Nonprofit Hospitals: The Relationship between Charitable Tax Exemptions and Medical Care for Indigents

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COMMENTS

NONPROFIT HOSPITALS: THE RELATIONSHIP BETWEEN CHARITABLE TAX EXEMPTIONS AND MEDICAL CARE FOR INDIGENTS

by A. Kay B. Roska

IN the United States the ownership and organizational structure of hospitals falls into different classes.1 The government owns and maintains public hospitals, which primarily serve as teaching institutions and as providers of medical care for indigents.2 The private sector operates hospitals both for profit and not for profit.3 Whereas for-profit hospitals (for-profits) traditionally benefited investors and depended on earnings and securities as their main sources of capital,4 nonprofit hospitals, both public and private, primarily benefited the disenfranchised and depended on charitable donations and governmental grants as their main sources of capital.5 Historically, the private nonprofit hospitals (nonprofits or voluntary hospitals), like the public hospitals, willingly provided unprofitable services and free, or at least below-cost, care to the poor.6 Operation for charitable purposes entitled these institutions to tax exemptions at the federal, state, and local levels.7

Exemption from federal tax under section 501(c)(3) of the Internal Reve-

1. B. Gray, For-Profit Enterprise in Health Care 3-11 (1986); see also Richards & Tucker, Nonprofit Organizations: Businesslike Nonprofit Hospitals Losing Traditional Special Treatment, Preventive L. REP., June 1987, at 3 (classifying hospitals on the basis of government or private ownership and whether conducted for profit).
2. See sources cited supra note 1.
3. Id.
4. Id.
5. Id.
6. Id.
nue Code (Code)\textsuperscript{8} renders hospitals eligible for many benefits.\textsuperscript{9} The exemption itself protects a nonprofit entity's net earnings, including interest on its endowments or funded depreciation accounts.\textsuperscript{10} Tax deductions available to individuals and private corporations for contributions to these charitable institutions encourage philanthropy.\textsuperscript{11} In addition, private foundations prefer making grants to exempt organizations because severe restrictions accompany grants to nonexempt organizations.\textsuperscript{12} Federal tax exemption also qualifies voluntary hospitals for grants from federal, state, and local governments.\textsuperscript{13} Forgiveness of property, sales, and other taxes at the state and local level frequently requires section 501(c)(3) status.\textsuperscript{14} As this partial list of federal tax-exemption benefits demonstrates, the government indirectly subsidizes private nonprofit hospitals.\textsuperscript{15} Private performance of a public responsibility, such as provision of uncompensated medical services to indigents, however, justifies the loss of tax revenues.\textsuperscript{16} The activities of charitable organizations thus improve society as a whole.\textsuperscript{17}

Several events have caused the voluntary hospitals to curtail their provision of charity care.\textsuperscript{18} The availability of third-party coverage for healthcare costs through Medicaid, Medicare, and private insurance, while initially decreasing the amount of uncompensated care necessary to treat the sick poor, heightened the demand for medical care, especially specialty services,
and stimulated the growth of investor-owned hospitals.\textsuperscript{19} For-profit institutions met the escalating need for technologically advanced diagnosis and treatment and attracted the paying patients.\textsuperscript{20} Inadequate capital placed the nonprofits at a competitive disadvantage.\textsuperscript{21} Diminished reimbursement from private and public insurers worsened the nonprofits' unfavorable economic situation.\textsuperscript{22} Nonprofits thus restructured in an attempt to generate additional capital resources.\textsuperscript{23} This restructuring blurred the distinctions between the nonprofits and the for-profits.\textsuperscript{24} Most notably, the voluntary hospitals limited their accessibility to indigent patients.\textsuperscript{25}

This Comment addresses the question of whether private nonprofit hospitals that have abandoned their historic mission to serve the sick poor should continue to qualify for tax exemption. Section I chronicles the change in the Code's charitable purpose standard for hospitals from "relief of the poor" to "promotion of health." Section II discusses the effect of the emergence of competitive investor-owned hospitals on the structure and function of nonprofits. Section III examines the likelihood that state courts and/or legislatures will require tax-exempt nonprofit hospitals to care for poor patients. Section IV analyzes who does, as opposed to who should, provide uncompensated medical diagnosis and treatment for the increasing number of medical indigents. Finally, the Comment recommends a statutorily mandated charity medical-care program for tax-exempt nonprofit hospitals as an alternative to the present law that equates nonprofit form and charitable purpose.

\textsuperscript{19.} See P. STARR, supra note 18, at 290-334.

\textsuperscript{20.} See Richards & Tucker, supra note 1, at 4.

\textsuperscript{21.} See id.

\textsuperscript{22.} See id.

\textsuperscript{23.} See P. STARR, supra note 18, at 420-49; see also Keenan, Not-For-Profit Systems Position Themselves To Meet Upcoming Challenges, HOSPITALS, Sept. 1, 1981, at 77 (describing the various types of multihospital systems); LaViolette, Nonprofits Setting Up For-Profit Divisions; May Even Sell Stock, MODERN HEALTHCARE, May 1982, at 98 (surveying multihospital systems); Squires, supra note 7, at 71-73 (examining the parent holding company model and identifying inconsistencies between it and tax-exempt status).

\textsuperscript{24.} Baldwin, Legislatures, Agencies Debating Whether Not-For-Profit Hospitals Deserve Their Tax-Exempt Status, MODERN HEALTHCARE, May 22, 1987, at 34; Herzlinger & Krasker, Who Profits From Nonprofits?, HARVARD BUS. REV., Jan.-Feb. 1987, at 93; Richards & Tucker, supra note 1, at 3; Squires, supra note 7, at 72.


\textsuperscript{26.} Treas. Reg. § 39.101(6)-1(b) (1954). This regulation stated that "[c]orporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor." Id. This view of charitable purpose was again expounded in Rev. Rul. 56-185, 1956-1 C.B. 202. See generally B. HOPKINS, supra note 7, at 53 (reviewing the historical federal tax-law meaning of charitable purpose).

\textsuperscript{27.} Rev. Rul. 69-545, 1969-2 C.B. 117. This ruling concluded that the promotion of health in general satisfies the charitable purpose requirement for tax exemption. Id. The Supreme Court, in effect, upheld this ruling by denying indigent plaintiffs the right to challenge it in court. Simon v. Eastern Ky. Welfare Rights Org., 426 U.S. 26, 41-43 (1975).
I. Federal Tax Exemption for Charitable Organizations

A. General Historical Perspective

The exemption of charitable organizations from federal income taxation as currently provided for in section 501(c)(3) of the Code originated conceptually as a part of the Tariff Act of 1894. Although the draftsmen of the Act did not specifically articulate the reasons for establishing this exemption, the similarity between it and English income tax statutes suggests that they intended to assure the continuation of a prior comparable practice.

28. I.R.C. § 501(c)(3) (1988). Section 501(c)(3) currently states: 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 sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.

29. Tariff Act, ch. 349, § 32, 28 Stat. 556 (1894): "[N]othing herein contained shall apply to ... corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes." The United States Supreme Court in Pollock v. Farmers' Loan & Trust Co., 158 U.S. 601 (1895), found the Tariff Act of 1894 unconstitutional for reasons unrelated to the charitable exemption provision. Congress included a similar exemption in every income tax act enacted after the ratification of the sixteenth amendment, which granted Congress the power to tax income. B. Hopkins, supra note 7, at 49. The Tariff Act of 1913 exempted from the income tax "any corporation or association organized and operated exclusively for religious, charitable, scientific, or educational purposes, no part of the net income of which inures to the benefit of any private shareholder or individual." Tariff Act, ch. 16, § II(G)(a), 38 Stat. 172 (1913). Subsequent income tax acts expanded the enumeration of exempt organizations to include entities "organized and operated exclusively ... for the prevention of cruelty to children or animals," Revenue Act, ch. 18, § 231(6), 40 Stat. 1076 (1919), as well as "any community chest, fund, or foundation," and literary groups, Revenue Act, ch. 136, § 231(6), 42 Stat. 253 (1921). The Revenue Act of 1934 added the requirement that "no substantial part of the activities [of an exempt organization could involve] ... carrying on propaganda, or otherwise attempting, to influence legislation," Revenue Act, ch. 277, § 101(6), 48 Stat. 700 (1934). The Internal Revenue Code of 1939 did not alter the prior law concerning tax-exempt organizations. I.R.C. §§ 101, 421 (1939). Eventually Congress enacted § 501(c)(3) of the Internal Revenue Code of 1954. I.R.C. § 501(c)(3) (1954). Congress again amplified the listing of tax-exempt organizations to include entities "organized and operated exclusively for ... testing for public safety ... purposes." Id. In addition, Congress did not allow tax-exempt organizations to "participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office." Id. The Tax Reform Act of 1976 exempted organizations that "foster national or international amateur sports competitions (but only if no part of its activities involve the provision of athletic facilities or equipment)." Tax Reform Act, tit. XIII, § 1313, 90 Stat. 1730 (1976). The 1986 codification of the Internal Revenue Code did not alter § 501(c)(3). I.R.C. § 501(c)(3) (1986). Section 501(c)(3) remained unchanged through 1988 except that the rule against political campaign activities supporting a candidate was expanded also to apply to opposing a candidate. I.R.C. § 501(c)(3) (1988). See supra note 28.

