

TAX-EXEMPT HOSPITALS: WHAT IS THEIR CHARITABLE RESPONSIBILITY AND HOW SHOULD IT BE DEFINED AND REPORTED?

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I. INTRODUCTION

In ancient Greece, taking money in exchange for providing life-saving services was grounds for electrocution by the gods. When Zeus was informed that Asclepius, the founder of medicine, was “bribed with gold” to bring the dead back to life, Zeus struck him dead with a thunderbolt.¹ The ancient tension between being a healer and getting paid to heal continues today in modern America. Now it is not an issue of whether healers should be paid, but rather, how much is paid, how the fee is collected, and whether or not the healers properly report their activities to the public. In Zeus’ place are many public officials, from federal and state lawmakers and enforcers to the I.R.S. and county tax authorities, all deeply concerned about whether nonprofit, tax-exempt hospitals deserve their tax-exemptions.

II. THE GATHERING STORM

In 2003, a series of articles in *The Wall Street Journal* detailed aggressive billing and debt collection practices of a number of highly respected nonprofit hospitals, marking the beginning of an upsurge in public attention to the charitable behavior of hospitals.² Class action lawsuits about unfair billing and collection practices and inadequate provision of charity care were filed in 2004 against hundreds of hospitals nationwide, spearheaded by Richard Scruggs, a lawyer who helped the states win huge settlements from the tobacco industry in the 1990s. In 2005, two powerful members of Congress, Representative Bill Thomas (California), Chairman of the House Ways and Means Committee, and

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1. ROBERT GRAVES, *THE GREEK MYTHS* 175 (Penguin Books 1964); see Ron Leadbetter, *Asclepius*, Encyclopedia Mythica, <http://www.pantheon.org/articles/a/asclepius.html> (last visited Jan. 8, 2007).

2. See Lucette Lagnado, *Full Price: A Young Woman, an Appendectomy, and a \$19,000 Debt*, WALL ST. J., Mar. 17, 2003, at A1; Lucette Lagnado, *Twenty Years and Still Paying: Jeanette White Is Long Dead But Her Hospital Bill Lives On*, WALL ST. J., Mar. 13, 2003, at B1.

Senator Charles E. Grassley (Iowa), Chairman of the Senate Finance Committee, began publicly questioning the value of hospital tax-exemption compared to the benefit the community received from them. According to Grassley, "Too many [hospitals] do little to nothing. Too often, it seems that tax-exempt hospitals offer less charitable care and community benefit than for-profit hospitals."³ Grassley has also expressed concern about hospital executive compensation levels, joint ventures with commercial organizations, and hospital for-profit subsidiaries.⁴ Thomas explained, "Congress has a responsibility to assure the American taxpayer that the tax-exempt hospital sector is living up to its community responsibilities."⁵

Meanwhile, for 2006, the I.R.S. announced a stronger enforcement presence for nonprofit hospitals, citing concern over hospital practices in the areas of executive compensation, community benefit accountability, and the use of the proceeds of tax-exempt bonds.⁶ As part of that effort, they sent out nearly six hundred "compliance check" letters to nonprofit hospitals requesting answers to eighty detailed questions.⁷

Between 2004 and 2006, state and local officials have also stepped up their challenges of hospital charitable behavior and tax-exempt status. From New Hampshire to Utah, state legislators and attorneys general have been actively questioning the appropriateness of billing and collection practices, while challenging tax-exemption requests for hospital-acquired property and businesses that were previously tax-paying. In New Hampshire, the legislature set up a committee to study hospital property tax exemptions.⁸ After a year of work, the committee cited continuing interest but offered no concrete proposals other than that hospitals should be required to report their financial statements to the public.⁹ In Ohio, the Ohio Tax Commissioner denied a local tax exemption for Cleveland Clinic's newly acquired clinic in a wealthy suburb because it provided minimal charity care.¹⁰ In Illinois, the state passed legislation requiring community benefit reporting in 2003; in 2006, the state

3. Robert Pear, *I.R.S. Checking Compliance by Tax-Exempt Hospitals: Inquiry May Bring Changes in Standards*, N.Y. TIMES, June 19, 2006, at A15.

4. Letter from Charles E. Grassley, Chairman, Committee on Finance, U.S. Senate, to Richard J. Davidson, President, American Hospital Association (Mar. 8, 2006), available at <http://finance.senate.gov/press/Gpress/2005/prg030806aha.pdf>.

