suits have been dismissed for want of standing.[228] The courts have held that I.R.C. § 501(c)(3) does not permit a private right of action against organizations for failure to fulfill their charitable mandates.[229] Likewise, the public lacks standing as a third-party beneficiary of a purported contract created when an organization receives exemption under I.R.C. § 501(c)(3).[230]

(requiring calculation of charity care without regard to bad debt); CBO, *supra* note 21, at 7 (discussing Catholic Health Association's standards requiring omission of bad debt from community benefit computation).

222. *See generally* Cohen, *supra* note 214, at 98-103 (recounting tales of hard-hearted hospital billing and collection practices).

223. *See id.* at 111-12 (discussing a series of class-action lawsuits).

224. *See id.* at 112-14 (describing the various complaints alleged in 2004 lawsuits against hospitals).

225. *See, e.g.*, *id.* at 113 (citing Class Action Complaint for Violations of the Fair Debt Collection Practices Act (15 U.S.C. § 1692, *et seq.*), Breach of Contract, Breach of Duty of Good Faith and Fair Dealing, Violations of New York General Business Law Section 349, Unjust Enrichment, Constructive Trust, Injunctive Relief and Declaratory Relief at 27, Carlson v. Long Island Jewish Med. Ctr., 378 F. Supp. 2d 128 (E.D.N.Y. 2004) (No. CV 04 3086); *see also*, Maldonado v. Ochsner, 237 F.R.D. 145, 152-53 (E.D. La. 2006); McCoy v. E. Tex. Med. Ctr. Reg'l Healthcare Sys., 388 F. Supp. 2d 760, 761 (E.D. Tex. 2005).

226. *See, e.g.*, *Maldonado*, 237 F.R.D. at 152-53; *McCoy*, 388 F. Supp. 2d at 761.

227. *See Maldonado*, 237 F.R.D. at 152-53.

228. *See McCoy*, 388 F. Supp. 2d at 768, 770 (dismissing claims for lack of standing under I.R.C. § 501(c)(3)); *cf. Maldonado*, 237 F.R.D. at 155 (denying class certification); Colomar v. Mercy Hosp., 242 F.R.D. 671, 673 (S.D. Fla. 2007) (same).

229. *See, e.g.*, *McCoy*, 388 F. Supp. 2d at 769-70.

230. *See id.* at 768.

Since the American public appears to lack standing to compel tax-exempt hospitals to comply with the letter and spirit of I.R.C. § 501(c)(3),[231] it is up to Congress and the I.R.S. The healthcare demands of the aging baby-boomer population will continue to increase competition for medical services.[232] Tax-exempt hospitals, left to their own devices, will likely continue to minimize charitable care in order to devote available resources to supplying the demand for services created by an aging population. Something must give, and soon.

IV. THE TAX-EXEMPT HOSPITAL: HOW CAN IT BE FIXED?

Notwithstanding the problems inherent in the current system, most tax-exempt hospitals provide some level of charity care and certain tax-exempt hospitals provide significant charitable care.[233] Moreover, some tax-exempt hospitals are also conducting activities that otherwise qualify for exemption under I.R.C. § 501(c)(3), such as education and scientific research.[234] But with forty-seven million Americans uninsured[235] and hospitals engaging in suspect conduct to collect fees, the status quo is unacceptable. What is needed is a set of standards that require hospitals to behave more charitably. In addition, these standards should clearly articulate what is required in order for a hospital to maintain its tax-exempt status.[236]

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231. *See* Fox & Schaffer, *supra* note 122, at 272 (noting the "unreviewable" status of Rev. Rul. 69-545).

232. *See* U.S. Dep't of Health and Human Servs., *Physician Supply and Demand: Projections to 2020, Growth and Aging of the Population*, http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/growthandaging.htm (last visited Jan. 2, 2008).

233. *See* CBO, *supra* note 21, at 2 (examining uncompensated care provided by hospitals in five states).

234. *See* Mancino, *supra* note 126, at 1031; *see also* Shelley A. Sackett, *Conversion of Not-for-profit Health Care Providers: A Proposal for Federal Guidelines on Mandated Charitable Foundations*, 10 STAN. L. & POL'Y REV. 247, 248 (1999).

235. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 18 (2007), http://www.census. gov/prod/2007pubs/p60-233.pdf.

236. *See Hearing on the Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. (2005) (testimony of David M. Walker, Comptroller General, U.S. General Accountability Office) *available at* http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2711 (suggesting that criteria could be established that would "allow nonprofit hospitals to be held accountable for providing services . . . to the public commensurate with their favored tax status").

