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NON-PROFIT HOSPITALS, TAX EXEMPTION AND ACCESS FOR THE UNINSURED: PITT HEALTH LAW CERTIFICATE PROGRAM 10TH ANNIVERSARY SYMPOSIUM FEBRUARY 5, 2007

Mary A. Crossley[*]

I want to approach the topic of tax exemption for non-profit hospitals from the perspective of the 46 plus million Americans who have no health insurance[1] and the significant additional number whom we might characterize as underinsured. In essence, persons who are underinsured have some form of health coverage but they remain at serious risk for significant out-of-pocket expenditures when they become sick.[2] From this perspective, the key question is what role, if any, do the non-profit health care sector and, more particularly, non-profit hospitals have to play in addressing the vexing problems posed by the large number of uninsured and underinsured. We tend to think of these problems primarily, although not exclusively, as problems of access.

To put the question in specific terms: Is tax exemption for non-profit hospitals a tool that could be used effectively to address, or at least to help to address, these problems? Should we try to fashion tax exemption standards for non-profit hospitals into a tool for responding to some of the challenges posed by the growing number of uninsured in our society?

I think that the historical perspective that Tom Hyatt provided in his keynote address is quite useful in highlighting that at one point there existed a charity care requirement attached to tax exempt status for non-profit hospitals. Beginning in the mid-1950's and extending until 1969, the IRS required a hospital seeking exemption under § 501(c)(3) to be "operated to the

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1. Kaiser Commission on Medicaid and the Uninsured, The Uninsured: A Primer 1 (2006), *available at* http://www.kff.org/uninsured/upload/7451-021.pdf.

2. *Cf.* Rashid Bashshur et al., *Defining Underinsurance: A Conceptual Framework for Policy and Empirical Analysis*, 50 MED. CARE REV. 199, 206 (1993) (asserting that underinsurance exist when out-of-pocket medical costs result in a serious financial burden or coverage limitations hinder the insured's ability to access needed care).

extent of its financial ability for those not able to pay for the services rendered."[3] This "financial ability standard"[4] reflected a conscious policy decision that tax-exempt hospitals should have to provide potentially significant amounts of care to people who could not pay for it. In other words, the benefits of tax exemption were used to generate free care for the poor.

In 1969, though, the IRS issued Revenue Ruling 69 545, which abandoned charity care as the key inquiry for exemption and instead ruled that the "promotion of health" for the general benefit of the community was itself a charitable purpose. The Ruling thereby gave rise to the "community benefit" standard, which has been in force now for nearly 40 years, with only modest regulatory glosses added over the years.[5]

It is perhaps ironic to note that the history of that change in standard suggests that it occurred partly in response to a perception that the financial ability standard no longer made much sense because fewer people actually needed charity care in 1969. The creation of the Medicare and Medicaid programs in 1965 provided new coverage for many of the medically indigent. According to one account,[6] the IRS issued the 1969 Revenue Ruling creating the community benefit standard partly in response to requests from non-profit hospitals that the IRS eliminate the free care requirement. What seems almost quaint from our viewpoint today is that the hospitals requested this change not because they asserted that the free care requirement was too onerous or would put them out of business, but because they believed the new federal programs would eliminate the demand for charity care.

In fact, that thinking was not far off base in 1969 . . . up to a point, and for a limited period of time. Indeed, the creation of Medicare and Medicaid in 1965 meant that many of the poor or elderly people who previously might have sought charity care from hospitals had been provided a form of public health insurance.

The creation of Medicare and Medicaid also had another, less obvious impact. Because the Medicare and Medicaid programs for nearly the first two decades of their existence generously reimbursed hospitals for services provided to public insurance beneficiaries, these reimbursements gave hospitals a nice plump financial cushion, which allowed the hospitals ample

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3. Rev. Rul. 56-185, 1956-1 C.B. 202, modified by Rev. Rul. 69-545, 1969-2 C.B. 117.

4. See JOINT COMMITTEE ON TAXATION, PRESENT LAW AND BACKGROUND RELATING TO THE TAX-EXEMPT STATUS ON CHARITABLE HOSPITALS 5 (Sept. 12, 2006).

5. Rev. Rul. 69-545, 1969-2 C.B. 117.

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

resources to provide services to people who still needed charity care. In essence, the government's payments to hospitals on behalf of Medicare and Medicaid beneficiaries helped to cross-subsidize the provision of charity care.