5. Luiza Ch. Savage, *Senator Eyes City Hospital in Tax Debate*, N.Y. SUN, May 26, 2005, at A1.

6. David M. Flynn & Philip H. Lebowitz, *2006 Exempt Organizations (EO) Implementing Guidelines* (Nov. 15, 2005), available at <http://www.mondaq.com>.

7. Pear, *supra* note 3.

8. Roger Talbot, *State Eyes Hospitals' Tax-Exempt Status*, UNION LEADER (Manchester, N.H.), Dec. 18, 2005, at A12.

9. *Id.*

10. Sarah Treffinger, *Ruling Presents New Challenge to Hospitals' Tax-Exempt Status*, CLEVELAND PLAIN DEALER, Nov. 27, 2005, at B6.

Attorney General proposed legislation (H.B. 5000) requiring minimum charity expenditures by nonprofit hospitals.¹¹ In North Carolina, a bill was proposed that would limit the types of property that can be exempt and would require provision of a minimum level of charity care expenditure.¹² In Kansas, the Attorney General opened an investigation of hospital billing and collection practices.¹³ In Utah, Intermountain Health agreed to less aggressive debt collection practices under pressure from the legislature.¹⁴ In Minnesota, the Attorney General investigated aggressive debt collection and inadequate provision of charity care, forcing four hospital systems to agree to discount charges to the uninsured by 40 to 60%.¹⁵ In 2005, eight states proposed bills regarding the provision of charity care and billing practices.¹⁶ While little has actually passed into law, it may be just a matter of time before a higher standard of charitable behavior will be established by certain states, and the federal government is likely to pass a bill in the near future.¹⁷ Representative Bill Thomas proposed the Tax Exempt Hospitals Responsibility Act of 2006, which would impose penalties on nonprofit hospitals failing to provide a minimum level of charity care, among other things.¹⁸

III. MAJOR THEMES TO RECENT TAX-EXEMPT CHALLENGES

The issues involved in state and federal challenges to hospital tax-exemption are much broader than simply how much charity care hospitals provide. They include excessive pricing, excessive personal gain, demonstrable value for the value of tax exemption, transparency, and accountability. This range of issues gives the political forces challenging nonprofit hospitals access to a more powerful spectrum of stakeholders than just advocates for the uninsured. It creates odd bedfellows coupling politically conservative advocates of health savings accounts (HSAs) with liberal consumer advocacy groups concerned about vulnerable populations of uninsured Americans. Local towns and school districts starving for tax revenue are leading the charge in some states. One sign of the widening political appeal of the issue was a recent *60 Minutes* segment that was critical

11. Editorial, *Charity Standard*, ST. LOUIS POST-DISPATCH, Feb. 11, 2006, at A49.

12. Hamilton C. Horton, Jr., *Re-Examine Tax-Exempt Status for Hospitals*, WINSTON-SALEM J., June 11, 2005, at A11.

13. Robert Pear, *Nonprofit Hospitals Face Scrutiny Over Practices*, N.Y. TIMES, Mar. 19, 2006, at 18.

14. Brian Baskin, *Fixing Charity Issues Seems Somebody Else's Problem*, ARK. DEMOCRAT-GAZETTE, July 3, 2005.

15. *Id.*

16. *Id.*

17. *Reform of Law on Tax-Exempts Inevitable, But Impact on Hospitals Seen Uncertain*, 16 BNA'S MEDICARE REP. 1296 (2005).

18. H.R. 6420, 109th Cong., 2d Sess. (2006).

of hospitals' charitable behavior.¹⁹ A deeper understanding of the hospital behaviors generating the political momentum clarifies why policy change is likely and why the momentum is not tied to hospital provision of charity care alone.

A. *Excessive Pricing*

Excessive pricing itself is multifaceted, with each facet bringing in a new set of political interests. The most obvious group subject to excessive pricing are the uninsured, who are routinely charged prices that are between two to six times the cost to produce the service. They are then aggressively pursued by debt collection agencies for years.