30. B. Hopkins, supra note 7, at 46. Charitable purposes listed in the preamble to the Statute of Charitable Uses of 1601 include:

Some for relief of aged, impotent and poor people, some for maintenance of sick and maimed soldiers and mariners, schools of learning, free schools, and scholars in universities, some for repair of bridges, ports, havens, causeways, churches, seabanks and highways, some for education and preferment of or-
enacting and perpetuating the charitable tax exemption, however, Congress did not define the term “charitable.” The commonly accepted usage of charitable is limited to “relief of the poor.” By contrast, the common-law meaning of charitable, as derived from the common law of charitable trusts, broadly includes any function promoting the general welfare of society. A review of the law that became Code section 501(c)(3) reveals that the Internal Revenue Service (IRS) interpreted charitable purpose to be synonymous with relief of the poor. The IRS’s view is evident, for example, in the regulations that interpreted the Internal Revenue Code of 1939. Congress incorporated sections 101 and 421 of the 1939 Internal Revenue Code as section 501 in the 1954 Internal Revenue Code, without any substantive changes. Consequently, the term charitable retained its common meaning for federal tax purposes. In 1956, however, a federal tax regulation expanded the scope of charitable purpose beyond relief of the poor, thereby officially recognizing the common-law meaning of charitable. Purposes other than relief of poverty that serve the general welfare of society thus may be charitable in the legal sense.

B. Nonprofit Hospitals as Charitable Institutions

Congress did not enumerate health care as one of the qualifying functions

phantoms, some for or towards relief, stock or maintenance for houses of correction, some for marriages of poor maids, some for supportation, aid and help of young tradesmen, handicraftsmen and persons decayed, and others for relief or redemption of prisoners or captives, and for aid or ease of any poor inhabitants concerning payments of fifteenths, setting out of soldiers and other taxes.

Id. (quoting preamble to Statute of Charitable Uses, 43 Eliz. 1, ch. 4 (1601)); see also RESTATEMENT (SECOND) OF TRUSTS § 368 comment a (1935) (referring to the preamble to the Statute of Uses of 1601 as the basis for the concept of charitable purposes).

31. B. HOPKINS, supra note 7, at 48.

32. Id. at 46; see also WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 378 (1961) (defining charitable as “generous in assistance to the poor”).

33. B. HOPKINS, supra note 7, at 48; see also RESTATEMENT (SECOND) OF TRUSTS, supra note 30, § 368 (identifying the common element of all charitable purposes as accomplishment of “objects which are beneficial to the community”).

34. B. HOPKINS, supra note 7, at 52.

35. For example, Treas. Reg. § 39.101(6)-1(b) (1952) generally described “[c]orporations organized and operated exclusively for charitable purposes... as organizations for the relief of the poor.” Id. Such corporations, however, “may receive voluntary contributions from the persons intended to be relieved” without forfeiting tax-exempt status. Id. (emphasis added).


37. Id.

38. Treas. Reg. § 1.501(c)(3)-1(d)(2) (1956). This regulation stated that “the term ‘charitable’ is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of ‘charity’ as developed by judicial decisions.” Id.

39. B. HOPKINS, supra note 7, at 53; see also Green v. Connally, 330 F. Supp. 1150, 1157 (D.D.C. 1971) (noting that although the term “charitable” is not defined with particularity in the Internal Revenue Code or Treasury Regulations, “a ‘strong analogy’ can be derived from the general common law of charitable trusts”).
or activities in Code section 501(c)(3). The IRS, however, has granted tax-exempt status to nonprofit hospitals as charitable institutions. Because the Code failed to specify what constituted a charitable purpose, the IRS evaluated nonprofit hospitals individually. The nonprofit hospitals thus requested some guidelines on qualification as a charitable institution. In Revenue Ruling 56-185 the Commissioner of the Internal Revenue Service (Commissioner) set forth four general requirements for tax exemption. Under these criteria the hospital was required: (1) to care for the sick; (2) to an extent commensurate with its financial ability, to provide free or below-cost care to those both sick and poor; (3) to permit all qualified physicians to use its facilities; and (4) not to benefit monetarily any private shareholder or individual. The second requirement, which technically defined charitable purpose in the context of health-care providers, was consistent with the historical function of hospitals. Until late in the nineteenth century hospitals provided custodial care without medical treatment for the poor. In addition, these almshouses depended on voluntary private donations, not governmental funding, for financial support.

For approximately thirteen years, the IRS conditioned a nonprofit hospital's charitable status upon the provision of indigent medical care. This policy, however, failed to account for the multidimensional transformation that the hospital industry had undergone. Hospitals evolved from primarily serving the sick poor to serving the whole community. Consequently, paying patients instead of philanthropy became the primary financial re-

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41. Rev. Rul. 56-185, 1956-1 C.B. 202 (establishing general charitable exemption requirements for hospitals); see also Simon v. Eastern Ky. Welfare Rights Org., 426 U.S. 26, 28-29 (1975) (reviewing the status of nonprofit hospitals under the then current Code). The Supreme Court acknowledged, the Code ... accords advantageous treatment to several types of nonprofit corporations, including exemption of their income from taxation ... . Nonprofit hospitals have never received these benefits as a favored general category, but an individual nonprofit hospital has been able to claim them if it could qualify as a corporation 'organized and operated exclusively for ... charitable ... purposes' within the meaning of 501(c)(3) of the Code ....
Id.
43. Id.
45. Id. at 203-04.
47. P. Starr, supra note 18, at 145, 149, 160.
48. Id.
49. Rev. Rul. 56-185, 1956-1 C.B. 202. This ruling required a nonprofit hospital to "be operated 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." Id. at 203. The Commissioner, however, permitted a nonprofit hospital to satisfy its charitable obligation by furnishing services at below-cost rates. Id. The 1956 ruling remained the announced policy of the IRS until the issuance of Revenue Ruling 69-545 in 1969. See Rev. Rul. 69-545, 1969-2 C.B. 117.
50. P. Starr, supra note 18, at 147-62.
51. Id. at 159.
source of health-care facilities. The advent of Medicaid, Medicare, and private insurance greatly reduced the number of poor people requiring charity medical services. In addition, many local governments began to provide indigent medical care through public hospitals.

In Revenue Ruling 69-545 the Commissioner promulgated another charitable purpose standard for tax-exempt status under Code section 501(c)(3). This ruling modified Revenue Ruling 56-185 by recognizing that provision of health services is an inherently charitable purpose that is not obviated by limiting hospital access of the medically indigent. The IRS thus deemed the promotion of health a per se benefit to the community. Revenue Ruling 69-545 contained an example of the kind of nonprofit hospital that would qualify for tax exemption. The IRS essentially required only that the nonprofit hospital provide emergency services to all persons and medical care to all persons able to pay the costs either directly or indirectly through third parties.

