"Who Profits from the Not-for-Profit Hospital—Is the Tax-Exempt Status Justified?"

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INTRODUCTION

RONALD ANDERSEN. Welcome to the 31st Annual George Bugbee Symposium on Hospital Affairs. Our topic is "Who Profits from the Not-for-Profit Hospital—Is the Tax Exemption Justified?" This symposium is sponsored by the Graduate Program in Health Administration and the Center for Health Administration Studies at the University of Chicago. The purpose is to address significant issues on the organization and financing of medical care and to understand relevant managerial and policy implications. The selection of the topic and speakers is made by a committee of faculty and alumni. I would like to acknowledge Margarita O'Connell and Carol Morris for their fine work in organizing the Symposium.

The Symposium is named in honor of George Bugbee, who was director of the Program and the Center from 1963 through 1970. Among George's many accomplishments was his instrumental role in the development of the Hill Burton Program, which provided government support following World War II for rural and later urban hospital development. It indicates the dynamics of our field that today we are addressing the potential loss of government subsidies to some of the same hospitals that were developed and supported by Hill Burton.

Our topic this year deals with issues of financing of not-for-profit hospitals and more fundamentally what the role and behavior of not-for-profit hospitals should be to merit government support. We have a distinguished and knowledgeable group of presenters to discuss these issues with us. Yesterday in our pre-symposium workshop on campus, Ross Mullner and Sue Sanders did a fine job of providing us with a background paper. They presented the rationale and history of tax-exempt status for hospitals and why it's being challenged and an overview of the current situation regarding the nature of the challenge and the response of health-care providers.

Today we'll deal in more detail with some of these issues. Specifically, this morning we'll provide some case studies of how specific providers have been challenged and their responses to these challenges. We'll also look at actions hospitals should follow to merit tax-exempt status and how such actions and behavior might be measured. And, finally, we'll look at specific strategies necessary to maintain tax-exempt status.

Each of our speakers will have about thirty minutes. Please hold your questions until the end of each session. We will allow ample time for discussion. Let's now move to our first general topic with presentations by people who know what it is to be part of the challenge and to give us their views of how their organizations are responding. First of all, immediately on my right, we have Dave Jeppson, Executive Vice-President of Intermountain Health Care in Salt Lake City. And next to him is John O'Donnell, who is Executive Vice-President of the Medical Center Hospital of Vermont in Burlington.

EXAMINING THE CONCEPTUAL AND EMPIRICAL BASES OF THE TAX-EXEMPTION OF NONPROFIT HOSPITALS

Susan Sanders and Ross Mullner

THE GROWING NUMBER OF CHALLENGES TO NONPROFIT HOSPITALS

The public's perception that nonprofit hospitals are becoming more "business-like" while seeming to provide less health care for the poor and the medically indigent challenges nonprofit hospitals to demonstrate the existence, vitality, and uniqueness of their nonprofit health care missions. However, the public is not the only source of a growing concern about the way nonprofit hospitals are currently choosing to provide health care services. For-profit competitors, legislators, and the courts have also joined the ranks of the critics.

For example, for-profit competitors question the seemingly unjustified competitive advantage nonprofit hospitals receive through exemptions from local, state, and federal taxes. Legislators, moreover, eye the potential influx of additional revenue that would come to federal and local governments if tax-exemption policies were to be repealed. For example, in terms of the federal corporate income tax—currently a rate of 34 percent—Simpson and Lee (1987) estimated that for California in 1985, the annual federal tax revenues foregone as a result of tax-exemption totaled roughly $198 million, and that the annual foregone state income tax revenue was approximately $41 million. Noting the potential sources of error in their estimates, Simpson and Lee concluded:

> When combined, the California and federal income tax exemption results in lost tax revenues from nonprofit community hospital operations of $239 million. Thus, the combined income and property tax revenue loss from the nonprofit community hospital tax exemption is $300 million in California, with $102 million of that revenue loss borne by California government at the state and local level. (Simpson and Lee, 1987, p.7)

In addition to the loss of revenue from the corporate income tax exemption, the federal and state governments lose revenue through the tax-deductible donations made to organizations by individuals who deduct their contributions under Section 170(c)(2) of the Internal Revenue Code (IRC). Moreover, nonprofit hospitals are exempt from federal unemployment taxes, the communications excise tax, and are eligible to use tax-exempt revenue bonds to finance capital projects (Clark, 1989).

While nonprofit hospitals realize substantial savings through exemptions from federal and state corporate income taxes, it is the exemption from state and local property taxes that provides the largest benefit to nonprofit hospitals. According to Simpson and Lee, the "annual revenue loss to local governments from the property tax-exemption for nonprofit community hospitals [in California] is in excess of $61 million." (Simpson and Lee, 1987, p.6)

How serious are the challenges to nonprofit hospitals to demonstrate why they deserve preferential treatment from the federal government? Recent activity in the courts, in Congress, in state legislatures, and in the private sector testifies that the challenges to the nonprofit mission are serious and multi-faceted.

The Seriousness of Court Challenges

In terms of activity in the courts, growing numbers of nonprofit hospitals have become involved in litigation over their tax-exempt status. Most prominent among recent court cases is that of *Utah County v. Intermountain Health Care, Inc.* (1985), where the Utah State Supreme Court denied the property tax exemption to two nonprofit hospitals and established a six-part test which the local tax board could use to determine whether nonprofit hospitals made a contribution to the community. Evidence of service to the community was a key component in this court's decision to withdraw the exemption from these nonprofit hospitals. Specifically,

> [t]he court examined the distinctions between not-for profit and for-profit hospitals, the extent to which the two hospitals involved were supported by donations and gifts, the 'profit' derived from operation, the charges levied on patients, the level of charity care provided, and several other factors before concluding that the hospitals did not qualify as charitable institutions. (Hyman and McCarthy, 1988, pp. 32-33)

In evaluating each hospital's operations with respect to these standards, the Utah State Supreme Court noted the importance of the nonprofit hospital's making a "gift" to the community, whether through charges lower than the prevailing market rate, or through an imbalance of services rendered relative to the value received for them. The Court found that:

> [t]he evidence was that both hospitals charge rates for their services comparable to rates being charged by other similar entities, and no showing was made that the donations identified resulted in charges to patients below the prevailing market rate..., and it is they who bear the burden of showing their eligibility and exemption.... The record also shows that neither of the hospitals in this case demonstrated any substantial imbalance between the value of the services it provides and the payments it receives apart from any gifts, donations, or endowments. The record shows that the vast majority of the services provided by these two hospitals are paid for by government programs, private insurance companies, or the individuals receiving care....It is precisely because such a vast system of third-party payers has developed to meet the expense of modern hospital care that the historical distinction between for-profit and nonprofit hospitals has eroded. (709 P. 2nd 256, 1985, pp. 11,13)

In summary, the Utah Supreme Court concluded that it believed that:

> ...the defendants in this case confuse the element of gift to the community which an entity must demonstrate in order to qualify as charity...with the concept of community benefit, which any of countless private enterprises might provide....[M]eeting a public need by a provision of services cannot be the sole distinguishing characteristic that leads to an automatic property tax-exemption....We cannot find...the essential element of gift to the community, either through the nonreciprocal provision of services or through the alleviation of a government burden. (709 P. 2nd 265, 1985, pp. 17-19)

While no other courts have adopted the Intermountain rationale (Clark, 1989), there have been several other challenges to the tax-exempt status of nonprofit hospitals. For example, in Burlington, Vt., the city government has appealed a Superior Court decision rejecting a $2.83 million property tax assessment. In California, a nonprofit hospital with a "profit" margin of over 10 percent paid $305,000 in county property taxes before the state Attorney General upheld the exemption based on "peculiar statutory language" (Clark, 1989).

In Pittsburgh, the Presbyterian-University Hospital has voluntarily agreed to pay the city $11.25 million in service fees over the next ten years. In addition, two other Pittsburgh hospitals are currently fighting similar efforts to place them on the tax rolls.