But it was nearly 40 years ago that the IRS promulgated the community benefit standard, and in that time truly remarkable changes have occurred in the health care sector. Certainly we have seen health care cost inflation that has continued to outstrip the general inflation rate.[7] We have also seen greatly increased competition among health care providers and insurers. We have seen the number of the uninsured grow to more than 46 million.[8] Another number that has grown is the magnitude of the financial benefit that non-profit hospitals reap from federal and state tax exemptions. Although the exact magnitude of this benefit is unclear, it has been estimated at twenty billion dollars annually in tax revenues forgone by the government.[9]

What is not clear, though, because of the vagueness of the existing community benefit standard, is exactly what kind of behaviors by non-profit hospitals this extremely large "carrot" of tax exemption is promoting? What kind of behaviors is tax exemption deterring? In other words, what are we getting in return for this expenditure of billions of dollars?

To make the question more pointed and to bring it back to a focus on access: To the extent that more than 46 million Americans have no health insurance and experience significant problems in accessing quality care, while we are spending billions of dollars to subsidize vaguely defined behavior by non-profit hospitals, we must ask whether this substantial expenditure of public dollars is being used efficiently and effectively to target needs or goals—policy goals—in high priority areas. Keep in mind that this question about the best use of the billions of public funds currently forgone as a result of tax exemption does not even pose the question of whether additional public money should be devoted to responding to the problem of the uninsured. Instead, it is just a question of whether our current expenditure of billions of dollars represents a good investment in terms of achieving policy goals.

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7. General Accounting Office, Health Care Spending: Public Payers Face Burden of Entitlement Program Growth, While All Payees Face Rising Prices and Increasing Use of Services, at 8 (2007) (showing inflation rates from 2000-2005).

8. *See* note 1, *supra*.

9. *See* NANCY M. KANE, TAKING THE PULSE OF CHARITABLE CARE AND COMMUNITY BENEFIT AT NONPROFIT HOSPITALS, STATEMENT TO THE U.S. SEN. COMM. ON FINANCE 2 (Sept. 13, 2006) (estimating value of exemption from all sources as approaching $20 billion per year); *but see* Richard L. Schmalbeck, *The Impact of Tax-Exempt Status: The Supply-Side Subsidies*, 69 L. & CONTEMP. PROBS. 121, 131 (2006) (suggesting that "not much revenue is lost due to the [§ 501(c)(3)] exemption").

This question has become even more pointed as the number of uninsured has grown and as stories regarding less than admirable behavior by some non-profit hospitals have been reported by the media. These are the stories that cast the purportedly charitable hospitals not simply as failing to come to the aid of those who cannot afford care, but as actually worsening their plights in some senses. The prime examples of this type of story are the stories reported about how hospitals charge patients without insurance significantly more than insured patients.[10] This practice appears to embody a cruel twist of fate whereby uninsured patients are expected to pay more, in a sense, to cross-subsidize the deep discounts that hospitals negotiate with private health insurers to provide care for insured patients. While the lawsuits filed to challenge this practice showed that no real basis exists for legal relief, it certainly makes for a great media story and gets people thinking more about the role of non-profit hospitals.

The other type of story making the question more pointed is the story that the behavior of non-profit hospitals as a group, on a variety of fronts, does not differ markedly from the behavior of for-profit hospitals with which they compete. People are left asking: what is the difference now between for-profit hospitals and not-for-profit hospitals? They are basically acting the same way, only one group of them gets a substantial tax subsidy.

I do not mean by my comments so far to conclude that tax exemption for non-profit hospitals is failing to enhance access to care and health outcomes for the uninsured population. It is important to remember that providing charity care to the uninsured is not the only way that non-profit hospitals might address substantial access problems or improve health outcomes in ways that for-profit hospitals do not. Tom Boyle mentioned wellness programs provided by hospitals; these programs may constitute a community benefit that has a direct impact in improving health outcomes in a community. In addition, non-profit hospitals may address access problems by providing services that are unprofitable even when provided to someone with insurance: services that for-profit hospitals may be less likely to provide.[11]

The point, then, is simply that the vagueness of the existing federal community benefit standard and its historically lax enforcement mean that we

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10. *See* Julie Appleby, *Hospitals Sock Uninsured with Much Bigger Bilk*, USA TODAY, Feb. 24, 2004; *see also* Gerard F. Anderson, *From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780 (2007) (finding that in 2004 hospitals charged uninsured patients and those who pay with their own funds 2.5 times more than those covered by health insurance).

11. Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Non-for-Profit Hospitals*, 50 UCLA L. REV. 1345 (2003).

do not really know what or how much beneficial conduct flows from the tax exemption and its forgone revenue, or whether that conduct is closely related to improving access and health outcomes for the uninsured or other groups. And I think that many who are paying attention to the debate are left with a sneaking suspicion that the net benefit provided is distributed quite unevenly across the hospitals that receive the tax subsidy. With that wind-up, the question becomes how to proceed in response to the concern that can be simply expressed: Given the unclear evidence of tangible benefits from exemption under the existing community benefit standard, do higher priority uses exist for the billions of dollars effectively being spent to subsidize non-profit hospitals?