The 1969 revenue ruling interpretation of the term charitable, which is consistent with a 1956 treasury regulation on Code section 501(c)(3), followed the common law of charitable trusts. Accordingly, the IRS cited Scott on Trusts and the Restatement of Trusts by Scott as its authority for a change in position regarding provision of indigent medical care. Some commentators view the common law of trusts as an inappropriate model for tax-exemption standards. Whereas the common law characterized trusts as charitable so that the associated property could be inalienable for an in-
definite time, contrary to the rule against perpetuities, the IRS granted charities tax-exempt status because the public benefit justified the loss of revenue. The purpose to be achieved in the two situations was different.

A criticism of Revenue Ruling 69-545 is that it is contrary to Congress's intent to benefit the medically indigent. First, Congress had passed health-care legislation to assure service to the sick who cannot pay. The Hill-Burton Act, which makes federal funds available for construction of governmental and nonprofit hospitals, requires that recipients of such public grant-in-aid programs provide a reasonable volume of uncompensated patient care. In addition, the federal government subsidizes health care to the aged and to certain classes of the poor through titles 18 (Medicare) and 19 (Medicaid) of the Social Security Act. Consistency with the congressional purposes inherent in these Acts would limit the charitable tax exemption to only those institutions that also provide medical care to poor persons who do not qualify for assistance through either the Medicaid or Medicare program or who have exhausted their third-party coverage.

Second, Congress failed to act positively in regard to the 1969 revenue ruling. The Tax Reform Bill of 1969, as reported by the House Ways and Means Committee, contained language that would have conformed the Code to the administrative interpretation of Code section 501(c)(3). The House recommended a separate tax-exempt status for hospitals in response to testimony on behalf of the American Hospital Association. The testimony highlighted the hospitals' uncertainty as to the extent to which they must accept the medically indigent as patients. The American Hospital Association took the position that the advancement of health without any qualifications is charitable. The Senate Finance Committee, however, deleted the House provision and referred the question raised by the provision to its staff for consideration in the context of a review of Medicaid and Medicare. Thereafter, the Staff of the Senate Finance Committee strongly recommended revocation of Revenue Ruling 69-545 until Congress could establish

66. Id. Scott observed that "'[t]he common element [of all charitable trusts] is that the purposes are of a character sufficiently beneficial to justify permitting property to be devoted for an indefinite time to their accomplishment . . . ." 4 SCOTT ON TRUSTS § 372 (3d ed. 1967).
67. Rose, supra note 65, at 184.
68. Id.
69. Id. at 183-84, 204.
70. Id.; see statutes cited infra notes 71-73.
72. Id.
74. Rose, supra note 65, at 184, 204.
75. Id. at 205; see sources cited infra notes 76-81.
77. Id.
78. Id.
79. Id.
guidelines for equating the volume of charitable service to the financial ability of the hospital. Despite the inconsistency between the 1969 revenue ruling and the apparent congressional intent at that time, Congress has refrained from enacting a statutory definition of the term charitable. Congress has thus implicitly accepted the broader meaning of charitable purpose as articulated by the IRS in the 1956 regulation and the 1969 revenue ruling.

Although Congress failed to take any action on the subject of Revenue Ruling 69-545, a class of indigents, in Simon v. Eastern Kentucky Welfare Rights Organization, challenged the ruling as contrary to the historical view that charitable purpose under Code section 501(c)(3) means relief of the poor. The plaintiffs sought to enjoin the IRS from granting exemptions without an obligation to the medically indigent. The United States Supreme Court remanded the cause to the district court with instructions to dismiss the complaint for lack of standing to bring suit because the class of indigents had not shown a direct causal relationship between their injury, namely the lack of access to health care, and Revenue Ruling 69-545; furthermore, the Court said the plaintiffs had not shown that a favorable decision would redress their injury. In regard to the latter finding, the Court concluded that a hospital might deny access to the poor even if its action could negatively affect its tax-exempt status. This decision precluded indigent plaintiffs from challenging the administrative conception of charitable purpose under Code section 501(c)(3). Consequently, interpretation of the Code lay exclusively within the discretionary power of the IRS.

Later, in Lugo v. Miller, a group of low income individuals attempted to overcome the Supreme Court's standing decision by suing specific tax-exempt nonprofit hospitals, along with federal Treasury officials, to require the tax-exempt nonprofit hospitals to accept a reasonable number of medically indigent patients. The Sixth Circuit, however, refused to address the merits of the case because it found that the plaintiffs lacked standing. This deferential approach by the judiciary to administrative discretion thus effectively rendered private citizens powerless to have the courts hear their grievances concerning agency action. The Supreme Court has since confirmed this position holding that class-action plaintiffs do not have standing to chal-
Tax commentators have expressed concerns about these decisions in light of the fallibility of the IRS in matters affecting public policy. They therefore suggest that Congress authorize third-party lawsuits against the IRS when constitutional guarantees are abridged.

In 1983 the IRS issued Revenue Ruling 83-157 in an attempt to clarify the prerequisites for charitable tax exemption for nonprofit hospitals. The IRS illustrated implementation of the ruling by amplifying the hypothetical in situation 1 of Revenue Ruling 69-545. The nonprofit hospital in both examples maintained a local board and an open medical staff, and it accepted paying patients. Unlike the original hypothetical, however, it did not operate an emergency room because a state planning agency decided such a service would unnecessarily duplicate nearby facilities. Consequently, the nonprofit hospital in the latter example did not provide any services without expectation of compensation. Nevertheless, the Commissioner concluded that it operated exclusively to benefit the community. Operation of a full-time emergency room, open to all, was thus not an essential requirement for charitable tax-exempt status. The IRS's interpretation of the term charitable allowed tax-exempt nonprofit hospitals to limit further access of the poor.

II. CURRENT ROLE OF NONPROFIT HOSPITALS
A. Emergence of For-Profit Hospitals

The recent history of the hospital industry reveals the impetus for the decline and subsequent resurgence of for-profit hospitals. After World War II the Hill-Burton Act provided federal money to build public and private nonprofit hospitals. These government grants hastened the growth

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94. See generally Simon, Supreme Court Limits Ability of Third Parties to Sue Agencies such as the IRS, 61 J. TAX'N 400 (1984) (questioning the validity of the IRS's interpretation of public policy).
95. Id. at 402.
98. Id.
99. Id.
100. Id.
101. Id. at 95.
102. Id. Other factors demonstrating that a hospital is operating exclusively to benefit the community include "a board drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research." Id.
104. Richards & Tucker, supra note 1, at 4; see also Herzlinger & Krasker, supra note 24, at 96 (summarizing the historical events initiating the rapid growth in the hospital industry from 1977 to 1981); P. Starr, supra note 18, at 235-449 (reviewing and analyzing the emergence of corporate medicine).
of nonprofits, thereby heralding the demise of the then-existing for-profits. Congress enacted this program to expand the nation’s health-care system and thereby to ensure the medically indigent access to hospitals. The rise of specialty medical training in the late 1940s was another factor in the growth of nonprofits because most medical schools were affiliated with either private or public nonprofits. Consequently, society placed greater confidence in the expertise of the nonprofit hospitals, especially those associated with medical schools, than in that of the for-profit hospitals. Nonprofit hospitals might have continued to dominate had not the focus of the medical practice itself changed from patients to finances.

The four events that revolutionized medical practice helped cause the shift in focus. The first major development was the implementation of aseptic technique. Next, the discovery of antibiotics provided a cure for bacterial diseases. Aseptic technique together with antibiotic treatment significantly diminished the risk of invasive medical procedures. Third, developments in science and technology following World War II led to technological advances in medicine and to specialty medical practices. Finally, the enactment of the Medicare and Medicaid programs and the establishment of private insurance schemes removed the cost restraints on the charges for medical care. These reimbursement plans stimulated a heightened demand for medical services.