In Nashville, seven hospitals have temporarily won a reprieve from paying $5.4 million in property taxes, and another hospital has won an appeal on a $500,000 property tax assessment. In nearby Chattanooga, the Tennessee Appellate Court has rejected a tax assessor's attempt to tax a hospital on the grounds that it did indeed improve the conditions in the community (Clark, 1989).

In Dallas, the Texas attorney general has threatened to dissolve several nonprofit hospital corporations on the grounds that they are not acting like charitable institutions in accordance with their state-granted charters (Hyman and McCarthy, 1988). And in Missouri, a nonprofit hospital has had to establish that it operated at a loss for two years and spent approximately 5 percent of its operating expenses on indigent care before the state Appellate Court rejected an attempt to tax it on the grounds that it had denied some services to indigent persons (Clark, 1989).

The Nature of Congressional Concern

The courts have not been the only governmental body to challenge nonprofit hospitals to give evidence of how they are fulfilling their mission and why they should be exempt from taxation. Congress has also begun to scrutinize the activities of the nonprofit sector. For example, members of Congress such as Ways and Means Chairperson Daniel Rostenkowski (D-IL) and Oversight Subcommittee head J.J. Pickle (D-TX) have sought testimony on the unrelated business income tax (UBIT). Later, they advised the IRS to improve its data collection efforts on tax-exempt organizations, especially on UBIT activities.

The IRS mandate was prefaced by Congressman Pete Stark's (D-CA) earlier testimony before Congressman Pickle's House Subcommittee on Oversight, Committee on Ways and Means. At the UBIT hearings, Congressman Stark leveled an attack against the current policy of tax-exemption for nonprofits. Citing Simpson and Lee's 1985 estimates of the levels of charitable care being provided in California relative to tax subsidies, Congressman Stark claimed that "not-for-profits in California received a tax-exemption worth $300 million but only provided $82 million in charity care."

Anticipating inquiries from Congress about the effects of the policy of tax-exemption, the Government Accounting Office (GAO) has authorized a three-part study of tax-exempt nonprofit organizations. Their study, which is to be completed in 1989, includes an examination of the history and background of the charitable organization tax subsidy, an analysis of the tax expenditures resulting from the policy, and a survey of hospitals to gather information about non-revenue producing charitable services (Abernathy, 1988).

State legislative committees have also been examining the privileged status of tax-exempt nonprofit organizations. For example, in Pennsylvania, a special legislative committee has been formed to study competition between for-profit and nonprofit enterprises. Other tax related legislation has been or is being considered in Minnesota, Oklahoma, Florida, Missouri, Virginia, and West Virginia (Hyman and McCarthy, 1988).

Clearly, nonprofit hospitals need to make efforts to demonstrate precisely the nature and extent of the contributions they make to society if they intend to maintain their tax-exempt status. But what types of behaviors and outcomes must they demonstrate? In part, the answer to this question is found in Section 501(c)(3) of the Internal Revenue Code (IRC). This section, while rather ambiguous, reflects both the historical and theoretical development of nonprofit organizations, and the many rationales that have been generated subsequently for granting tax-exemptions to nonprofit hospitals.

SOME BACKGROUND ON NONPROFIT HOSPITALS: A TRADITION OF STEWARDSHIP, SERVICE, TRUST, AND LEGITIMACY

In general, nonprofit organizations have enjoyed a long and distinguished history of being identified with public stewardship, of serving the diverse needs of a variety of people, and of enjoying a high level of legitimacy and trust (Hall, 1987). Much the same can be said of nonprofit hospitals with their long tradition of making health care available to the poor (Starr, 1982).

Most of the earliest hospitals were established by voluntary community or religious groups (Anderson, 1985). Church groups were particularly integral to the development of hospital-centered health care insofar as they offered a place where care could be provided for the poor. The wealthy, more often than not, received care in their homes, and it was not until later when the wealthy began to seek the services of surgeons that the hospital was considered an appropriate site for health care (Anderson, 1985; Starr, 1982).

However, it was not long before these hospitals, grounded in a tradition of charity care for the poor, began to respond to the effects of a rapidly industrializing capitalist society that transformed hospitals from almshouse infirmaries to public and voluntary hospitals sponsored by wealthy philanthropists and/or religious organizations. In a relatively short time, hospitals went "from treating the poor for the sake of charity to treating the rich for the sake of revenue and only belatedly gave thought to the people in between" (Starr, 1982, p. 159). It was not until the government took a more active role in the health care of its citizens and voluntary and private insurance were offered through the work-place that nonprofit hospitals were able once again to provide for any significant number of poor people.

In recent years, nonprofit hospitals have been caught in a financial squeeze, and many nonprofit hospitals have cut back substantially on charity services and on services to the local community. Since these charity cutbacks, many nonprofit hospitals have begun to lose their credibility and legitimacy with many as nonprofit charitable institutions.

LINKING THE HISTORICAL AND THEORETICAL DEVELOPMENT OF NONPROFIT ORGANIZATIONS

Nonprofit organizations, and nonprofit hospitals among them, have been characterized by a tradition of public stewardship, by diversified service to a range of people, and by a widely held, though currently eroding, public perception of legitimacy and trust. Given this history, what theories have been offered that reflect this tradition and explain the subsequent growth of the nonprofit sector?

In general, researchers have identified three types of arguments to explain why organizations take the nonprofit form:

1) nonprofits exist to maximize goals other than profit (usually either altruistic, religious, or ideological goals);

2) nonprofits are viewed as a response to governmental failures;

3) and nonprofits are a response to market failures, especially contract failure resulting from information asymmetries, transaction costs, or agency problems.

The Nonprofit Form: A Way To Maximize Goals Other Than Profit

Prominent among the reasons for some organizations taking the nonprofit form is that nonprofits exist to maximize something other than profit. This set of theories is based on the assumption that it is the objective function of nonprofits that differs from for-profits rather than the inputs of the organization.

What might nonprofits be maximizing that makes them differ from for-profit organizations? Several goals, some ideological, some pecuniary, and some altruistic, have been suggested.

The more ideological include the following: the ideological goals or motivations of the founders of the organization (Rose-Ackerman, 1986a,b; Young, 1983; James and Rose-Ackerman, 1986) and, most especially, the founder's or manager's religious goals or vision of a just society (James and Rose-Ackerman, 1986; Rose-Ackerman, 1986a,b).

Toward the more pecuniary, the following have been suggested: the manager's own goals, expense preferences, income, power, or prestige (James and Rose-Ackerman, 1986; Niskanen, 1971, cited in Young, 1983 and in James and Rose-Ackerman, 1986; Williamson, 1964, cited in James and Rose-Ackerman, 1986, and in Gassler, 1986); the power and prestige of the organization or charity (Tullock 1966a, cited in Young, 1983, and in James and Rose-Ackerman, 1986); or the organization's total budget (Niskanen, 1971, cited in James and Rose-Ackerman, 1986).

More altruistic and communitarian orientations can be explained by the behavior of managers who want to maximize quality service (Hansmann, 1980; Rose-Ackerman, 1983, cited in James and Rose-Ackerman, 1986); or of those who want to engage in works that serve the public interest (Weisbrod, 1979, cited in Young, 1983); or who want to "buy into" an organization by contributing to it or by engaging in communal behavior (Rose-Ackerman, 1986b); or who have been socialized into unselfish behavior (Margolis, 1982).

The actions of nonprofit managers may reflect perceptions of self-interest that do not fall easily into any of the above categories. For example, a manager, because

he or she cannot benefit too directly or too obviously from the activities of the organization, may try to cross-subsidize one organizational activity with another. Typically, this is accomplished by down-grading the quality of one activity to subsidize the other one that he or she, for whatever reason, prefers (James, 1983; Hansmann, 1980).