While charges that bear little resemblance to cost may have had relatively benign motivations twenty-five years ago,²⁰ they have become highly visible symbols of nonprofit hospital "corporate" behavior toward the defenseless consumer. Average collection rates on these inflated bills run roughly 20% of the *cost* (not charges) of care,²¹ which implies that only pennies on the dollar amounts billed are actually collected. Yet some nonprofit hospitals pursue former patients to extremes including putting liens on homes, garnishing wages, and even imprisoning debtors.²² Intended or not, aggressive debt collection practices discourage patients with medical debt from returning for additional care.

The impact on people owing the bills, regardless of whether they pay, can be disastrous. People with high medical indebtedness (whether insured or not) are less likely than others to seek appropriate medical care when needed and will curtail activities that might result in injuries, such as participation in sports.²³ Many people with medically-related debt file for personal bankruptcy. These vulnerable people constitute the working poor and the middle class, a large segment of U.S. society.

A very different constituency concerned about excessively high hospital prices are commercial health insurers, backed by conservative policymakers who believe that high-deductible health plans (HDHPs), coupled with tax-subsidized HSAs, will be the magic bullet that slows the rate of health care cost increases in the country. HDHPs and HSAs could give consumers strong financial incentives to exercise "individual responsibility" for their health care choices through choosing less expensive providers and avoiding unnecessary

19. *60 Minutes: Is the Price Right?* (CBS television broadcast Mar. 5, 2006).

20. See *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways and Means*, 108th Cong. 13–14 (2004) (statement of Nancy M. Kane, DBA, Harvard Sch. of Pub. Health).

21. See MEDPAC REPORT TO THE CONGRESS: SELECTED MEDICARE ISSUES, 186 tbl. C-12 (June 2000) (classifying bad debtors under the "uncompensated care" payer category).

22. Editorial, *supra* note 11.

23. Hugh F. Daly III et al., *Into the Red to Stay in the Pink: The Hidden Cost of Being Uninsured*, 12 HEALTH MATRIX 39, 43, 58–59 (2002).

care. However, excessive hospital prices charged to the self-paying patient present a major obstacle to the realization of effective consumer purchasing.

This latter group may be the political force behind congressional pressures on the Office of the Inspector General to adopt as a final regulation a 2003 proposed rule that defines “excessive prices” to Medicare. The proposed rule suggests that hospital prices be considered excessive if they are greater than 120% of average net payments of all private sector payers, excluding charity discounts and capitated payments.²⁴ Such a rule, if implemented, would threaten hospitals with exclusion from participating in the Medicare program if they submitted claims found to contain excessive charges. Since hospitals are not allowed to have different charge-masters for different patient-payer classes (discriminatory pricing), prices would have to be adjusted for all patients, including direct-pay patients to a level compliant with the 120% rule. With private sector discounts averaging roughly 50% of charges, such a rule could lower charges to self-paying patients by roughly 40% off current levels. Perhaps even more important, Medicare would be brought into the pricing battle as both a directly affected party (some Medicare payments are influenced by hospital charges) as well as potentially becoming the regulatory and administrative vehicle that collects hospital charges and private sector discounts, investigates them for reasonableness, and makes that data available to the public.

B. Excessive Personal Gain

This concern, too, is multifaceted. Most visible is the level of executive compensation that hospital boards approve. According to one source, nonprofit executive salaries have grown by 20 to 30% per year over the past five years (2000–2005), far exceeding the pay raises of other workers.²⁵ Health system executives earning over a million dollars in annual salary and retiring with \$5 to \$6 million “golden handshakes” at a time when low-wage hospital employees have to enroll their children in Medicaid catches the attention of policymakers and the I.R.S. In 2005, the I.R.S. Commissioner, Mark Everson, announced a crackdown on excessive compensation within tax-exempt organizations, and Senator Grassley included detailed questions about executive compensation and benefits in his letters to ten hospitals requesting information about what makes them charitable.²⁶

24. Medicare and Federal Health Care Programs: Fraud and Abuse; Clarification of Terms and Application of Program Exclusion Authority for Submitting Claims Containing Excessive Charges, 68 Fed. Reg. 53,939, 53,942 (Sept. 15, 2003).