Nonprofits attempted to meet the escalating need for technologically complex and expensive specialty medical services by borrowing money beyond private philanthropy for expansion. They had, however, limited access to

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106. Richards & Tucker, supra note 1, at 4.
107. Id.
108. Id. To be considered a specialist a physician had to spend one or more additional years in training before entering private practice. Id. These post-graduate programs “increased the moral authority of nonprofit hospitals” over for-profit hospitals. Id.
109. Id. For-profit hospitals had a dubious reputation because the Flexner report closed for-profit medical schools. Id. The American Medical Association commissioned the Flexner report in 1910 in an effort to upgrade medical schools in the United States. P. Stark, supra note 18, at 118.
110. Id. Prior to the shift in medical practice, a physician served primarily as a counselor to his patients. Id. Physicians, as well as hospital administrators, focused on good works, rather than financial compensation. Id.
111. Id.; see also P. Stark, supra note 18, at 333-78 (describing the events that changed the nature of American health care).
112. Richards & Tucker, supra note 1, at 4-5.
113. Id.
114. Id.
115. Id.
116. Id.; see supra text accompanying note 73; see also Herzlinger & Krasker, supra note 24, at 96 (concluding that “[t]he adoption of Medicare and Medicaid changed the industry by creating a huge class of consumers armed with government-backed health insurance”).
117. Herzlinger & Krasker, supra note 24, at 96.
118. Id.; see also Richards & Tucker, supra note 1, at 4-5 (noting the adoption of proper business procedures by nonprofit hospitals). The adoption of proper business procedures, such as formal budgeting processes, was “a salutary change.” Id. at 5. The correlative change in the traditional structure of nonprofit hospitals, however, “began the erosion of the moral authority of nonprofit hospitals.” Id. The courts’ rejection of the doctrine of charitable immunity for hospitals became the first indication of diminished public confidence in these institutions. Id.
capital. Sensing this market opportunity, private entrepreneurs invested in for-profit hospitals. For-profit hospitals purchased state-of-the-art technology for diagnosis and treatment and employed highly qualified physicians to render specialty care. Suddenly, nonprofits were in direct competition with for-profits. This circumstance created unique problems for nonprofits—they are one of the few charitable organizations that experiences direct competition for resources from a for-profit counterpart.

B. Consequences of For-Profit Hospital Competition

Nonprofit hospitals lacked adequate capital to compete effectively with for-profit hospitals. In an attempt to improve economic conditions nonprofit hospitals diversified by creating new businesses. Some of these businesses were substantially related to promotion of health and were therefore exempt from taxation. Others, however, were unrelated to the promotion of health and were therefore subject to taxation. In either case capital for such subsidiaries came, at least in part, from the tax-exempt earnings of the nonprofit hospitals. Moreover, when the subsidiary itself was also a tax-exempt organization, it could sell its product or service at a lower cost than a comparable taxable business. The business community thus claimed that nonprofit hospitals used their tax-exempt status to gain unfair competitive advantages.

119. Richards & Tucker, supra note 1, at 5; see also McCoy, Health Care and the Tax Law: Reorganizations, Structural Changes, and Other Contemporary Problems of Tax-Exempt Hospitals, 44 N.Y.U. Inst. on Fed. Tax’n § 58.03(2), at 6 (1986) (for-profit hospitals “can compete on purely commercial and economic grounds, free of the restrictive rules of IRC section 501(c)(3),” such as no private inurement of net earnings and no private benefit). 120. Herzlinger & Krasker, supra note 24, at 96; see also Richards & Tucker, supra note 1, at 5 (observing that access to equity capital markets gave for-profit hospitals an economic advantage over nonprofit hospitals). 121. Richards & Tucker, supra note 1, at 5. 122. Id. at 3, 5. 123. Id. at 3. 124. See sources cited supra note 119. 125. Baldwin, supra note 24, at 34-35. 126. Squiers, supra note 7, at 70-71. 127. Treas. Reg. § 1.501(c)(3)-1(e)(1) (1956). This regulation provided: An organization may meet the requirements of section 501(c)(3) although it operates a trade or business as a substantial part of its activities, if the operation of such trade or business is in furtherance of the organization’s exempt purpose or purposes and if the organization is not organized or operated for the primary purpose of carrying on an unrelated trade or business, as defined in section 513. 128. Baldwin, supra note 24, at 42. 129. Id. 130. Id.; Tax Status of Nonprofit Ventures Challenged, Hospitals, Jan. 5, 1987, at 46 (an interview with John Motley, director of federal legislation for the National Federation of Independent Business, who voiced the business community’s concern that tax-exempt organizations undercut prices, forcing many for-profit hospitals out of business).
Nonprofit hospitals also pursued more creative options to generate financial resources. To realize economies of scale, some nonprofits joined together to form chains. An alternative cost reduction approach involved participation in partnerships and joint ventures. The most common response of voluntary hospitals to competition from investor-owned hospitals, however, was to reorganize into a multi-entity structure. This adaptation has been described as the “polycorporate enterprise” model. A tax-exempt parent holding company containing both for-profit and nonprofit subsidiaries usually comprised the multi-entity structure. At least one of the nonprofit subsidiaries was a hospital. Ownership of for-profit corporations did not affect the federal tax-exempt status of either the parent holding company or the nonprofit subsidiaries as long as the after-tax profits of the for-profit corporations supported the nonprofit corporations.

The Utah Supreme Court and some commentators have concluded that these adaptations of nonprofit hospitals to the competitive market abolished the distinctions between for-profit and nonprofit hospitals. Both types of hospitals now rely on governmental or private health insurance proceeds and direct payment for financial survival. This dependence on paying patients eliminates or, at the very least, significantly restricts provision of uncompensated care to the medically indigent.

A controversial study by Regina E. Herzlinger, a professor at Harvard Business School, and William S. Krasker, vice-president of Salomon Brothers, compared nonprofit and for-profit hospital chains. The study essentially concluded that private nonprofits do not deserve tax-exempt status, because they do not benefit society to any greater extent than investor-owned hospitals. Several observations substantiate this conclusion. First, orga-
nizational form does not appear to influence the cost of services, as evidenced by the fact that for-profit and nonprofit hospitals generate similar patient revenues.145 Second, nonprofits have lower earnings, but higher operating costs, than for-profit hospitals.146 As a corollary to this finding, for-profit hospitals function more efficiently than nonprofit hospitals.147 Finally, patients with little or no health-insurance coverage have as much access to for-profit hospitals as to nonprofit hospitals.148 For-profit hospitals thus do not limit admission only to those patients with adequate to generous insurance coverage.149

Critics of Herzlinger's and Krasker's study challenged its exclusive focus on nonprofits associated with multihospital chains.150 According to a critique, prepared for the Catholic Health Association by Bradford H. Gray, a scholar at the National Academy of Science's Institute of Medicine, at the time of the study multi-hospital chains represented less than thirty percent of all nonprofits, while that form dominated the investor-owned sector.151 The basic criticism is that the chain data does not accurately reflect the function of nonprofits.152 The authors of the study defend it on the grounds that economic factors will eventually force all hospitals to unite.153 Irrespective of the questionable applicability of Herzlinger's and Krasker's findings to freestanding nonprofits, their study establishes that at least some nonprofits are functionally indistinguishable from their for-profit counterparts.

One crucial consequence of limited availability of medical care for indigents is "patient dumping."154 Patient dumping is a calculated refusal to initiate critical treatment of an emergency patient or to continue necessary treatment of a hospital patient when the financial resources of the patient are inadequate to cover the cost of care.155 Private hospitals transfer such patients to public hospitals.156 In recent years the number of uninsured patients inappropriately transferred from private to public hospitals has increased dramatically.157 Federal, state, and local governments recognize

145. Id. at 101.
146. Id. at 103.
147. Id. The Herzlinger and Krasker study indicated that for-profits "use fewer full-time employees (or their equivalent) and generate 10% more patient days per bed than do the nonprofits." Id.
148. Id.
149. Id. The authors concluded that affluent patients find for-profit and nonprofit hospitals equally accessible. Id.
150. Baldwin, supra note 24, at 40 (summarizing the critics' objections to the study conducted by Herzlinger and Krasker and the authors' response to the criticism).
151. Id.
152. Id.
153. Id.
155. Dallek & Waxman, supra note 154, at 1413.
156. Id.
157. Id.
this nationwide problem.\textsuperscript{158}

A federal House and Senate Conference Committee introduced the Consolidated Omnibus Reconciliation Act of 1985, which addressed the issue of patient dumping as well as many other issues unrelated to health care.\textsuperscript{159} The Act required Medicare-participating hospitals to evaluate all emergency-room patients regardless of ability to pay.\textsuperscript{160} In addition, the Act prevented hospitals from transferring a patient with an emergency medical condition\textsuperscript{161} or in active labor\textsuperscript{162} without stabilization or certification that the medical benefits of an unstabilized transfer outweighed the medical risks of an unstabilized transfer.\textsuperscript{163} Congress enacted this proposed legislation.\textsuperscript{164}

Texas has passed an antidumping law\textsuperscript{165} similar to the federal law, specifying minimum standards that govern patient transfers between hospitals. The state prohibits the transfer of unstabilized emergency patients, unless a hospital lacks essential expertise or appropriate equipment for stabilization.\textsuperscript{166} Hospitals can thus transfer emergency patients for medical reasons only.\textsuperscript{167} By inference, hospitals may still make an economic decision not to treat stabilized emergency patients and nonemergency patients.