In addition, the assumption of altruism on the part of nonprofit institutions has been challenged. For example, Pauly and Redisch (1973), argue that nonprofit hospitals arise as "physicians' cooperatives" where physicians work together to maximize their own incomes.

Given the wide variety of goals other than profit that nonprofit organizations might choose to maximize, what, in particular, might nonprofit hospitals be attempting to maximize? At the time of their founding, the goal of the nonprofit hospital did not seem to be the maximization of profit as much as the maximization of access to health care. Whether for religious or ideological reasons, nonprofit hospitals expanded the health care opportunities to the poor, the disenfranchised, and/or those who were discriminated against on the basis of race, religion, or color. Clearly, the desire of the founders of nonprofit hospitals was to enhance the social welfare of the populace. Altruism, whether for religious or ideological reasons, seemed to play more of a role in motivating this type of behavior than did the possibility of making a profit. An important element of the current debate over the tax-exempt status is whether this altruism has remained central to the mission of nonprofit institutions.

The Nonprofit Form: A Response to Governmental Failures

In contrast to theories which hold that nonprofits arise in order to maximize goals other than profit, Weisbrod (1977) argues that nonprofits arise due to governmental failures. Governments, he argues, while still having the ability to compel behavior in order to overcome free-ridership problems, often fail to produce the goods and services society wants because they, like private individuals, lack information about consumer demands. Moreover, because a government, like an individual, can operate in its own self-interest rather than following the "collective will" of the people in its allocation of goods and services, it may not choose to produce the goods and services in which some segment of society has expressed an interest. Thus, "depending on whether the publicly provided good is primarily a collective or individual type good," nonprofit organizations will supplement the public production of public goods (Weisbrod, 1977, p. 69).

As "quasi-governmental organizations," nonprofits provide goods similar to those provided by the government (Lee and Weisbrod, 1977). For example, in their empirical study of nonprofit hospitals, Lee and Weisbrod (1977) developed a "collectiveness" index by which to compare the services of public, private, and nonprofit hospitals. Through their research, they found that the service mix of nonprofit hospitals is more like that of public hospitals than that of private hospitals, and "that voluntary hospitals differ from private hospitals in the same way as do public hospitals," thus suggesting that nonprofit hospitals specialize in public goods as does the public sector (Lee and Weisbrod, 1977, p. 81).

Through the private provision of public goods, nonprofit organizations presumably make positive contributions to society by saving money that the government would otherwise have to spend and, perhaps, would spend less efficiently. Citing the research of James, James and Rose-Ackerman note that:

> ...constraints on the government's ability to use market-clearing prices and wages make it cheaper to delegate production of quasi-public goods to the private sector and monitoring problems frequently make it politically expedient to choose nonprofit rather than for-profit organizations for this delegation and subsidy. (James and Rose-Ackerman, 1986, p. 20)

By delegating some economic production to the nonprofit sector, some researchers believe that nonprofit organizations may not only save money for the government, but also may be Pareto-superior to the government's providing public goods alone.

> If government production does not go down as a result [of the private production of goods through nonprofits] and if private benefits do not exceed social benefits, the possibility of supplementary private production moves us closer to efficiency. (James and Rose-Ackerman, 1986, p. 27)

Using economic models and game theory, however, Weiss (1986) demonstrates the conditions under which the private provision of public goods is not necessarily Pareto-superior. Specifically, he demonstrates that if the private provision of public goods does indeed reduce governmental expenditures on public services, those with high demands for public services may end up worse off when nonprofits exist.

How do nonprofit hospitals fit into the picture of nonprofits as quasi-governmental agencies? While most nonprofit hospitals were originally founded to help a specific group of people—whether a specific ethnic or religious group or the citizens of a particular locale—it was not long before nonprofit organizations opened up their services to a more ethnically, socially, and economically diverse group of people. Through their expanded public service activities, nonprofit hospitals often took the lead in providing services that the government could not or chose not to provide its citizens. Thus, the development of a theory which suggests that nonprofit organizations arise in response to governmental failures reflects the nonprofit's expansion into many social welfare areas, and particularly in the area of health care.

The Nonprofit Form: A Response to Market Failure

A third theoretical argument, developed first by Hansmann (1980, 1987), and later by Easley and O'Hara (1986), and by Ben-Ner (1986), suggests that nonprofit organizations arise because of market failure. Generally, this theory suggests that nonprofits contribute positively to society by serving as corrections to problems of particular types of markets characteristically plagued by contract failure resulting from problems of asymmetric information, transaction costs, or agency problems (Krashinsky, 1986).

Hansmann, among others, argues that nonprofit organizations remediate situations where consumers cannot ordinarily or easily observe or monitor organizational inputs or outputs. Consequently, ordinary contractual mechanisms do not generally operate effectively because there is an incentive to shirk on quality or "to capture for personal gain any fees paid by prospective consumers" (James and Rose-Ackerman, 1986, p. 21).

According to the argument, nonprofits promote economic efficiency through the non-distribution constraint. The nondistribution constraint prohibits the distribution of earnings to shareholders and thereby serves as a signal to consumers that the

nonprofit is 'trustworthy' because neither the nonprofit nor the individual manager has an incentive to take advantage of the consumer. Presumably, because the organization cannot realize a pecuniary gain, the consumer has a good incentive to invest the nonprofit with his/her trust in situations where the quantity and/or quality of the organization's output is difficult to detect.

> The nondistribution constraint allegedly reduces the incentive for the firm to downgrade quality and reassures the consumer that high quality will be maintained. The consumer, finding the nonprofit more 'trustworthy,' is willing to contract with it for goods whose quality can be monitored. NPOs have a comparative advantage in the provision of such goods, and enhance the overall efficiency of the marketplace by enabling them to be produced and consumed. (James and Rose-Ackerman, 1986, p.21)

Under circumstances where outputs cannot be easily monitored, nonprofits would have a comparative advantage over for-profits, Thus, their existence presumably increases the efficiency of the market by making it possible to produce goods and services that would not otherwise be produced.

How are nonprofit hospitals characterized by contract failure? Because nonprofit hospitals rely more on selling their services than on financing their activities through donations, Hansmann does not believe that the nondistribution constraint plays much of a role in providing consumers of health care with the type of additional information that remediates contract failure. Rather, Hansmann's view is that the development of nonprofit hospitals may be more of a historical artifact of a time when nonprofit hospitals relied more on donations than on the sale of health care services.

PROPOSED RATIONALES FOR TAX-EXEMPTION: REFLECTIONS OF THE HISTORICAL AND THEORETICAL DEVELOPMENT OF NONPROFIT ORGANIZATIONS

As is true of the development of nonprofit organizations, there is no single theory or rationale that explains the existence of tax-exemptions for nonprofit organizations, much less for nonprofit hospitals. Rather, several explanations have been offered. The logic of some of these explanations is strikingly similar to one or another of the theories that have been developed to explain the rise of nonprofit organizations: that nonprofits supplement or replace governmental services and/or enhance beneficial community values or goals (Simpson and Lee, 1987, p.5); that nonprofits have a comparative advantage over the government in providing goods and services; and that nonprofits help the private market function more efficiently. A fourth rational for tax-exemption—more tied to current accounting practices than to the behavior of nonprofit organizations—can also be suggested: that nonprofits are tax-exempt because technically, they make no "profit" on which they can be taxed.

Nonprofits Supplement or Replace Governmental Services

Consonant with the theory that says nonprofit organizations develop in response to governmental failures, the first rationale suggests that tax-exemptions are awarded to nonprofit organizations as a "reward" for undertaking activities that the government either cannot or chooses not to fund. Implicit in this rationale is some sort of *quid*

pro quo where the government chooses not to tax nonprofit organizations in return for the socially desirable activities that nonprofits undertake. Presumably, if nonprofit organizations had chosen not to engage in these activities, the government itself would have had to bear the costs of producing them directly. This rationale was mentioned both in the Filer Commission report on philanthropic organizations (1975) and more recently by Hopkins in his work on *The Law of Tax-Exempt Organizations* (1987) (Cited in Dale, 1988).