25. Joe Rojas-Burke, *Scrutiny Rises with Hospital Paychecks*, THE OREGONIAN, Dec. 22, 2005, at A1.

26. See, e.g., Savage, *supra* note 5.

Besides executives, policymakers are concerned about hospital-physician joint ventures in which the hospital may provide the capital and/or share the operating risk with physician owners of profitable freestanding services in imaging, laboratory, day surgery, and specialty inpatient care. Such ventures are often driven by physicians seeking to enhance their income, which has declined in real dollars in recent years as the payment environment has tightened.²⁷ One of Senator Grassley's questions that hospitals were asked to respond to included whether they agreed that "[m]any nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons."²⁸

House Ways and Means Committee Chairman Bill Thomas expressed concern that hospitals have become "increasingly commercial" in their operations.²⁹ Hospitals have diversified into many businesses in the last twenty years, from health insurance and physician practices to assisted living facilities, software companies, and even venture funds investing in the commercialization of medical discoveries. Many of these business ventures are for-profit, owned solely by the health system or in partnership with a for-profit organization. Some turn out to be expensive business failures financed by charitable dollars.³⁰ The magnitude of investment and return are very difficult to detect as multiple entities are involved, only some of which must file a 990 tax return with the I.R.S. Over ten years ago, this movement into commercial operations was recognized by some as likely to negatively impact the social mission of hospitals. In January 1995, Cardinal Joseph Bernadin was quoted as saying, "I am becoming increasingly concerned that our healthcare delivery system is rapidly commercializing itself, and in the process is abandoning core values that should always be at the heart of healthcare."³¹ Ten years later, growing controversy over hospital tax-exemption reflects society's recognition that, indeed, commercialization and charity are often incompatible core values.

27. Ha T. Tu & Paul B. Ginsburg, *Losing Ground: Physician Income, 1995-2003*, TRACKING REP. 15 (Ctr. for Studying Health Sys. Change), June 2006, at 1.

28. Savage, *supra* note 5.

29. *Id.*

30. See Lawton R. Burns et al., *The Financial Performance of Integrated Health Organizations*, J. OF HEALTHCARE MGMT 191, 206 (May-June 2005).

31. David W. Johnson, Managing Director, Citigroup, Presentation at Harvard School of Public Health, Financing the Future: Healthcare Trends and Their Impact on Capital Funding (Mar. 18, 2005).

C. Demonstrable Value for Tax Exemption

In 2005, in response to a request by the House Ways and Means Committee, the Government Accountability Office (GAO) produced a report on differences found in the provision of uncompensated care (bad debt and free care combined) among private nonprofit, publicly-owned, and investor-owned hospitals.³² They concluded that government hospitals maintained significantly higher uncompensated care burdens (defined as the ratio of uncompensated care relative to total operating expense) than the other groups, while nonprofit private and investor-owned hospitals showed only small differences in uncompensated care burden.³³ Furthermore, only a very small proportion of hospitals provided the bulk of the private nonprofit uncompensated care burden.³⁴ The GAO commented that

current tax policy lacks specific criteria with respect to tax exemptions for charitable entities If these criteria are articulated in accordance with desired goals, standards could be established that would allow nonprofit hospitals to be held accountable for providing services of benefit to the public commensurate with their favored tax status.³⁵

Studies comparing the value of tax exemptions to the provision of charity care have found that most hospitals would not earn their tax exemption on the value of charity care alone, particularly when charity care is expressed in terms of costs, not charges.³⁶ Hospitals argue that they provide many community benefits other than charity care, and that these benefits should be considered when comparing value for tax exemption. However, even within the hospital industry there is disagreement as to which activities should justify tax exemption. Currently, for instance, the American Hospital Association (AHA) disagrees with the Catholic Healthcare Association (CHA) over whether bad debt expense and “Medicare shortfalls” (excess of cost over payment) should be considered community benefits, with the AHA asserting that they should be

32. DAVID M. WALKER, U.S. GOV'T ACCOUNTABILITY OFF., COMPTROLLER GENERAL OF THE UNITED STATES, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS (May 2005).

33. *Id.* at 3.

34. *Id.*

35. *Id.* at 19.