Because antidumping laws do not assure indigents access to private hospitals for nonemergency medical care, public hospitals must provide a high proportion of health care to the poor.\textsuperscript{168} Consequently, they serve a lower proportion of privately insured patients.\textsuperscript{169} In most hospitals the financial surplus from private insurance covers the cost of care to the uninsured.\textsuperscript{170} When revenues from private insurance are limited, provision of a relatively large amount of uncompensated care will result in chronic financial difficulties, which in the case of public hospitals can only be rectified by increasing taxes.\textsuperscript{171} This problem raises the question of whether the government should either increase taxes or require nonprofit hospitals to provide medical services to nonemergency indigent patients. Considering that tax exemptions are a form of subsidy equivalent to the amount of taxes the nonprofits would otherwise have paid,\textsuperscript{172} society is entitled to expect tax-exempt insti-

\begin{itemize}
  \item \textsuperscript{158} Id.
  \item \textsuperscript{159} Id. at 1414 (citing H.R. 3128, 99th Cong., 1st Sess. § 1867 (1985)).
  \item \textsuperscript{160} H.R. 3128, 99th Cong., 1st Sess. § 1867(e)(1) (1985).
  \item \textsuperscript{161} Id.
  \item \textsuperscript{162} Id. § 1867(e)(2).
  \item \textsuperscript{163} Id. § 1867(e)(4)(B).
  \item \textsuperscript{164} 42 U.S.C. § 1395dd (Supp. V 1987).
  \item \textsuperscript{165} TEX. REV. CIV. STAT. ANN. art. 4438a (Vernon Supp. 1989).
  \item \textsuperscript{166} Id. § 1(c).
  \item \textsuperscript{167} Id.
  \item \textsuperscript{168} Feder, Hadley & Mullner, Poor People and Poor Hospitals: Implications for Public Policy, 9 J. HEALTH POL., POL'Y AND LAW 237, 239 (1984).
  \item \textsuperscript{169} Id.
  \item \textsuperscript{170} Id. at 247.
  \item \textsuperscript{171} Id.
  \item \textsuperscript{172} See Perkins & Dowell, supra note 15, at 473 (noting that tax expenditure budget items such as tax exemptions "represent the revenue losses attributable to provisions of the federal income tax laws that are intended to encourage certain economic activities, such as support of charitable institutions").
\end{itemize}
tutions to serve public interests.173

III. STATE REQUIREMENTS FOR TAX EXEMPTION

A. Relationship Between Federal and State Tax Exemption

The federal tax-exempt status of a nonprofit hospital directly affects its eligibility for state and local tax exemptions.174 Federal tax exemption under Code section 501(c)(3) is a common prerequisite for forgiveness of various state and local taxes.175 Frequently section 501(c)(3) qualification is the sole requirement.176 All states at least respectfully consider the IRS definition of charitable purpose when interpreting their own charitable tax-exemption statutes.177 Consequently, recognition of promotion of health, per se, as a charitable purpose under Code section 501(c)(3) negatively affects state and local efforts to ensure care for the medically indigent.

B. State Constitutions and Statutes

State constitutions empower legislatures to create tax exemptions for charitable institutions.178 The constitutions variously describe such tax-exempt institutions as organized and operated for "charitable purposes,"179 "purely public charity,"180 or "exclusively charitable purposes."181 Accordingly, state statutes contain the same general phrases.182 Most state statutes neither enumerate charitable activities183 nor establish affirmative obligations to the poor.184 Nevertheless, state courts have often interpreted their constitutional and statutory provisions to require nontaxable hospitals to...

173. Id.
174. See generally Bromberg & Teplitzky, supra note 7, at 70 (itemizing the benefits of federal tax exemption); Squiers, supra note 7, at 67 (discussing the benefits of federal tax exemption).
177. See sources cited supra note 174.
178. See selected constitutional provisions cited infra notes 179-181.
179. W. Va. Const. art. X, § 1 (providing "property used for... charitable purposes... may by law be exempted from taxation").
180. Ga. Const. art. VII, § 1; Minn. Const. art. 10, § 1; Pa. Const. art. VIII, § 2; Tex. Const. art. VIII, § 2 (providing "the legislature may, by general laws, exempt from taxation... institutions of purely public charity").
181. Colo. Const. art. X, § 5; Fla. Const. art. VII, § 3; Ill. Const. art. IX, § 6; Utah Const. art. XIII, § 2 (providing "lots with buildings thereon used exclusively for either religious worship or charitable purposes... shall be exempt from taxation").
182. Tex. Tax Code Ann. § 11.18(d) (Vernon Supp. 1982). The statute provides that "[a] charitable organization must be organized exclusively to perform... charitable... purposes... ." Id.
184. Ginsberg, supra note 7, at 315. But cf. Ala. Code § 40-9-1 (Supp. 1988) (exempting "[a]ll property... used exclusively for hospital purposes... where such hospitals maintain wards for charity patients or give treatment to such patients; provided, that the treatment of charity patients constitutes at least 15 percent of the business of such hospitals... .") ; Miss. Code Ann. § 27-31-1 (Supp. 1987) (exempting "[a]ll property... which is used for hospital
care for the medically indigent.\textsuperscript{185}

\section*{C. State Court Decisions}

In 1985 the Utah Supreme Court in \textit{Utah County v. Intermountain Health Care, Inc.}\textsuperscript{186} created a stringent test that nonprofit hospitals in the state must pass to gain exemptions from county property taxes.\textsuperscript{187} The test determines whether a particular institution actually uses its property exclusively for charitable purposes as required under the Utah Constitution.\textsuperscript{188} The test consists of several elements:

1. whether the governing instrument of the hospital identifies gratuitous service to needy patients as the purpose;
2. whether philanthropic contributions substantially support the hospital;
3. whether the hospital requires any financial reciprocation from charity patients;
4. whether the gross income, including philanthropic contributions and patient revenues, exceeds operational and long-term maintenance expenses;
5. whether the hospital freely or selectively extends gratuitous service and, if charity care is limited, whether the selection criteria further the hospital's charitable objectives;
6. whether private parties receive any form of financial benefit during operation or upon dissolution of the hospital; and
7. whether commercial functions are secondary to charitable ones.\textsuperscript{189}

The Minnesota Supreme Court first outlined these criteria in \textit{North Star Research Institute v. County of Hennepin}\textsuperscript{190} as guidelines for case-by-case purposes . . . and which maintains one or more charity wards that are for charity patients . . . ").


\textsuperscript{186} 709 P.2d 265 (Utah 1985). The Utah State Tax Commission overruled the Utah County Board of Equalization's decision not to grant charitable property tax exemptions to Utah Valley Hospital, owned and operated by Intermountain Health Care (IHC), and American Fork Hospital, leased and operated by IHC. Utah County sought a review of the Commission's ruling. Both hospitals, as well as IHC, were nonprofit corporations. The record, however, showed neither "nonreciprocal provision of services" nor "alleviation of a government burden" under the court's test of charitableness. \textit{Id.} at 278; see infra text accompanying note 189. The hospitals' failure to demonstrate "any substantial imbalance between the value of the services [they] provide[] and the payments [they] receive[] apart from any gifts, donations, or endowments" led the court to conclude that neither hospital used its property exclusively for charitable purposes under the Utah Constitution. 709 P.2d at 274. The court, therefore, denied both hospitals charitable property tax exemptions. \textit{Id.} at 278.

\textsuperscript{187} 709 P.2d at 269.

\textsuperscript{188} \textit{Id.}

\textsuperscript{189} \textit{Id.} at 269-70.