As with the theory that nonprofits arise due to governmental failure, the "in lieu of government" rationale for tax-exemption has its weaknesses. For example, it is obvious that health care in this country is not only provided by nonprofit hospitals, but that it is also provided through for-profit and governmentally sponsored hospitals. Why, then, does the government not accord tax-exemptions to for-profit hospitals when they also produce health services that presumably the government would have to produce if they did not exist?

The rationale for granting tax-exemptions to nonprofits on the basis of their "quasi-governmental" activity is also flawed because, to date, the government has made no effort to determine whether an actual monetary *quid pro quo* exists between tax-exempt organizations and the government. Do tax-exempt organizations actually provide services equivalent to their monetary tax-exemption reward? The benefit/cost calculation that will answer this question has yet to be done. However, even if this question were answered, the problem of the inconsistent treatment which currently requires that for-profit hospitals and not nonprofits pay local, state, and federal taxes, will still not be resolved.

Having a Comparative Advantage, Nonprofit Organizations Contribute to Market Efficiency and Pluralism in Production

Presenting the rationale that tax-exemptions should be allowed nonprofits because they create an economic incentive for nonprofits to engage in activities where they do a better job than either the public or private for-profit sector, Dale (1988) recognizes that nonprofits have a comparative advantage over the government or private sectors in certain production areas. Operating in areas where they have a comparative advantage, nonprofit organizations promote overall efficiency and presumably contribute to overall social welfare.

Whether nonprofit organizations actually have a comparative advantage over the other sectors, and whether they actually do a better job than for-profits operating in the same area of activity, is open to debate. However, the fact that many social services in this country are provided by the private nonprofit sector rather than by the government does speak to what Dale (1988) and Belknap (cited in Dale, 1988) have identified as still another justification for tax-exemption—that nonprofit organizations contribute to pluralism by promoting diversity and private activity, sometimes in lieu of public sector activity.

As with the other rationales for tax-exemption that have been discussed, however, the pluralism rationale also has a fundamental weakness. Simply, as Dale notes, "the argument for pluralism proves too much because for-profit firms could also claim it..." (Dale, 1988, p.5).

Nonprofits Remediate the Problems of Contract Failure

By operating in areas where there is contract failure, nonprofit organizations enhance the functioning of the market. By increasing overall market efficiency, all of society is better off.

Given this reasoning, tax-exemptions can be justified on the grounds that they promote the efficient functioning of the market. Moreover, the tax-exemption incentive for nonprofits may be justified because of the difficulties nonprofit organizations have in raising capital.

Because they have no shareholders, nonprofits are particularly constrained in their abilities to raise money for capital development (Hansmann, 1980, 1987). Thus, tax-exemptions may be justified as a "crude" way to subsidize capital formation in the nonprofit sector. (Hansmann, 1981)

However, while it may be true that nonprofits are hampered in their abilities to raise capital, it is nevertheless unclear why tax-exemptions rather than some other form of financing provides the best assistance to nonprofit organizations. Moreover, in the absence of overwhelmingly clear evidence that nonprofit organizations are economically efficient, it is conceivable that the resources channeled to nonprofit organizations through the tax-exemption contribute to inefficiencies rather than to efficiencies.

Nonprofits Cannot Be Taxed Because They Make No Profit

Perhaps more dependent upon current accounting procedures than upon the nature of nonprofit activities is the rationale that nonprofit organizations should not be taxed because they literally do not make a profit. Addressing this concern, Bittker and Rahdert (1976) argue that

> exempt organizations engaged in public service activities share one common feature: if they were deprived of their exempt status and treated as taxable entities, computing their 'net income' would be a conceptually difficult, if not self-contradictory task. (Bittker and Rahdert, 1976, p. 307)

However, others, most notably Hansmann (1981), believe that Bittker and Rahdert have "overstated" the difficulties involved in computing net income. Generally, these researchers believe that it would be possible to calculate the net worth of a nonprofit organization in the cases of commercial nonprofit organizations, which typically rely on the sale of goods and services rather than on donations to finance their activities.

THE CURRENT POLICY OF FEDERAL CORPORATE INCOME TAX-EXEMPTION

Several rationales, most of which derive from theories of the rise of nonprofit organizations, and most with obvious weaknesses, have been suggested as justifications for the tax-exemption of nonprofit organizations. Despite their weaknesses, however, they provide some background for understanding the current IRS criteria for tax-exemption. These criteria include both organizational and operational tests.

According to Section 501(c)(3) of the IRC, nonprofit organizations, including nonprofit hospitals, must first be organized and operated as a nonprofit corporation

before they can be exempt under this federal corporate income tax law. Specifically, Section 501(c)(3) exempts:

> [c]orporations, and any community chest, fund, or foundation 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, nor 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 any candidate for public office. (IRC Section 501(c)(3), 99th Congress, 2nd Session, 1987, St. Paul, MN: West Publishing Company, p. 669)

This passage broadly characterizes what are known as the organizational test, that is, that "no substantial part of the net earnings issue to the benefit of any private stockholder or individual"; and the operational test, that is, that exempt organizations be "operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes...."

The Organizational Test

Through the organizational test, the IRS mandates a "non-distribution constraint" for nonprofit hospitals (Hansmann, 1980, 1987). Specifically, the non-distribution constraint prohibits nonprofits from distributing organizational earnings to its members. Nonprofits can pay for labor and salaries. They can even earn a profit—and indeed must earn an excess of revenues over expenses if they are to survive. However, the non-distribution constraint dictates that these profits must be used to finance the activities of the organization, which has been founded to serve a limited number of purposes within a state's laws of incorporation.

In contrast to for-profit organizations, there are no stockholders or shareholders in nonprofit organizations because nobody owns the nonprofit corporation. The nonprofit corporation "owns itself," and because there are no outside equity interests, the organization is usually governed by a self-perpetuating board of directors.

Because "the organizational test is one of the easiest to clear," and because articles of incorporation "are ordinarily amendable and since after amendment, the resolution of an organizational test question is only the first step in determining whether an organization is exempt" (Hopkins, and *IRS Exempt Organization Handbook*, IRS 7751, Section 338(2)), matters of "greater substance" center around the operational test.

The Operational Test

Through the operational test, the IRS suggests several criteria against which to evaluate requests for tax-exemption. For the most part, these criteria are implicit

rather than explicitly stated within the Code. Because of the ambiguity, it has become the task of the courts to develop further the meaning of these criteria.

Some of the operational criteria are prescriptive in that they define what an organization *must* do to maintain its tax-exempt status. Other criteria are proscriptive and outline what an organization *may not* do if it hopes to be granted an exemption from taxes. A summary of these implicit operational criteria includes the following:

1) prescriptive: that the purposes of the group must be "exclusively" charitable;
2) proscriptive: that the organization cannot advocate the election of a particular candidate or intervene in his or her election campaign;
3) and proscriptive: that nonprofits cannot be engaged in activities that generate profit, but which are unrelated to the primary purpose or mission of the organization without being taxed.

Obviously, these criteria are broadly defined. What does the IRS mean by "exclusively charitable purposes," the key term that provides the basis for the exemption of nonprofit hospitals?

Defining the Concept of "Charitable Purpose"

While the IRC does not define the term "charitable,"

> [t]here is a substantial body of case-law throughout the U.S. interpreting tax exemption provisions as they apply to nonprofit community hospitals. Although there are significant exceptions, it is fair to say that the majority of these cases appear to stand for the proposition that an institution which: (1) offers hospital services to the general public; (2) is organized as a nonprofit corporation, and (3) satisfies certain limitations on private benefit, lobbying, etc. is entitled to an exemption. (Simpson and Lee, 1987, citing 71 AM JUR 2d STATE AND LOCAL TAXATION, Section 385 (1973) and *Evangelical Lutheran.* (Neb, 1967) (Hospitals operated as nonprofit institutions are universally classed as charitable institutions.)