36. See CONG. BUDGET OFF., NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (Dec. 2006); U.S. GEN. ACCT. OFF., NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION (May 1990); HEATHER O'DONNELL & RALPH MARTIRE, CTR. FOR TAX AND BUDGET ACCOUNTABILITY, AN ANALYSIS OF THE TAX EXEMPTIONS GRANTED TO COOK COUNTY NON-PROFIT HOSPITALS AND THE CHARITY CARE PROVIDED IN RETURN (2006); Nancy M. Kane & William H. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, 78 MILBANK Q. 185, 199 (2000).

considered and the CHA saying they should not.³⁷ The GAO study discussed earlier noted that hospitals reported a wide range of other community benefits, but that there was no clear pattern distinguishing nonprofit from investor-owned hospital groups.³⁸ Furthermore, there was no independent audit or meaningful monitoring of the data reported to states, and states that required community benefit reporting were not routinely using the data to review hospital tax status.³⁹ The Commissioner of the I.R.S., Mark Everson, was quoted as saying that agents “often found little difference between nonprofit and for-profit hospitals ‘in their operations, their attention to the benefit of the community, or their levels of charity care.’”⁴⁰

Besides questioning the value of charity care and other community benefits relative to the value of tax exemption, federal policymakers are exploring the distribution and use of tax-exempt bonds when hospitals could have used internal assets to meet their capital investment needs. Termed “tax arbitrage,” some large nonprofit hospital systems borrow using tax-exempt bonds even though they have investment assets (unrestricted marketable securities that were earned through unrestricted gifts, investment income, retained earnings, and funded depreciation) that could cover some or all of the cost of needed capital projects. Hospitals engage in tax arbitrage when the tax-subsidized cost of borrowing is below the returns they can earn on investment assets. As one hospital system noted in its 1999 Bond Prospectus: “Management has taken a pro-active approach to managing the debt position and the investment portfolio for the System. The overall weighted average interest rate on long-term debt is 5.50%, while the overall investment portfolio has generated an average annual return in excess of 14%.”⁴¹

One study found that over half the tax-exempt debt held by hospitals in 1996 could have been eliminated if hospitals had used their “endowment assets” before borrowing.⁴² The same study also found that both endowment assets and tax-exempt bonds are concentrated in a minority of hospitals, indicating that tax subsidies are benefiting cash-rich hospitals while not helping those cash-poor hospitals most in need of outside financing.⁴³ Congress and the I.R.S. are now looking into whether this is an appropriate use of tax-exempt bonds, which represent a significant “tax expenditure” of the

37. David Burda, *Stop Playing Politics with Charity*, MOD. HEALTHCARE, June 5, 2006, at 20.

38. WALKER, *supra* note 32, at 3–4.

39. U.S. GEN. ACCT. OFF., *supra* note 36, at 20.

40. Pear, *supra* note 13.

41. Official Statement for Revenue Bonds, Series 1999 A, UPMC Health System, A-15.

42. William M. Gentry, *Debt, Investment, and Endowment Accumulation: The Case of Not-for-Profit Hospitals*, 21 J. OF HEALTH ECON. 845, 871 (2002).

43. *Id.* at 870.

federal government.⁴⁴ With over \$100 billion in tax-exempt debt outstanding as of 2002, the possibility that half was used for tax arbitrage rather than for expanding access to capital for cash-strapped hospitals could generate even more taxpayer indignation.⁴⁵

A final area of broad inquiry into the value of tax exemption comes from the local level, where property tax exemption requests by hospitals are increasingly meeting resistance by local tax authorities. In 2005, the Fiscal Research staff of the North Carolina General Legislature noted that tax-exempt hospitals represent as much as 2% of total county property value in the state, and that the percentage was growing as hospitals acquired medical office buildings and residential real estate.⁴⁶ This finding prompted proposed Senate Bill 175, which would require that rental housing, physician offices off hospital grounds, and health clubs and child care facilities open to the public be subject to county property taxes.⁴⁷ New Hampshire's General Legislature appointed a committee to "study the exemption from property taxes for not-for-profit hospitals."⁴⁸ Among its conclusions was that hospital acquisitions of doctors' clinics and offices had "defeated the legislative intent of broadening the business tax base," referring to the Business Enterprise Tax, enacted in 1993.⁴⁹

In more substantive action, the Ohio Tax Commissioner recently ruled against Cleveland Clinic's request to extend its tax exemption to an acquired family health and surgery center in a wealthy suburb.⁵⁰ Here, the Beachwood school district contested the request, claiming that the clinic itself provided little to no charity.⁵¹ While the Cleveland Clinic appeals that ruling, certain Cleveland-area school districts are challenging the tax-exempt status of other Cleveland Clinic properties, worth an expected \$17 million for the Clinic and its system as a whole.⁵²

In all of these property tax challenges and investigations, the amount of charity provided was considered as part of the expected value that localities considered. As the North Carolina legislature and others have discovered, the value of charity care provided varies considerably within a geographically-defined group of nonprofit hospitals, as well as within facility members of a

44. See, e.g., CONG. BUDGET OFF., NONPROFIT HOSPITALS AND TAX ARBITRAGE (Dec. 2006).

45. The amount of tax-exempt financing outstanding in 2002 was between \$94 billion and \$124 billion. Email from Dennis Zimmerman, CBO Analyst (Aug. 9, 2006) (on file with author).