\textsuperscript{190} 306 Minn. 1, 6, 236 N.W.2d 754, 757 (1975). More recently, the Minnesota Supreme Court applied the \textit{North Star} criteria to deny a health maintenance organization exemption from sales and use taxation. \textit{Share v. Commissioner}, 363 N.W.2d 47, 50-51 (Minn. 1985).
analysis of whether an institution qualifies for a charitable tax exemption. Both supreme courts stressed that compliance with all factors was not essential to merit tax-exempt status.

Factors two through five represent three different criteria for evaluating a nonprofit’s provision of medical services to indigent patients. Factor two indirectly indicates the extent to which patient revenues cover the institution’s operational expenses; if patient revenues are the primary source of financial support, then the charitableness of the nonprofit is questionable. Factor three addresses remuneration for services rendered; if the nonprofit expects payment, then it is not generously providing care for the sick poor. Factors four and five concern whether the nonprofit is functioning as a for-profit business; if the nonprofit generates a surplus and limits access of the poor, then it is neither relieving a governmental burden nor benefiting the community. The essential element of charity, therefore, is “gift to the community,” which requires performance of a public responsibility or provision of services without reciprocal payment. This holding negates two common conceptions: (1) the equivalence of nonprofit status and charitable purpose, and (2) the direct relationship between federal tax-exempt status and state tax-exempt status.

Although no other state court has enunciated particularized preconditions for charitable tax exemptions, most case-by-case rulings are consistent with the principles governing the Utah decision. For example, the Colorado Supreme Court has consistently interpreted the state constitutional mandate that exempt property be used exclusively for charitable purposes as requiring generosity of services to needy persons. Such uncompensated care of the

191. 306 Minn. at 6, 236 N.W.2d at 757; accord Intermountain Health Care, 709 P.2d at 270.
192. 306 Minn. at 6, 236 N.W.2d at 757. In Intermountain Health Care the Utah Supreme Court explicitly stated that “each case must be decided on its own facts, and the foregoing factors are not all of equal significance, nor must an institution always qualify under all [fac- tors] before it will be eligible for an exemption.” 709 P.2d at 270.
193. 709 P.2d at 272-76. For an analysis of the Intermountain Health Care decision, see McCoy, supra note 119, at 7-10, and C. Havighurst, supra note 88, at 197-200.
194. See case and sources cited supra note 193.
195. Id.
196. Id.
197. Id. In a later case the Utah Supreme Court held that “provision of low-cost housing to low-income handicapped and elderly people in a proper environment constitutes charity.” Yorgason v. County Board of Equalization, 714 P.2d 653, 656 (Utah 1986). The court based its holding on a social-benefit rationale, acknowledging that purposes other than “the mere relief of the destitute or the giving of alms” may qualify as exclusively charitable. Id.
198. Intermountain Health Care, 709 P.2d at 278.
199. See generally Perkins & Dowell, supra note 15, at 476-78 (reviewing state court decisions); Perkins & Dowell, supra note 185, at 247-49 (reviewing more recent state court decisions).
200. West Brandt Found., Inc. v. Carper, 652 P.2d 564, 569-70 (Colo. 1982); United Presbyterian Ass’n v. Board of County Comm’rs, 167 Colo. 485, 448 P.2d 967, 971 (1968). The court in United Presbyterian Association quoted with approval the definition of charitable purpose articulated by Mr. Justice Gray in Jackson v. Phillips, 96 Mass. (14 Allen) 539 (1867): “A charity, in the legal sense, may be more fully defined as a gift, to be applied consistently with existing laws, for the benefit of an indefinite number of persons, either by bringing their minds or hearts under the influence of education or
medical indigent relieves a governmental burden and benefits society by obviating the necessity of increased taxes to support state welfare programs. Florida, Illinois, Missouri, and West Virginia courts have reached similar conclusions regarding provision of unobstructed charity. State courts, however, have held that mandatory payment from financially competent patients does not defeat a charitable tax exemption. Fees only become dispositive of state tax-exempt status when the hospital expects all patients to pay for care and bases the quality of services rendered upon

religion, by relieving their bodies from disease, suffering or constraint, by assisting them to establish themselves in life, or by erecting or maintaining public buildings or works or otherwise lessening the burdens of government.

Id. at 971-72 (emphasis added by Colorado Supreme Court).

201. 


204. Community Memorial Hosp. v. City of Moberly, 422 S.W.2d 290, 295-96 (Mo. 1967). The court quoted with approval 15 Am. JUR. 2d Charities § 148 (currently § 183 (1976)):

A hospital cannot . . . without losing its character as a public charitable hospital, receive pay patients to such an extent as will exhaust its accommodations and prevent its receiving and extending hospital service to the usual and ordinary number of indigent patients applying for admission under proper rules and regulations adopted by the authority managing and controlling the operation of such hospitals, since a hospital purchased with funds donated for the purpose of establishing and operating a public charitable hospital must be conducted as such a hospital.

Id. The Missouri Supreme Court in Jackson County v. State Tax Comm'n, 521 S.W.2d 378 (Mo. 1975), relying on Community Memorial Hospital, concluded that "providing of hospital facilities for the sick in a nonprofit manner rises to a charitable purpose tax-exempt status if the same is available to both rich and poor." Id. at 383.

205. State ex rel. Cook v. Rose, 299 S.E.2d 3, 6 (W. Va. 1982). The court first established the rule that taxation is the norm, whereas tax exemptions are the exception. Id. Courts thus strictly construe tax exemptions. Id. The court then enumerated several factors to consider when determining charitable tax exemption status. Id. The factors include, but are not limited to, the following:

1. [t]he purpose of the organization as set forth in its charter, articles of incorporation or partnership;
2. [t]he activities or services being offered on the premises of the property;
3. [t]he availability to the general public of the services or activities offered by the organization . . . in the particular property being considered;
4. [t]he presence or absence of rental income obtained from private organizations or persons for use of the property;
5. [w]here an exemption for charitable uses is claimed the amount of fees or other charges instituted for participation in the services or activities offered; and
6. [t]he sources of income used to operate and maintain the property on a "nonprofit" basis [and to] share deficits caused by expenses exceed[ing] receipts.

Id. (citing GUIDE FOR ASSESSORS 8-13 to 8-15 (1979)). The court acknowledged that treatment of indigent patients is "probably the single most important element necessary for a finding that a hospital is charitable under West Virginia property tax law." Id. at 7 (quoting GUIDE FOR ASSESSORS, 8-83 to 8-85 (1980) (emphasis added by court)).

206. See cases cited supra notes 200-205.
the amount the patient is able to pay.\textsuperscript{207}

By contrast, Texas courts currently do not equate charity with relief of the poor. In \textit{City of Houston v. Scottish Rite Benevolent Association}\textsuperscript{208} the Texas Supreme Court initially defined an “institution of purely public charity” as one that “[makes] no gain or profit; . . . [accomplishes] ends wholly benevolent; and . . . [benefits] persons, indefinite in numbers and in personalities, by preventing them, through absolute gratuity, from becoming burdens to society and to the state.”\textsuperscript{209} In a later decision the supreme court held, however, that absolute gratuity is not an essential element of charity\textsuperscript{210} and thus accepted the federal government’s position that charity is more than relief of the poor.\textsuperscript{211} Thereafter, a Texas court of appeals permitted a nonprofit whose only source of revenue was paying patients to retain its charitable tax exemption because it treated some indigents.\textsuperscript{212} Although the primary purpose of the nonprofit appeared to be provision of compensated services, the court held that it satisfied the ultimate requirement of a material assumption of a potential public obligation or duty.\textsuperscript{213} In accordance with the rationale and decisions in these cases another appellate court interpreted benevolent to include any act designed to promote the welfare of others, thereby giving it a broader meaning than charity.\textsuperscript{214} This decision further relaxed the defini-

\textsuperscript{207} \textit{Id.} For example, the Colorado Supreme Court held that “where material reciprocity between alleged recipients and their alleged donor exists—then charity does not.” West Brandt Found., Inc. v. Carper, 652 P.2d 564, 568 (Colo. 1982). Similarly, the Illinois Supreme Court held that the fee structure of a charitable institution cannot relate to “the bargaining of the commercial marketplace.” Methodist Old Peoples Home v. Korzen, 39 Ill. 2d 149, 157, 233 N.E.2d 537, 542 (1968).