Moreover,

> The term 'charitable' is frequently used in this broader context notwithstanding the fact that 'charitable' is only one of the eight descriptive words and phrases used in the Code to describe the various organizations of Code Section 501(c)(3). That is, the term 'charitable' is considered a generic term and, in its expansive sense, includes 'religion,' 'scientific,' 'educational' and like purposes. (See *United States v. Proprietors of Social Law Library* 102 F. 2nd 481; 1st Cir. 1939)

Nonprofit hospitals are typically exempt from taxes because they are charitable in the "expansive" sense of the term. Teaching hospitals, on the other hand, may be exempt because of their educational purposes.

At least at the time of their establishment, the charitable purposes of nonprofit hospitals were fairly obvious: in general, they were first established to provide health care to those who could not access it, whether for reasons of cost, discrimination, or

unavailability. Religious nonprofit hospitals were often established to alleviate the problem of lack of access due to prohibitive cost or discrimination. Community nonprofit hospitals were often established to bring health care services to areas where they were previously non-existent. Thus, at the time of their founding, nonprofit hospitals were clearly charitable in purpose, and they were exempt from taxes because they helped more people access health care than would ordinarily be able to access it by paying for health care in their homes, as was common among the wealthy.

Obviously, providing free or below cost care was part, although not all, of the early mission of nonprofit hospitals. However, the economic status of the individuals who benefit[ed] from the nonprofit hospital's activities was not necessarily a factor in determining whether a nonprofit hospital was meeting the organizational and operational test for tax-exemption. Citing revenue rulings and case law, Hopkins (1979, p. 46) notes that the economic status of individuals is only a factor "where relief of poverty is the basis for the designation of the purpose as 'charitable.' "

Thus, the first operational criterion stated in the IRC, although ambiguously defined, is that a nonprofit hospital must have a charitable purpose. This charitable purpose, while not necessarily linked to the economic status of the potential recipients, has traditionally had a dimension of making health care available to those who could not otherwise access it. In some cases, lack of access was due to cost. In these cases, the obviously charitable purpose would be easily recognized by the hospital's providing free or reduced cost care. In other cases, lack of access was due to geographic unavailability, inconvenience, or market forces which made some types of health care or health care technology too costly to develop. In these cases, a hospital's charitable purpose was evident in providing services that were not cost-effective and/or in starting hospitals in areas that had previously been under-served. Thus, the first criterion for tax-exemption of nonprofit hospitals would seem to be that they be engaged in a charitable purposes, and that the charitable purpose be, in some way, linked to the provision of health care to those who could not access it.

In 1956, the IRS recognized a hospital's charitable purpose in "the extent of its financial ability for those not able to pay for services rendered" (Rev. Rul. 56-185, 1956-1 C.B. 202). However, the 1956 ruling indicated that a nonprofit hospital may also accomplish its charitable purpose "by furnishing services at reduced rates which are below cost, or it may set aside earnings for use for improvements and additions to hospital facilities" (Clark, 1989).

By 1969, the IRS had modified its 1956 ruling and eliminated the requirement that a nonprofit hospital had to care for patients at no or reduced cost (Rev. Rul. 69-445, 1969-2, C.B. 117). Further, the hospital could limit admissions to those who demonstrated the ability to pay. It did, however, require, that if a nonprofit hospital operated a full-time emergency room, no one could be denied emergency treatment because of the inability to pay. This decision was later modified somewhat in 1983 (Rev. Rul. 83-157, 1983-2, C.B. 94).

Based on the 1969 ruling, charitable activity for a nonprofit hospital was evident simply because the hospital promoted health, which was of benefit to the community as a whole, even if the beneficiaries of hospital activity were not necessarily the indigent (Clark, 1989).

The "community benefit" dimension of this ruling reflects the second operational criteria for granting tax-exemptions to nonprofit hospitals. While not necessarily distinct in all ways from the first criterion, the second criterion links charitable purpose to a social or community welfare dimension. Drawing from the

law of charitable trusts and English Common Law, Hopkins researched the concept of charity and found that it included the following:

> 1) the relief of poverty by assisting the poor, distressed and underprivileged, 2) advancement of religion, 3) advancement of education and science, 4) performance of government functions and lessening of the burdens of government, 5) promotion of health and 6) promotion of social welfare for the benefit of the community (Hopkins, 1979, p.44)

Thus, it is English Common Law, later reinforced by judicial rulings, that establishes the second criterion for the operational test for tax-exempt organizations: that is, that tax-exempt organizations must promote the social welfare for the benefit of the community. According to Hopkins, "the result of the organizations' activities and the assistance [may be] considered 'charitable' in nature as long as the effect is to benefit the community rather than merely individual recipients" (Hopkins, 1979, p. 47). Citing Res. *Trusts* 2nd Sections 368 (comment a.) and an 1877 Supreme Court ruling (95 U.S. 303, 311 (1877), Hopkins concludes:

> ...the 'common element of all charitable purposes is that they are designed to accomplish objectives which are beneficial to the community.' A frequently cited case on this point is *Ould v. Washington Hospital for Foundlings*, where the Supreme Court stated: 'A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-doing and well-being of social man.' (Hopkins, 1979, p. 51)

Not unlike the definition of charitable, neither the IRS nor the courts say much about the nature or amount of the beneficial activities, nor about the operating style of the organization. Nor do they state anywhere that charitable care is to be defined as free care or free service, although providing free service to people, especially the poor, is certainly one kind of charitable or socially beneficial activity. Quite the contrary, the Supreme Court has held that nonprofit hospitals do not have to provide any free care at all in order to be charitable.

Just as the law does not require nonprofit organizations to provide services free of charge, neither does it require that nonprofit organizations refrain from engaging in activities undertaken in the private for-profit or public sectors. Nor does the law require that nonprofits improve upon what the for-profit and public sectors do. While some of these ideas may be suggested in the rationales that have been developed for tax-exempt organizations—rationales that derive from and reflect the historical and theoretical development of nonprofit organizations—current tax law requires nonprofit organizations to meet the organizational and operational tests for tax-exemption: organizationally, that nonprofit organizations be subject to the nondistribution constraint; and operationally, that nonprofits be engaged in a charitable purpose and that they serve the community by engaging in activities that benefit the social welfare in some way.

A REVIEW OF EMPIRICAL RESEARCH ON NONPROFITS

When health care organizations are threatened with extinction, any treatment that accords a financial advantage to one type of organization over another is often viewed as a competitive advantage by the rival organizations (Seay, 1988). While unfair competition is not necessarily in evidence due to differential tax treatment (Rose-Ackerman, 1986c), the current policy of tax-exemption is frequently perceived as the government's giving an important financial advantage to nonprofit hospitals when, according to some critics, research has shown that there are few or relatively insignificant differences between for-profit and nonprofit hospitals. What, specifically, has empirical research shown about the differences between for-profit and nonprofit hospitals?

Supporting the findings of differences between nonprofits and for-profits, Ruchlin, et al., (1973) found that nonprofits provided more therapeutic and occupational therapy per inpatient day than for-profits. More germane to the tax-exemption question, however, they also found that despite the reporting of similar demographic and income characteristics, for-profit investor-owned chain hospitals reported "a lower proportion of their patient census with public third-party payer coverage than their nonprofit counterparts" (p. 21). That is, Ruchlin, et al., found evidence of "skimming" in for-profit hospitals. In a subsequent re-evaluation, Rafferty and Schweitzer (1974) found that proprietary "skimming" was probably understated in the prior work of Ruchlin, et al.