The purpose of the remainder of this presentation is not to advocate for any particular response to this question, but instead to sketch out several different approaches that others have suggested. One possibility is to go back to an explicit charity care requirement for tax exemption.[12] This approach would require hospitals to account for the charity care they provide. The first challenge, of course, would be to define clearly what counts as charity care,[13] but once a standard definition is established, hospitals could account for the charity care they provide. Texas has enacted legislation along these lines, essentially requiring hospitals to be more accountable, specifically for charity care.[14] On a certain level, that approach seems like a nice, clean quid pro quo. In exchange for tax benefits, a hospital provides a quantifiable level of charity care. This approach explicitly views the tax expenditures associated with exemption as, in part, subsidizing free care for the poor.

While this type of approach has its advocates, it also presents a fair number of challenges both in terms of how the charity care provided would be measured and accounted for and in terms of enforcement. In addition, it is far from clear that improving access to hospital services is the best way of improving health care and health outcomes for the uninsured. Finally, when you get right down to it, the amount of exemption-based tax expenditures is really just a drop in the bucket in terms of the amount needed to address the access problems faced by the uninsured,[15] so even a strictly enforced and stringent charity care standard would not solve those access problems.

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12. See N.M. Kane & W.H. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, 78 MILBANK Q. 185 (2000).

13. *See* John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y L. 623, 636-37 (2006).

14. TEXAS HEALTH & SAFETY CODE ANN. §§ 311.043-311.047.

15. *See* Kane & Wubbenhorst, *supra* note 12.

A strict charity care approach also ignores the value of the intangible benefits that flow from non-profit status and from hospitals' attempts to satisfy the community benefit standard in ways that are unrelated to charity care. An alternative approach to tax exemption that seeks to be more flexible and more cognizant of the variety of benefits non-profit hospitals may provide would require an individual hospital or health system to articulate a plan as to how it will provide a community benefit consistent with its specific mission and its particular community, and then to account for that benefit either in terms of what the hospital spends or in terms of what outcomes it produces.[16] This more flexible approach would recognize that in some communities charity care may not be the most pressing need. A hospital may provide significant benefits to a community's health by doing things other than providing free care, but this approach would demand accountability rather than loosely assuming that such benefits exist.

A third response to the question regarding the justifiability of the tax expenditures associated with non-profit hospitals' exemption is more dramatic. This response advocates the elimination of tax exemption for non-profit hospitals. Keep in mind that rejecting the proposition that providing health care is an inherently charitable activity would not mean that all non-profit hospitals would lose their tax exemption, because hospitals that are teaching hospitals or that are engaged in significant research would likely be able to obtain exemption under other subsections of 501(c)(3) on scientific or educational bases.[17] But some argue that tax exemption should be ended for the remaining non-profit hospitals—typically the ones that look and act most like their for-profit competitors—and should be replaced with targeted incentives, such as tax credits or other types of monetary incentives encouraging specific hospital behaviors that as a matter of policy the IRS or Congress decides it wants to promote.[18] These types of targeted incentives arguably could be provided on an entity-neutral basis: If it is desirable to encourage a certain kind of behavior, why not encourage it equally for non-profit hospitals and for-profit hospitals alike? The concern by many with this type of approach is that many non-profit hospitals would essentially have to either go out of business or give up their non-profit form and mission in order to survive in a highly competitive environment without the benefit of the tax exemption subsidy. A further concern is that society may end up worse off by

16. *See* John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29 (2005).

17. Colombo, *supra* note 13, at 635.

18. *See* David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J.L. & MED. 327 (1990).

losing the intangible and perhaps unmeasurable benefits that flow from the non-profit hospital sector.[19]

In conclusion, my purpose today is not to argue that any of these approaches provides the obvious right answer. Instead, to circle back to where I started, I am more concerned about the proper framing of the questions regarding how our country spends billions of dollars annually in public funds. Since this is public money that is being spent, we must ask whether there is a resulting public benefit. It is easy to lose sight of that question because of the indirect method by which the IRS effectively creates health policy, but as the problems related to the mounting number of uninsured become more prominent in the public's awareness, I think it is going to become increasingly difficult to avoid that question. Accordingly, it is going to become increasingly important for non-profit hospitals, if they wish to maintain the benefits of tax exemption, to be able to make the case that they are providing tangible, measurable benefits that in some way distinguish them from their for-profit competitors.

19. *Cf.* Colombo, *supra* note 13, at 639.