\textsuperscript{208} 111 Tex. 191, 230 S.W. 978 (1921).

\textsuperscript{209} \textit{Id.} at 198, 230 S.W. at 981.

\textsuperscript{210} City of McAllen v. Evangelical Lutheran Good Samaritan Soc’y, 530 S.W.2d 806, 809-10 (Tex. 1976). The court in \textit{Evangelical Lutheran Good Samaritan Society} noted that other “courts have defined charity to be something more than mere alms-giving or the relief of poverty and distress.” \textit{Id.} The court held that the determination of tax-exempt status should be based upon “an evaluation of the total operation of the institution engaged in humanitarian activities whose services are rendered at cost or less and which are maintained to care for the physical and mental well-being of the recipients.” \textit{Id.} at 810 (emphasis added). The court thus expected that a charitable institution would not derive a profit from its services. \textit{Id.} The court further stated that the institution must perform a government function. \textit{Id.} This holding has been followed more recently by the courts in Dallas County Appraisal Dist. v. Leaves, Inc., 742 S.W.2d 424, 427 (Tex. App.—Dallas 1987, writ denied), and Lamb County Appraisal Dist. v. South Plains Hosp.-Clinic, Inc., 688 S.W.2d 896, 905-06 (Tex. App.—Amarillo 1985, writ ref’d n.r.e.).


\textsuperscript{212} \textit{Lamb County Appraisal Dist.}, 688 S.W.2d at 905.

\textsuperscript{213} \textit{Id.} at 906. The court quoted the opinion of the Texas Supreme Court in \textit{Evangelical Lutheran Good Samaritan Society}, 530 S.W.2d at 810, as controlling precedent:

[\textit{I}t is well settled that the fact that paying patients predominate over those unable to pay does not detract from the charitable nature of the service rendered . . . . Reliance upon percentages of paying patients versus non-paying patients, however, should not be the controlling factor. With the advent of present day social security and welfare programs, the traditional concept of charity, involving the extension of free services to the poor and alms-giving, will be rarely found since wide ranging assistance is available to the poor under such programs.]

\textit{Id.} at 905-06 (emphasis added by appellate court).

tion in *Scottish Rite Benevolent Association* of purely public charity. In Texas, as in some other states, charitable tax-exempt status for nonprofits, therefore, is not contingent upon provision of free or even reduced-rate medical services.

### D. State Legislative Activity

The loss in tax revenue, the steady increase in the number of indigent patients and medically needy patients, and the rise in the cost of health care have collectively prompted most, if not all, state legislatures to address the problem of health care for those patients who are unable to pay for medical services. A 1988 survey of state legislatures reveals that at least nine states, including Texas, are reevaluating charitable tax exemptions for nonprofit hospitals, and some are even considering setting minimum-care requirements for indigent patients and medically needy patients. Texas organized a state task force to study this problem and ultimately to recommend the threshold level of charity care that nonprofit hospitals must provide in exchange for tax exemption. If such legislation is enacted, the state comptroller as well as the courts would have a legal duty to require all nonprofit hospitals to accept their proportionate share of indigent and medically needy patients.

### IV. Proposal

The present health-care system has created a serious social problem. As for-profit hospitals began to capture the medical market, nonprofit

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215. 111 Tex. at 198, 230 S.W. at 981; see *supra* text accompanying notes 208-209.

216. *West Allegheny Hosp. v. Board of Property Assessment, Appeals & Rev.*, 455 A.2d 1170 (Pa. 1982). The *West Allegheny* court reversed a lower court holding that the hospital was not entitled to a property tax exemption because the hospital recovered approximately 97% of in-patient care charges and 80% of out-patient care charges. 63 Pa. Commw. 555, 439 A.2d 1293, 1296 (1981). The Pennsylvania Supreme Court held that "the word 'charity' as used by the Legislature does not contemplate the requirement that there be only a nominal charge to beneficiaries." 455 A.2d at 1173. The dissent presents a good counter analysis. *Id.* at 1173-75.


219. *Id.*

220. Telephone interview with Edward Hopkins, member of the Texas Attorney General's Region V Committee for the Special Task Force to Study Not-For-Profit Hospitals and Unsponsored Charity Care (Sept. 23, 1988). With the change in personnel in the Attorney General's office, the status of this task force is uncertain.


222. See *supra* text accompanying notes 18, 25. Although the free market should operate to improve the efficiency, accessibility, and quality of health care, at least one commentator suggests that its overall effect has been detrimental because of several anomalies of the medical market. Relman, *The New Medical-Industrial Complex*, 303 N. ENG. J. MED. 963, 963, 966-67 (1981). First, government-funding of health care and health-related research fosters the view that the public is entitled to medical services as a fundamental right. *Id.* Second, public or private insurance covers a large fraction of the cost of most medical services, thereby reliev-
hospitals, to compete, modified their financial structure by manipulating privileges associated with section 501(c)(3) status\(^2\) and changed their focus from caring for the sick poor to attracting paying patients.\(^3\) That transforming individuals of direct financial responsibility for their health care. \(\textit{Id.}\) This compensation system creates consumers who are insensitive to price and therefore interferes with the normal economic operation of supply and demand. \(\textit{Id.}\) Finally, patients, unlike consumers of other products or services, usually do not determine their medical needs. \(\textit{Id.}\) Physicians, in effect, make such decisions for patients because patients generally do not have adequate knowledge to evaluate health-care options in a meaningful manner. \(\textit{Id.}\) The public thus entrusts physicians and hospitals with its health. \(\textit{Id.}\) Despite this trust relationship, the private health-care industry encourages overuse and misuse of its services. \(\textit{Id.}\)

\(^2\) Many nonprofits responded to the financial pressures of the marketplace by restructuring into multi-entity forms. Keenan, \textit{supra} note 23, at 77; LaViolette, \textit{supra} note 23, at 98; McCoy, \textit{supra} note 119, at 11; Squiers, \textit{supra} note 7, at 71-72. The nonprofit hospital and other nonprofit businesses as well as for-profit businesses become subsidiaries of the parent. See \textit{supra} text accompanying notes 134-138. Examination of this multi-entity enterprise reveals the advantages. Squiers, \textit{supra} note 7, at 71-73. First, the proprietary subsidiaries pay all or the appropriate percentage of their profits as dividends to the parent, which then transfers the gain to the nonprofit hospital subsidiary, thereby increasing the hospital's revenues without subjecting it to tax consequences. \(\textit{Id.}\) Normally, the IRS requires a tax-exempt nonprofit hospital to pay taxes on income derived from any ancillary activity that does not promote the institution's charitable purpose. \(\textit{Id.}\); see I.R.C. §§ 511-515 (1954) (provides for taxation of unrelated business income). In addition, if the noncharitable purpose of the ancillary activity becomes the primary purpose of the nonprofit hospital, then the hospital loses its tax-exempt status. See Treas. Reg. § 1.501(c)(3)-1(e)(1) (1956) (defining operation of trade or business). By establishing parent holding companies, nonprofit hospitals circumvent such statutory limitations. Squiers, \textit{supra} note 7, at 72.

The parent holding company also provides opportunities for private individuals associated with the nonprofit hospital to benefit financially without violating the noninurement clause of Code § 501(c)(3). \(\textit{Id.}\) at 72-73. For example, members of the hospital's medical staff may invest privately in the affiliated for-profit corporations and receive dividends in return. \(\textit{Id.}\) In addition, the for-profit alternative provider subsidiaries such as outpatient renal dialysis, rehabilitation, or ambulatory surgery services may also employ members of the hospital's medical staff. \(\textit{Id.}\) at 71, 73. Because salaries for such corporations are not statutorily regulated, compensation may exceed the value of the employee's actual contribution to the outpatient service. \(\textit{Id.}\) Consequently, physicians at nonprofit hospitals may now benefit monetarily from the financial success of the multi-entity enterprise and thus indirectly the hospital. A nonprofit hospital as a subsidiary to a nonprofit parent holding company or as a member of another multi-entity form can enjoy both the benefits of tax exemption and the advantages of a proprietary business.