Also concerned with the "skimming" problem, Sloan and Vraciu (1983) reached a different conclusion than Ruchlin, et al., and Rafferty and Schweitzer. Using data from Florida, they found few differences between for-profits and nonprofits in terms of the percentages of Medicare and Medicaid patient days. In addition, by using a net operating revenue cost measure per adjusted admission, they found that nonprofit and for-profit hospitals were virtually identical in net operating funds, in after-tax profit margins, and in the amount of uncompensated care adjustments to operating revenue. Further, Sloan and Vraciu found that nonprofit hospitals were no more likely to offer "nonprofitable" services than for-profit hospitals.

Most recently, Herzlinger and Krasker (1987) have also addressed the skimming question and whether the poor/uninsured/medically indigent have better or worse access to for-profit or nonprofit hospitals in terms of the range of services being offered. Their research indicted that there was no difference between nonprofit and for-profit hospitals in the range of services being offered to the medically indigent. Similar findings of no difference in levels of uncompensated care were reported by Richards (1984) and the AHA (1986), both of whom were cited in Lewin, et al. (1988), and for systems, Shortell, et al., (1986).

Reporting different results, however, a survey conducted by the Office of Civil Rights (OCR) in 1981 reported that while public hospitals bear the greatest proportion of uninsured patients—16.8 percent—nonprofit hospitals admitted 7.9 percent uninsured while for-profit hospitals admitted 6 percent (OCR, cited in Institute of Medicine (IOM), 1986b). Moreover, data from a 1983 AHA survey reported that uncompensated care constituted 4.2 percent of gross patient revenues in nonprofit hospitals, and 3.1 percent in for-profit hospitals (AHA, cited in IOM, 1986b).

Turning from the issue of skimming to a comparison of costs, Sloan and Vraciu found that for-profit hospitals had lower operating expenses than nonprofit hospitals. A 1986 report of the IOM, however, contradicts their findings about costs and

expenses at for-profit hospitals (IOM, 1986a). Recognizing that variations in the cost allocation processes "can make expense comparisons among institutions imprecise" (IOM, 1986a, p. 75), the IOM reviewed the literature contrasting expenses in for-profit and nonprofit hospitals. They found that in six of the seven studies that compared expenses per admission, for-profit expenses were higher. These differences ranged from statistically insignificant levels to 8 percent to 10 percent higher (Pattison and Katz, 1983; Becker and Sloan, 1985; Pattison, 1986; Coelen, 1986). Moreover, when charges were measured per inpatient day or admission, or in Medicare charges per case, the IOM found that for-profit hospitals were generally higher than nonprofit hospitals. Further, additional research indicated that for-profit hospitals, which had significantly lower occupancy rates than nonprofit hospitals (Kralovec, 1985, cited in IOM, 1986), had not contained rising expenses during the late 1970s and early 1980s any better than did nonprofit hospitals (Coelen, 1986; Pattison, 1986).

In terms of administrative costs, national and California data showed that for-profits have higher costs than nonprofit hospitals (Pattison and Katz, 1983; Pattison, 1986; Watt, et al., 1986a). In addition, Watt (1986a) showed that for-profit hospitals employed fewer full-time equivalents per average adjusted daily admission, but also paid higher salaries and benefits per employee than did nonprofit hospitals.

Focusing on capital costs, Anderson and Ginsberg (1983) and Watt, et al. (1986 a,b) found that for-profit chains operated with "significantly higher capital costs relative to operating costs" than did nonprofit hospitals (IOM, 1986a, p.80). Other researchers, who focused on comparing the profitability of nonprofit and for-profit hospitals, found that, depending on the measures, for-profits had achieved more profitability before and after taxes than nonprofits (Lewin, et al., 1981; Watt, 1986a,b, Coelen, 1986). Using 1980 Florida data, however, Sloan and Vraciu (1983) found the opposite to be true. Using statistical controls, Sloan and Vraciu found no statistically significant difference in after-tax margins of for-profits and nonprofit chains.

In terms of the relative efficiency of nonprofit hospitals versus for-profit hospitals, Freund, et al., (1985) found that for-profit hospitals were not more efficient than nonprofit hospitals when efficiency was measured in terms of length of stay. This empirical finding stands in contradiction to the earlier theoretical work of Clark (1980), who maintains that nonprofit hospitals are fundamentally inefficient and that they exploit their patrons, and James and Rose-Ackerman (1986), who argue that nonprofits are characterized by managerial inefficiencies, if not improprieties, because nonprofits do not have a monitoring body that is able to oversee the outputs of the organization.

In one of the earliest studies of nonprofit hospitals, Newhouse (1970) concluded that nonprofit hospitals were inefficient. While ignoring case load and service-mix differences between teaching and non-teaching hospitals, Newhouse found that nonprofit hospitals do more esoteric procedures than routine ones.

In a later study of system-related hospitals, Shortell, et al., (1986) found that nonprofit system hospitals provide more alternative services than for-profit system hospitals in all service subcategories except for outpatient diagnostic services. Further, Friedman and Shortell (1988) found that nonprofits and for-profits were comparable in terms of quality of services and in costs per adjusted admission, after allowing for diversification and growth strategies.

While most comparisons of for-profit and nonprofit health care organizations have been undertaken on hospitals, acute care facilities are not the only type of health facility where researchers debate differences. For example, Hall and McGuire (1987) contrasted for-profit and nonprofit mental health clinics. They found that

"payments to proprietary mental health clinics exceeded payments to private nonprofit clinics by 27 percent, public clinics by 19 percent, and religious clinics by 17 percent." This finding suggests that for-profit clinics are more commercially orientated than nonprofit facilities (p. 1179).

Obviously, empirical research on the similarities and differences between nonprofit and for-profit hospitals and health care facilities has not resulted in clear-cut statements about the efficiency or contributions of nonprofits relative to for-profits. While the literature establishes some differences between nonprofits and for-profits, especially in terms of service-mix, charges, costs, or length of stay, the statistical and substantive importance of these differences varies widely depending on the nature of the sample, the methodology, and/or the data that were analyzed.

Despite the inconclusiveness of this research and the fact that most of these studies were undertaken for organizational rather than policy purposes, the results of some of these studies are being used in arguments for or against the differential treatment the government accords nonprofit hospitals relative to for-profit hospitals. The underlying principle in this approach is implicit, but clear. By at least one definition, justice occurs when entities of "one and the same essential category" are treated the same way (Perelman, 1980, p.11). Hence, for differences in treatment of for-profit and nonprofit hospitals to be just, nonprofit and for-profit hospitals must belong to essentially different categories. If this is not the case, then the preferential treatment accorded nonprofit hospitals is clearly unjustified.

But what constitute the essential differences between nonprofit and for-profit hospitals? This question, clearly one that is not easily answered by researchers, raises additional questions for those in the academic, policy-making, and health care communities alike.

- Do nonprofit and for-profit hospitals provide ostensibly the same services, or are there essential differences between the two?
- How are these differences reflected in the mission and operations of nonprofit hospitals?
- What should a nonprofit hospital be doing to merit its tax-exempt status?
- How are health care providers responding to challenges on their tax-exempt status? How should they be responding?

While relatively ambiguous and untested at the federal level, and varied at the state level, the criteria for tax-exemption for nonprofit hospitals mandate that a hospital be engaged in a charitable purpose and that its activities benefit the community.

- Operationally, what types of activities constitute charitable and community benefit activities? How can they be measured? Who determines how much charity care and community benefit activity is "enough" to merit tax-exempt status?
- By whose standards, and to what degree must a nonprofit hospital demonstrate that it is meeting the operational tests of doing charitable activities and/or activities that are beneficial to the community?
- Given that it is possible to identify, operationalize, and measure how nonprofit hospitals differ essentially from for-profit hospitals, does demonstrating a difference warrant a tax-exemption for nonprofits?

- In terms of equity and efficiency, is a policy of tax-exemption, whether from the corporate income tax or from the property tax, the best way to promote health care in the nonprofit sector? the best way provide health care for the indigent? the best way to contain the escalating costs of medical care? or are there more effective policies that can be adopted?