46. Horton, *supra* note 12.

47. *Id.*

48. Talbot, *supra* note 8.

49. *Id.*

50. Treffinger, *supra* note 10.

51. *Id.*

52. *Id.*

hospital system. The New Hampshire committee report pointed out that historically, charity was “the reason that led the legislature to grant these hospitals tax exemption.”⁵³ However, all parties to these studies point out that the charity standard is not well articulated and is insufficient for today’s health care system.

D. Transparency

The lack of transparency of hospital activities adds fuel to the fire of public ire and policymakers’ distrust. Inadequate public reporting of charity care and community benefits is common. This is apparently a problem across the nonprofit sector. One of the major recommendations of the Panel on the Nonprofit Sector’s June 2005 Report to Congress is that “[i]nformation about the organization’s charitable purpose and key program achievements should be included on the first pages of the Forms.”⁵⁴ Part of that can be changed by policymakers themselves; neither the I.R.S. Form 990 nor the Medicare Cost Report, the only two national sources of mandatory public reporting by nonprofit hospitals, has a standard definition of charity care or a fixed place to report it in their forms. Unfortunately, a recent attempt by the Centers for Medicare and Medicaid Services to require uncompensated care information (the new Schedule 10) suffers from ambiguous reporting instructions, rendering the 2004 reported results unusable.⁵⁵

Meanwhile, the Catholic Healthcare Association, the Voluntary Hospital Association, the American Hospital Association, and others have attempted to standardize reporting for community benefits—both charity and other types of activities—but the standards are voluntary and vary with the source. A significant area of disagreement is how to count bad debts, as well as the “Medicare shortfall.” State efforts to define a standard for community benefit have been undermined at times by industry insistence that the broadest possible definition be used, thus rendering a standard or requirement meaningless.⁵⁶

Not only do many hospitals fail to inform the public and tax authorities of their charitable activities, but they also fail to inform their patients of charity care eligibility and availability policies. One of the most egregious allegations against Yale-New Haven Hospital, described in a 2003 report authored by a staff researcher of the Service Employees International Union, was that the

53. Talbot, *supra* note 8.

54. PANEL ON THE NONPROFIT SECTOR: STRENGTHENING TRANSPARENCY, GOVERNANCE, AND ACCOUNTABILITY OF CHARITABLE ORGANIZATIONS 27 (June 2005).

55. See Jack Ashby & Craig Lisk, Presentation before the Medicare Payment Advisory Commission, Public Meeting, 176, 183–85 (Nov. 8, 2006), http://www.medpac.gov/public_meetings/transcripts/1108_1109_medpac.final.pdf.

56. For instance, see the Utah community benefit standard as described in Alice A. Noble, Andrew L. Hyams & Nancy M. Kane, *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, J. L. MED. & ETHICS, Spring 1998, at 116, 121.

hospital had a large, donor-restricted fund dedicated to providing free care to qualified patients, yet the hospital chose instead to pursue indigent patients as bad debtors.⁵⁷ Many indigent patients never knew of the existence of charity funds. As one dunned uninsured former patient said, “I asked Yale-New Haven’s triage and billing staff if the Hospital had charity care. They said no. The doctors and nurses all said they didn’t know anything.”⁵⁸ Meanwhile from 1996 to 2001, the free care fund more than doubled in value, while free care provision decreased by 46% and bad debt expense rose by 50%.⁵⁹

Finally, pricing transparency remains a major problem for hospitals and for those who want consumers to become more effective purchasers of care. While it is difficult if not impossible to know in advance every service and procedure that a patient might receive for a given condition, it is possible to put the combined average prices of the bundle of services required for common treatments and procedures such as normal deliveries, standard radiology exams and lab tests, or a trip to the emergency room on a public web site. Some states have passed legislation recently requiring public disclosure of prices of common inpatient and outpatient services or procedures.