\(^3\) Kennedy, \textit{The Proprietarization of Voluntary Hospitals}, 61 \textit{BULL. N.Y. ACAD. MED.} 81, 81-82 (1985); Richards & Tucker, \textit{supra} note 1, at 3-6; Squiers, \textit{supra} note 7, at 71-73. Several studies based on national averages indicate for-profits and nonprofits treat similar numbers of medically indigent patients. Herzlinger & Krasker, \textit{supra} note 24, at 101-03; Relman, \textit{supra} note 25, at 1199. Critics of these studies claim that national averages are statistically inaccurate because they do not account for the considerable variations in the percentage of state populations that are medically indigent. Lewin, \textit{supra} note 25, at 1213; Relman, \textit{supra} note 25, at 1199. In addition, the extent of each state's dependence on private hospitals for charity care varies. \(\textit{Id.}\) Volunteer Trustees for Not-for-Profit Hospitals, therefore, commissioned a study to examine the differences in amounts of uncompensated medical care among hospitals in five states: California, Florida, North Carolina, Tennessee, and Virginia. Lewin, \textit{supra} note 25, at 1213. These states satisfied three criteria: (1) in each state for-profit and nonprofit hospitals competed directly with each other; (2) in terms of size and geographical location the states represented a cross-section of the United States; and (3) each state collected data suitable for analyzing the comparative degree to which the voluntary hospitals and investor-owned hospitals relieved the charity care burdens. \(\textit{Id.}\) This study demonstrated that nonprofit hospitals provided 50% to 90% more free care than for-profit hospitals in four of the five states surveyed. \(\textit{Id.}\) at 1214. In California, where charity care is publicly financed, all private institutions contributed equally. \(\textit{Id.}\) Low Medicaid reimbursement, as in Florida and Tennes-
mation of the nonprofits, coupled with a general reduction in federal financial resources to supplement health-care costs, has resulted in a decline in the availability of adequate medical services for indigent patients. Both Congress and the Supreme Court have implicitly sanctioned this decline, the former by accepting the IRS's broad interpretation of the Code's charitable purpose standard, and the latter by refusing to hear challenges to that interpretation.

Society has begun to question the tax-exempt status of nonprofit hospitals. Its primary concern is whether nonprofits provide appropriate levels of uncompensated and/or below-cost medical care. Taxpayers, who are indirect shareholders in tax-exempt nonprofits, arguably expect such institutions to treat a proportionate share of the sick poor. For-profit hospitals do not have the same obligation to society. The extent to which for-profits provide charity care, therefore, is not relevant to the determination of how much charity care nonprofits should provide. As public hospitals cannot service all of the medically indigent patients, private nonprofit hospitals must also care for the sick poor.

State legislatures should rise to the challenge and accept the responsibility of statutorily establishing affirmative obligations to the sick poor as a prerequisite to charitable tax-exempt status. Each state legislature should determine the extent of its indigent medical care problem and, accordingly, set a minimum level of charity medical services to be provided by tax-exempt hospitals. A similar situation exists in Texas. Kennedy, supra, at 86.

The overall and individual state evaluations reveal that the structure of a study predetermines its results. This aspect of selective statistical evaluation diminishes its reliability. Such studies thus do not facilitate solving the problem of who should care for medically indigent patients.

225. Kennedy, supra note 224, at 86; Squiers, supra note 7, at 66. For many years Medicare reimbursement was based on the actual cost of hospital services to charity patients, which was offset by some types of hospital income. Id. Today hospitals receive a fixed amount for a specific treatment regardless of the actual cost. Id. Because such payments can be no greater than they would have been under the original system, hospital remuneration has not necessarily improved. Id. A progressive trend toward less governmental support, however, preceded the change in the Medicare reimbursement system. Id. For example, the percentage of hospital charges covered by Medicare decreased from 75% in 1974 to only 68.7% in 1982. Id. Similarly, private insurance tightened controls on reimbursement. Id.; Kennedy, supra note 224, at 86. Consequently, hospitals could no longer cover their unreimbursed costs on Medicare patients with revenues from privately insured or self-insured patients. Lewin, supra note 25, at 1212.

226. Kennedy, supra note 224, at 81-82; Richards & Tucker, supra note 1, at 3-6; Squiers, supra note 7, at 71-73.

227. See supra notes 82-84 and accompanying text.

228. See supra notes 85-95 and accompanying text.

229. Baldwin, supra note 24, at 34-35; Special Report, Indigent Care, supra note 217, at 22; Special Report, Survey, supra note 218, at 28-41.


231. See Relman, supra note 25, at 1199. Relman believes that the preferential tax treatment of voluntary hospitals is only justified if these institutions follow their historic mission to care for the medically needy. Id.

232. See Dallek & Waxman, supra note 154, at 1413 (examining patient dumping problem).
nonprofit hospitals. This level could be phrased as a percentage of total patient care. Because in-patient services are more costly to a provider than out-patient services, a statute should stipulate that no more than half of a nonprofit hospital's charity care may be related to out-patient services without approval of a state's taxing entity. A statute should also provide for transfers of nonemergency, stable emergency, or long-term indigent patients from a hospital handling a significant number of indigent cases to one not receiving sufficient requests for charity medical services. Such a provision would equalize indigents' access to health care by making tax-exempt nonprofits located in affluent areas available to needy patients. If a tax-exempt nonprofit cannot satisfy the charity care requirement after a good faith effort to comply, then the institution should be able to request permission from a state's taxing entity to conduct an alternative community service such as a program for acquired immune deficiency disease syndrome (AIDS) victims or substance abuse sufferers. Otherwise, a nonprofit hospital not in complete compliance with such a statute would be granted only a partial tax exemption related to its actual provision of charity care, or denied tax-exempt status altogether, depending on the surrounding circumstances. A state's taxing entity, however, should have the authority to recognize an exception to this provision when (1) a nonprofit is financially incompetent to satisfy the charity care requirement, (2) a denial of tax-exempt status would cause bankruptcy, and (3) the community needs the institution.

Although a for-profit hospital would not have a legal responsibility to care for medical indigents, a statute should include a tax-incentive program to encourage such community service. This program should adjust a for-profit's tax rate or provide a tax credit according to the degree to which the institution relieves the state's indigent medical-care burden. This tax advantage would be an option to treating the charity service amount as a tax-deductible business loss.233 To function as an incentive to care for the sick poor, the charity service advantage must therefore be a more favorable tax treatment than the business loss deduction.234

Opponents of mandatory charity medical care by nonprofits might argue that it is inappropriate to place the burden of public health exclusively on nonprofit as well as public hospitals and indirectly their paying patients. Rather, they might propose national health insurance, because it directly distributes the public health burden among all taxpayers, and it guarantees universal coverage, uniform fees, and comprehensive services.235 Society, however, has given physicians and hospitals a monopoly on health care, thereby creating a trust relationship between physicians/hospitals and society. Requiring government-subsidized hospitals to relieve public health burdens is therefore clearly appropriate and reasonable. In addition, state-

235. See Kennedy, supra note 224, at 88-89.
regulated hospital charity is likely to be a more economical and beneficial solution than national health insurance. Under the proposed statutory scheme hospitals would keep the cost of health care low for financial reasons and the quality of health care high for public-relations reasons. By contrast, the administrative costs of a national program would offset, at least partially, any reduction in medical service fees, and health care providers reimbursed by national health insurance would probably be less sensitive to public opinion and thus less concerned about the quality of their services.

V. CONCLUSION

The United States currently faces an indigent medical-care crisis. Factors contributing to this problem include: (1) increase in the number of medical indigents, (2) rise in health care costs, (3) change in the focus of nonprofit hospitals from patient welfare to financial success, (4) decrease in the amount of charity medical care provided by nonprofit hospitals, and (5) elimination of the charity medical-care requirement for federal tax-exempt status under Code section 501(c)(3). Many state courts have sought to rectify the indigent health-care crisis by construing their constitutions and statutes to require tax-exempt nonprofit hospitals to serve the medical needs of the sick poor. This approach, however, results in inconsistent application of the law. State legislatures, therefore, should amend their charitable tax-exempt statutes, legally obligating a nonprofit hospital to treat its proportionate share of the indigent patient population. This Comment proposes guidelines for such a statutory amendment.