While gains in efficiency may be realized by a nonprofit's becoming more businesslike, many question whether survival has totally supplanted other organizational goals, especially those related to a nonprofit hospital's traditional mission of stewardship, trust, and public service, especially to those without access to health care.

- Is it true that nonprofit hospitals have abandoned their service mission for bottom-line considerations?
- Should nonprofit hospitals continue to be "rewarded" for the services they provide, presumably in lieu of the government's providing them?
- And more specifically, is an exemption from taxes, whether corporate or property, the best reward for their contribution?

Presumably, the speakers at the Bugbee Symposium will provide more information that will make possible an intelligent discussion of these issues.

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INTERMOUNTAIN'S RESPONSE TO THE COURT'S DECISION

DAVID H. JEPPSON. It is a pleasure to be here this morning and share some of the Utah experience with you. I usually don't, when I speak on this subject, just speak on our own experience in the Intermountain West, but I will certainly keep most of my comments right on that subject today, because the program so beautifully broadens the topic, with the experience of others and also provides such a fine array of expertise relative to the breadth and depth of this subject. So I will narrow things down a little bit and try to stay right on the subject I've been assigned and that's simply to share the experience of the Utah situation, even though it's very clear that the question of tax-exemption is being raised in many other parts of the country. In fact, if the literature that's been reporting activity in this area is accurate, there is some form of tax exemption challenge in traditional nonprofit health industry currently under scrutiny in about two-thirds to three-fourths of the states in the Union.

I think ours was one of the early ones. We've been at it a number of years and it's taken some interesting twists and directions and we could be, and already have been, in a situation where some of the legal decisions that have been made about the issue may well be precedent setting.

The first issue I'd like to address, relative to the Utah situation is *why*. What are the major environmental factors that have raised the issue? Let me first state my opinion on the ultimate question. Quite often I'm asked the ultimate question; "Dave, do you feel that nonprofit organizations ought to be given ongoing immunity from taxation?" My feeling as I've developed it over the last few years and the tug-of-war that's been occurring in Utah is almost identical with the opinion of our state supreme court. And that is, yes, in some situations it may be appropriate, but I would qualify with the word *may*. I think that tax exemption is something that absolutely must be demonstrated as being something that an organization has earned and is worthy of and that it shouldn't be any kind of a permanent gift given by the community. If tax exemption is used by a tax-exempt organization as an inappropriate competitive advantage over its tax-paying competitors and it hasn't been earned and it hasn't demonstrated its worthiness, then it should be denied. And, so I will stake myself out in that direction and then proceed to share my experience and maybe give you a feel for why I feel this way.

In terms of the major environmental factors that have influenced, I think Utah is sort of at the forefront. I won't give you an exhaustive list, but I'll give you several factors relative to why the issue has been raised in our part of the country. First, and I think the article that Bob Sigmond and his associate laid out in *Frontiers* in February is right on when it says that they suggest that the images of many nonprofit organizations have been tarnished, and have been confused with organizations that offer health care, but pay taxes. Nonprofit hospitals, number one, have responded as aggressively in many markets and sometimes more aggressively than their tax-paying competitors. They've changed their behavior. They have become more hyperactive, if you will, more competitive. They've become very aggressive relative to decisions and the placement of technology and in some cases technology that could be questioned in terms of community needs.

Those of you that have traveled the world know that in many of our metropolitan areas, we have technology far beyond the technology of the rest of the world and in some cases technology that may be over-utilized as a result of the fact it's there, thereby influencing spiraling health costs.

The aggressive diversification of health services is another reason. Many organizations, including our own, during the early 1980s, after we had completed our first phase—the first phase being horizontal acquisition and merging with other hospitals—began diversifying into other services outside the traditional hospital role. That would allow our systems to have a verticalness, if you will. And in many cases as diversification took place, as was the case in our situation, we found ourselves not only competing with our traditional hospital entities, but also now stepping on the toes of local business people that had been involved in selling and distributing products that were related to the health-care industry. And many of them became incensed as a result of the fact that these organizations were getting more aggressive and moving in a competitive way into services that they had uniquely provided in the past. And then with a feeling that, "Wait a minute, traditional hospitals and hospital organizations are now moving into products like the same that we have been providing, and perhaps are enjoying a tax-exemption status that gives them an unfair advantage in the marketplace." There's been a great deal of disdain in our market area, and in others, over this issue.

Likewise, another form of diversification is this next one. A number of organizations, including our own, in order to protect their destiny had moved into the direct offering of health-insurance plans, so that we would not be totally subject to the tough negotiations that take place with other third-party payers. In our situation, in 1981, we moved into the health-insurance arena and it really changed the complexion and the milieu in which we operate a great deal. Thereby, a couple of things happened. A number of insurance carriers became very angry that a health care provider, again a tax-exempt provider, was offering health insurance, even though taxes are paid on this side of the business.

Other issues, tough contracting strategies have drawn a lot of heat and have caused, if you will, a personality change in the traditional nonprofit health-care organizations. The relationships that Blue Cross had, as an example, with hospitals traditionally has been abruptly changed in the early 1980s, when many plans suddenly found themselves hiring aggressive legal representation to drive the hardest and best bargains they could find. At the same time that was occurring, other health insurers were doing the same thing.

These are some of the things that are starting to tarnish and change the image of our traditional nonprofit health care providers.

Some of you probably read or heard yesterday on the news that it takes 124 days of our working year to pay off our taxes. This is the highest number of days in our history and that seems to be increasing every year and as a result, in many markets and throughout the country we're seeing taxpayer coalitions formed to reduce tax rates, putting a lot of pressure back on assessors and boards of equalization and those that collect and distribute the proceeds of taxes. As a result of this occurring—and it's occurring in many areas—governmental entities, including assessors, are scurrying into their files to determine, "Okay, how do we broaden the tax base?" And therefore, it's little wonder that this is happening in places like Utah, where our tax rates are among the highest in the country, and places like Pittsburgh, where tax-exemption has been taken from several hospitals; Pittsburgh, a community that has almost 50 percent of all its property on the tax-exempt roll. This is occurring at the same time our governmental budget's going up. This has certainly been the case in Utah, and has had a tremendous influence on the issue of whether or not hospitals that have been traditionally exempt should continue to be exempt from taxation.

Tax revenue shortfalls are not news to anyone in many communities and even with tax rates stable and inflating slightly, that hasn't been sufficient to meet the budget commitments and the spending patterns of local governments in many situations.

As a result of increased competition, private businesses are becoming more competitive with the traditional hospitals, exempt organizations; more concerned, angry. Another influence has been, particularly in markets like ours, that there really are virtually no free-standing health-care delivery institutions anymore. I think in the state of Utah there are four free-standing hospitals left. All the rest of the hospitals in the state belong to larger multi-hospital groups and there are three or four large investor-owned competitors in that marketplace. Therefore, the size of these organizations make them a bigger target.

Another factor is that the investor-owned systems feel that they've been put in an unfair situation as a result of competitors that have had tax exemption, and they are speaking out. In fact, as we sit here today, there are hearings at the Tax Commission in the state of Utah in which there is a very vigorous debate going on between traditional nonprofit organizations and the investor-owned entities in which both are taking very aggressive postures in informing the Tax Commission relative to both sides of the issue.

Still another issue is the fact that there is certainly a public perception that costs are too high and, in addition, that the rate of inflation is far too high. And one of the national news media certainly took the health industry to task on this subject during the month of May. The fact is that for years the medical market basket, if you will, has outstripped in its inflationary trends the CPI and other measures of inflation.

Perhaps not in Utah, but in some parts of the country, still other contributing factors have been the fact that nonprofit organizations may in some cases have taken excessive margins, perhaps more than they could justify. I think that many of them have done this feeling that during these few years we've had a shift from traditional forms of fee for service, cost reimbursement, kinds of reimbursement to be prepaid; perhaps that was the time to strengthen the balance sheet for a rainy day that was yet to come. And where there have been unwarranted margins, that has really been a problem.