A. *Redefining Charitable Care*

1. An Ounce of Prevention

At present, a hospital can meet the community benefit standard set forth in Revenue Ruling 69-545 by maintaining an emergency room that provides services to members of the community without regard to their ability to pay for such services.[237] Disregarding the fact that the resulting arrangement is fraught with aspects that render the benefit less than charitable,[238] the community benefit standard may result in higher costs to both the hospital and the patient. Uninsured patients cannot afford preventive care and so will inevitably wait until what may have been a minor illness evolves into a full-on emergency.[239] If hospitals were required, as a condition of exemption, to provide free preventive and routine care, perhaps in a clinic setting, the overall costs to both parties may be reduced.[240] Tax-exempt hospitals may resist such a requirement because, in order for this to work, patients would have to understand, in advance, that they are not required to pay for these services. Under the current regime, many jurisdictions do not require hospitals to notify patients that they may be eligible for charitable care.[241]

Hospitals should still be required to provide free emergency care, unless sufficient services are available at other area hospitals. This aspect of the current structure[242] should remain unchanged.[243] Furthermore, even hospitals that conduct other charitable activities should be required to comply with these rules.

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237. *See* Rev. Rul. 69-545, 1969-2 C.B. 117-18.

238. *See* discussion *supra* Part III.C.

239. *See* Cohen, *supra* note 214, at 106 (citing FAMILIES USA, GOING WITHOUT HEALTH INSURANCE: NEARLY ONE IN THREE NON-ELDERLY AMERICANS 15 (2003), http://www.familiesusa.org/assets/pdfs/Going_without_report3b26.pdf.

240. *See id.*

241. *See id.* at 103-04 (citing several studies that indicated "hospitals did not tell the uninsured about charity care, did not offer charity care, did not discount bills to the uninsured and aggressively pursued payment").

242. *See* Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 83-157, 1983-2 C.B. 94.

243. *Cf.* STAFF OF S. FIN. COMM. - MINORITY, 110TH CONG., TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT 7, http://www.senate.gov/~finance/press/Gpress/2007/prg071907a.pdf [hereinafter DISCUSSION DRAFT]. (calling for an annual minimum of five percent devoted to charity care calculated as a percentage of either revenue or expenses)

2. Transparency

In spite of the requirement that a tax-exempt hospital's emergency room provide care to persons without regard to their ability to pay, most seek payment for services rendered.[244] Not advised by the hospitals of their right to charity care, indigent patients are generally ignorant of the fact that they may receive services without payment.[245]

Tax-exempt hospitals should be required to make full disclosure to emergency room patients regarding their tax-exempt status.[246] Patients should be advised that they may be eligible for free care under certain circumstances. In order to curb abuse by persons that are financially able to pay, hospitals could require emergency room patients to agree to make payment in the event they are unable to meet federal guidelines for free care. Congress and the I.R.S., in conjunction with the U.S. Department of Health and Human Services, could establish such guidelines much the same way that they establish guidelines for other governmental services.[247] Critics would oppose such measures as they would invariably entail higher administrative costs for the hospital. But the result is that persons who truly need free medical care would be receiving it.

Guidelines for debt collection by hospitals and those acting as agents for the hospital should be refined to eliminate aggressive practices for hospitals seeking payment for emergency services. The exigencies of a situation generally require patients to accede to the hospital's payment terms to obtain treatment for serious illness or injury. To later harass the patients to collect this debt is unseemly. This type of coercive behavior has no place within the context of a charitable activity.

3. Parity

The reduced revenues that hospitals receive from private and government insurance are being subsidized by higher charges to non-insured patients, the ones that can least afford to

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244. *See* Cohen, *supra* note 214, at 103-04 (discussing investigations into hospital billing practices).

245. *See id.* at 96.

246. *See, e.g.*, DISCUSSION DRAFT, *supra* note 244, at 6 (recommending that tax-exempt hospitals be required to develop and make widely available a written charity care policy that describes benefits, eligibility, and procedures for obtaining charity care).

247. *See, e.g.*, TEHRA § 4968A(b) (proposing "maximum allowed charges" to uninsured individuals by reference to their annual income in relation to the poverty line established under 42 U.S.C. § 9902).

pay increased costs.[248] New legislation for tax-exempt hospitals should require that hospitals not be permitted to charge uninsured patients more than the average charge to insured patients.[249] Uninsured patients who ultimately pay should not be required to pay more than their insured counterparts.

There is some evidence to suggest that a hospital's pricing structure is dictated by an interpretation of Medicare legislation that prohibits the hospital from reducing charges to patients.[250] There is also a concern that if the price is lowered, revenues from private insurance, which typically pays a percentage of the reasonable charge, would suffer.[251] Clearly, there are collateral issues that would need to be addressed with other agencies of the government at both federal and state levels. Inter-agency cooperation is indispensable to correct what has become a national healthcare crisis.[252] The problem cannot be fixed by one agency alone. The inadequacies of Revenue Ruling 69-545 illustrate this point.[253]

4. Transition

Hospitals not wishing to comply with a new regulatory regime should be permitted to convert to for-profit status over a specified number of years. Moreover, guidance should be provided that establishes safe-harbor provisions for conversion.[254] The conversion to for-profit status is generally accomplished when the tax-exempt hospital sells its healthcare

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248. *See* Leah Snyder Batchis, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 494-95 (2005) ("[U]ninsured patients are charged 15-50% more than what is paid by private insurance companies and government healthcare programs.").