E. Accountability

The United States is unique among industrialized nations in its reliance upon private nonprofit charitable hospitals competing for resources in a market-oriented, fragmented payment environment. Other countries have independent nonprofit hospitals but these institutions generally must be accountable to a public authority that controls the funds, such as a provincial or national health authority whose primary responsibility is the health of a geographic area. Also, most wealthy industrialized nations do not have millions of uninsured people. In the U.S., no public entity is responsible for the health of a geographic area; instead, geographic areas are viewed as “markets” within which hospitals compete for paying patients and try to keep the nonpaying patients from putting them at a serious competitive disadvantage. The private nonprofit hospital in the U.S. is also uniquely dependent upon private markets for capital financing, which further raises the pressure on hospitals to be driven by economic concerns.

Accountability for the charitable behavior of a nonprofit private hospital in the U.S. rests officially with its board, which is a self-perpetuating group of citizens often chosen for their role as donors, rather than as overseers of the hospital’s charitable mission. Even highly conscientious board members find it challenging to understand the complexities of modern hospital enterprise,

57. GRACE ROLLINS, CONN. CTR. FOR A NEW ECON., UNCHARITABLE CARE: YALE-NEW HAVEN HOSPITAL’S CHARITY CARE AND COLLECTIONS PRACTICES 11–12 (Jan. 2003).

58. *Id.* at 6.

59. *Id.* at 16.

and CEOs do not always fully inform their boards about sensitive issues such as how self-pay patients are billed or even about the details of executive compensation.

Egregious malfeasance may be challenged by the state attorney general, but this is rare because most state attorneys general have many competing interests as well as very limited resources with which to monitor nonprofit hospital behavior. The I.R.S. receives Form 990 filings from hospitals every year, but it lacks the resources to even review the forms, much less determine whether or not the content is valid or the reported activities appropriate. From 1996 through 2001, staffing for the tax-exempt division of the I.R.S. fell by 15%, while the number of Form 990s filed by charities increased by 25%.⁶⁰ The Form 990 examination rate for all charities was less than 1% over that period.⁶¹ Even with more resources and reviews, the information in the Form 990 does not allow the I.R.S. to determine whether or not a hospital is fulfilling its charitable mission. While the I.R.S. is now stepping up its efforts to review and investigate nonprofit hospitals and other tax-exempt entities with respect to whether or not their charitable status is merited, it still lacks a clear standard by which to make that judgment.

Our unique system of hospital accountability provides the greatest level of institutional discretion, thus fostering innovation and responsiveness to local opportunity. However, it has a negative side, which includes resistance to external accountability and the potential for excessive responsiveness to economic incentives to the detriment of charitable responsibilities.

III. CONCLUSION

Much of the public uproar about hospitals' behavior with respect to their charitable obligations is not about illegal behavior, but about behavior that falls below broadly held social expectations of charitable hospitals and health systems. As a judge ruling on one of the class action lawsuits over hospital charity care and billing practices wrote, "[P]laintiffs have come to the judicial branch for relief that may only be granted by the legislative branch."⁶² It is likely that laws will be passed that better reflect these emerging social expectations.

The range of federal policy options goes from simply revoking tax-exempt status to setting a higher and more articulated standard for tax-exemption that addresses at least some of the five broad issues described here.

60. U.S. GEN. ACCT. OFF., TAX EXEMPT ORGANIZATIONS: IMPROVEMENTS POSSIBLE IN PUBLIC, IRS, AND STATE OVERSIGHT OF CHARITIES 3 (Apr. 2002).

61. *Id.* at 22.

62. Pear, *supra* note 13 (quoting Judge Loretta A. Preska of the Federal District Court in Manhattan about a ruling against the class action plaintiffs in 2005).

The option of simply revoking tax-exempt status for hospitals has a number of critical drawbacks. One is that it punishes a whole industry, including the many hospitals that have responsibly balanced their charitable mission with their financial requirements and have maintained a high degree of transparency and accountability to their communities. Another drawback is that the value lost to hospitals would greatly exceed the gain in federal tax revenues, as federal tax-exempt status is required for hospitals to receive most grants and donations and qualifies hospitals for state and local exemptions and tax-exempt debt. Perhaps most important, charitable nonprofit status is still associated with community trust, an intangible asset with enormous value in many markets.

Loss of tax exemption would push nonprofit hospitals into joining the investor-owned for-profit sector—a group that profits from cherry-picking locations and services.⁶³ Investor-owned hospitals have also been particularly adept at exploiting loopholes in complex tax and payment systems, experiencing regular cycles of litigation and settlement costs over such activities as fraudulent Medicare billing and reporting practices, inappropriate medical care, and I.R.S. tax challenges.

Far better would be for Congress to define a higher standard for federal tax exemption, one which articulates meaningful behavioral expectations of tax-exempt hospitals. These could include:

- Requiring that eligibility for charity or discounted care be tied to the magnitude of the self-pay portion of the bill relative to the patient's financial resources, regardless of patient insurance status. The I.R.S. would regularly review this policy for reasonableness and require that it be provided on a standardized disclosure form attached to the I.R.S. Form 990 and on the hospital's web site. While this could encourage some people to not buy health insurance or to buy high-deductible plans without HSAs,⁶⁴ it is already the case that self-paying people expect (and take) "discounts" when they cannot pay the bill. There is some evidence that if the bill is set at a level that they can reasonably be expected to pay, patients are more likely to pay it.⁶⁵
- Requiring that hospitals and related health service-providing entities ensure that patients are aware of the availability of charity care and discounted care. Part of the requirement would be a regular monitoring of the level of awareness in the community of the hospital's charity care and

63. See Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345, 1382–1383 (2003).

64. Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. HEALTH ECON. 225, 241 (2005).

65. James Unland, *Letters to the Editor: Unfair Attack on Hospitals*, CHICAGO SUN-TIMES, Mar. 2, 2006, at 32.

discounted care policies, particularly among the most vulnerable populations.

- Requiring that hospitals justify to the I.R.S. their debt collection practices (and those of their agents) in terms of methods used and collection rates (amounts collected relative to amounts owed) over a rolling five-year period. The I.R.S. would regularly review these reports to ensure that hospitals and their agents are not using aggressive debt collection practices primarily to discourage access to health services (for example, very low collection rates associated with highly aggressive collection tactics).
- Requiring that hospitals partner with community groups and agencies to improve access to care for vulnerable populations in their service area, with regular reports to both the I.R.S. and the hospital or system board.
- Requiring that hospitals produce a community benefit report as an attachment to the I.R.S. Form 990 and available on the hospitals' web sites that is compliant with the voluntary reporting guidelines established by the Catholic Healthcare Association and its collaborators. Any deviance from the guidelines should be highlighted and the impact noted (e.g., inclusion of bad debt or Medicare shortfalls should be separately identified if reported at all).
- Requiring that hospital boards maintain a permanent "tax-exempt compliance" committee responsible for review, monitoring, and reporting on charity care policies and provision, other community benefits, collection policies, executive compensation, and joint venture arrangements, as well as the transparent reporting of such activities to the public and the I.R.S. The committee should regularly review hospital bad debt collection practices and collection rates and develop means of assessing billing and collection impact on the health of patients who owe money or are uninsured in the community.

These guidelines would not be onerous for the many hospitals seeking to behave appropriately. However, they would set forth more clearly than does current law what behaviors are expected of our charitable hospitals. These do not address some of the issues under debate today, such as pricing transparency for individual purchasers or how to deal with the use of tax-exempt financing proceeds if "tax arbitrage" is not consistent with congressional goals for subsidizing hospital debt. These activities may best be addressed separately from the general issue of a standard for charitable tax exemption, as they are amenable to adjustments in regulations already governing Medicare participation and eligibility for tax-exempt financing.

Some might argue that defining a higher standard of behavior for charitable tax-exempt status gives for-profit hospitals a competitive advantage over exempt hospitals or might encourage some exempt hospitals to convert to for-profit status rather than comply with the standard. However, this ignores the fact that in today's environment, having no effective charitable standard

has resulted in a relatively small number of nonprofit hospitals shouldering the bulk of the charitable burden for vulnerable communities. This puts them at a huge disadvantage relative to their nonprofit competitors who fail to acknowledge such charitable obligations. It is time to level the charitable playing field with an enforceable and clear charitable standard reflective of society's expectations.