249. *See* TEHRA § 4968A(a) (imposing an excise tax on medical care providers that overcharge low-income uninsured individuals for "specified medically necessary care"). *Cf.* DISCUSSION DRAFT, *supra* note 244, at 13-14 (suggesting that medically indigent patients should be charged the lower of cost of service or the amount that would be reimbursed by Medicare/Medicaid).

250. *See* Cohen, *supra* note 214, at 107 ("[F]ederal fraud and abuse laws aimed at preventing overbilling to the Medicare system may have inadvertently inhibited hospitals from offering reduced charges and from forgiving debt.") (citing CAROL PRYOR & ROBERT SEIFERT, THE COMMONWEALTH FUND, UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT 4 (2003), http://www.accessproject.org/downloads/unintended.pdf).

251. PRYOR & SEIFERT, *supra* note 251, at 5.

252. *See* Fox & Schaffer, *supra* note 121, at 276-77.

253. *See id.* at 276-78; *see also* DISCUSSION DRAFT, *supra* note 244, at 5 ("The community benefit standard has been widely viewed as a failure . . . in providing measurable benefits to low-income families.").

254. *See generally* Sackett, *supra* note 235, at 253-57 (presenting proposals for conversion to for-profit status of tax-exempt hospitals).

assets to a for-profit entity.[255] Care must always be taken that the sale is transacted at fair market value. In the event that the assets are sold for less than fair market value, the I.R.S. could allege an excess benefit transaction[256] or private benefit.[257] An incorrect valuation, which can be highly subjective, can result in big penalties to participants to the transaction.[258] Safe-harbor rules that define standards for valuation could minimize the risk to hospitals that wish to divest themselves of the burdens associated with exemption.

V. CONCLUSION

The foundation on which hospital exemption stands is somewhat unstable. Congress has declined for almost a century to draw a clear line of demarcation where hospitals are concerned. Accordingly, nothing in the I.R.C. speaks to a per se exemption for hospitals.[259] Indeed, Congress has rejected out-of-hand proposals to add it.[260] The foundation is no less unstable because the I.R.S. borrowed from the charitable law of trusts when it adopted healthcare as a charitable activity in promulgating Revenue Ruling 69-545.[261]

As the above discussion illustrates, many of today's hospitals do not behave charitably. They sacrifice charitable goals in favor of profit-seeking activities. This is a substantial non-exempt purpose and should disqualify from exemption those hospitals that make such a sacrifice.[262] But the history of hospital exemptions in America has supported the continued exemption of hospitals. This is true even though the system we have today has little in common with the exempt hospital of early America. It is time to dispense with our traditional notions of the hospital as a purveyor of services to the poor and acknowledge the real

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255. *See id.* at 250-51 (describing the process of conversion).

256. *See* I.R.C. § 4958 (2000) (imposing excise taxes on transactions where the "economic benefit . . . provided [by the exempt organization] exceeds the value of the consideration . . . received for providing such benefit").

257. *See, e.g.*, Caracci v. Comm'r, 118 T.C. 379, 413 (2002) (finding the sale of home health care organizations yielded more than $5 million in excess benefits under I.R.C. § 4958), *rev'd*, 456 F.3d 444, 462 (5th Cir. 2006) (finding I.R.S. did not meet its burden of proof in establishing valuation of business).

258. *See* I.R.C. § 4958 (2000) (allowing for a 25 percent tax on any disqualified person who is involved in an excess benefit transaction. If the problem is not corrected, a 200 percent tax on the disqualified party may be assessed).

259. *See, e.g.*, I.R.C. § 501(c)(3) (2000).

260. *See* discussion *supra* at Part III.B.2.a.

261. *See* discussion *supra* at III.B.2.c.; *see also* Fox & Schaffer, *supra* note 121, at 256 ("Congress could not have meant 'charitable' in the broad common law sense.").

262. *See* discussion *supra* Part II.B.2.a.

truth: hospitals in America today are big business and, in many cases, charitable goals are secondary to other non-exempt purposes.

What is needed is legislation that requires increased charitable conduct in return for exemption.[263] Legislation designed to address the underlying problems would entail adding preventive and routine care to the gambit of services offered by tax-exempt hospitals. In addition, tax-exempt hospitals would be required to behave in a charitable manner by advising eligible patients of their right to free care, curtailing aggressive debt-collection practices, and establishing a pricing system that treats the uninsured at least as well as the insured.

Forty-seven million Americans today are without health insurance[264] while tax-exempt hospitals save billions of dollars each year[265] by virtue of their tax-favored status. Basic notions of equity require that hospitals use these tax savings to do more to help those in need. While there is no doubt that positive change will require a massive cooperative effort among state and federal governments and agencies, reforming federal hospital exemptions is a huge step in the right direction.

Terri L. Brooks

263. *See* Memorandum, *supra* note 191 ("[T]he public has a right to expect real public benefits in return [for exemption].").

264. CARMEN DENAVAS-WALT, BENADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006 (2007), http://www.census.gov/prod/2007pubs/p60-233.pdf.

265. *See* Chuck Grassley, *Grassley recommends reform of other charities besides veterans charities*, 2007 TNT 241-52 (Dec. 14, 2007).