Another issue has been the perception that some organizations are not meeting essential public responsibilities, responsibilities that they need to meet in order to maintain exemption. Just the fact that our health delivery entities have become larger and more selective in their services, I think, has caused other feelings than perhaps traditionally were there. These are large organizations. They are perceived to be fiscally strong enough to be able to pay taxes.

And then, lastly, I think this one has been very clear, certainly, as we have been challenged in Utah. This issue is the lack of documentation on the financial value of the gifts that nonprofit organizations have given back to the community. Many nonprofit organizations, including our own, were caught very, very short relative to being able to be in a position to accurately document the extent, particularly the fiscal value, of the gift in all of its forms that has been given back to the community. A little later we'll talk about my perceptions of what those gifts ought to be.

So, those are the key environmental factors as I see them, and I'm sure some of you have ideas on others, but I think to a greater or lesser extent these have been the key issues that have tarnished the reputation of traditional nonprofit organizations and have caused this issue to come into sharp focus.

Now let me just give you a quick overview of the key events in the state of Utah and I'll bring you right up to date and then give you a little feel for what is yet to come in the state of Utah, probably in the next year or two.

It all began in the city of Provo, a community of about 250,000, about 45 miles south of Salt Lake, when the County Assessor and the Board of Equalization in Utah County, without any advance indication, sent one of the large hospitals, a 400-bed hospital, a property tax statement in the amount of just under a half a million dollars. There are many, many vignettes relative to what triggered the action on the part of the county. The hospital denied it had an obligation and as a result the question went into the local courts and then moved all the way to the Utah Supreme Court. The decision of the supreme court on hearing the question was a rather gray decision. In their decision, and, incidentally, they weren't hasty in making a decision; they took almost three years to deliberate the merits of the issue, the longest that they had taken on any decision that'd ever come to them. And their decision was, again, a fairly gray answer. In fact the wording on the decision was, "In certain circumstances, our traditional nonprofit organizations offering health care services in the state of Utah *may* be required to pay taxes. Under certain circumstances they *may* be obliged to pay taxes at the county level."

Now the issue that was being determined was strictly focused on property taxes, but it was very clear that the Utah State Tax Commission was watching this very carefully with a secondary question and that being, if property taxes are appropriate, sales taxes are probably appropriate. Traditional nonprofit organizations were nervous. The cost of property taxes for the nonprofit organizations would be somewhere around nine to ten million dollars. The implications of sales tax would be just a little more than double that amount, so we're talking, with those two issues, an amount around twenty million dollars.

Now, the supreme court laid out some fairly, to say the least, broad questions that ought to be raised in determining the appropriateness of tax exemption. The first is, "Are the organizations that are seeking tax exemption basically organized for a charitable purpose?" They never said or drew lines relative to the extent to which it was, but are they organized for a charitable purpose? Is that their *raison d'etre*? And there were no specific measures, just that question was raised.

The second question was, Do they operate for charitable purposes? And again, absolutely no guidelines or indicators relative to the question of the extent to which they might operate for charitable purposes. But these are conceptual considerations that they said were important in determining whether or not an organization was worthy to maintain tax exemption.

The next questions or issues that were raised were, Is there any private inurement? Are there any stockholders? Are there any individuals or organizations that derive economic gain as a result of their margins? Is there any evidence of entrepreneurship or inurement? And then a second issue that was very close to it was, to what extent are the organizations engaged in commercial activity that may be mainstream with entities that are providing services on a tax-paying basis? And again here the question was not quantified. It was, "Is there any? Is there any inurement? Is there any commercial activity?," with nothing really said about the extent the activity had to reach before becoming a determinant.

The other two factors were, What is the nature of, and what is the amount of, the total gift to the community? And I think the thinking here was pretty clear: What services are these entities providing that might fall back to governmental sponsorship if they weren't provided? And, secondly, What is the nature of the recipients of those gifts? And again, just the broad concepts, with absolutely nothing said relative to the extent of either one of these, or any attempt to try to quantify.

As a result of this decision, it was also the supreme court's decision to put the question, then, of determining worthiness for tax exemption back on the individual counties throughout the state. As a result of that decision, then, county commissioners who are on local boards of equalization were obliged to provide an annual examination to all of the traditional health care providers that wished to maintain tax exemption. And the only thing they had to go on in making their decision were these broad concepts, these six broad concepts laid out by the state supreme court.

It's no wonder, then, as a result of what the supreme court laid out, that the counties follow different patterns. The questions that were put before the counties quickly became very political. There were no guidelines for them to follow. They were left to their own devices within the framework of these six broad conceptual considerations by the supreme court. And it really became quite a zoo to watch the results.

I'll show you in a minute what the results of the county hearings were in the first year, but before I do that, let me just say that as a result of the decision of the supreme court, the legislature were angry about the nature of the decision and decided they'd take matters in their own hands and change the state constitution and redress the issue by making far clearer than was stated in the constitution previously, that nonprofit hospitals were indeed exempt. And by a very strong margin, the initiative was passed and put before the electorate. And, when the constitution is changed in Utah, it requires approval of the electorate.

So Proposition One appeared on the ballot a couple of falls ago, 1986, and the rhetoric began. And it was fascinating to hear the rhetoric. There wasn't a lot said about the issue until about maybe two months before the election at which time a number of television stations, the talk shows, got into the discussions publicly. And the investor-owned competitors were anxious to do whatever they could to influence the vote. And it became a fairly intense issue, when it started out as a fairly benign issue. And, on the side of those who felt that hospitals may be in a position to be paying taxes, the media clearly aired the position that if the vote on Proposition One defeats nonprofit status as an ongoing right, it certainly doesn't indicate that tax exemption should be denied. It simply protects the fact that traditional tax exempts and entities ought to undergo an examination on a periodic basis, and what's more fair than that?

And that rhetoric was, without question, the issue that tipped the scale, even though it was a very close vote. The spread on the decision was just a little over a thousand votes. About one-tenth of a percent of the electorate favored the annual examination and continuing that process.

Now, in the first year, as the counties examined the question of tax exemption, there were 20 exemptions granted; there were four denied, one of them was for a long-term facility, three were for acute facilities, and the appeals are pending on each of those. The costs that were involved in the hearings and the costs involved in the appeals have been enormous. And compared to the value of taxes, I don't have exact numbers, but I know that a great deal of money's been spent on the issue.

Now, here are the key issues that have surfaced as a result of the questions that have been put before the county. If there's any rhetoric or any questions that have surfaced that are very clear messages more than others, there are just three, and here they are. First, "Do people needing care get it regardless of their ability to pay? To what extent are these organizations extending themselves in their basic charitable purpose?" Second issue that's been raised about as frequently as the first is, "Does the organization's total gift back to the community exceed the value of the tax exemption?" And if an organization can demonstrate that its gift back to the community in its various

and legitimate forms is accurately quantified and exceeds the value of taxes, it probably should be given tax exemption. And then this one, which is very interesting: "To what extent does the public understand the charitable nature of the organization's commitment?" Particularly in the face of changed behavior, which I pointed out in the early environmental analysis.

Now as a result of the status of this situation, the decision of the supreme court which still applies in the state of Utah, the State Tax Commission watching the jungle, the lack of guidelines on a hospital by hospital and county by county basis, have decided that they will take appropriate steps to develop clearer guidelines for counties to follow. And that debate is occurring this spring and into the summer. They're now taking testimony from all sides of the issue to try to determine what the guidelines should be within the framework of the questions raised by the supreme court in order to give some consistency and uniformity on a county by county basis in the granting of taxes. Their intent is to assure tax-exempt status review on a more rational basis.

I think it's very clear that whatever the Tax Commission decides won't be the end of it, because there are appeals pending. It's very clear that regardless of what the state Tax Commission decides, they may provide some things that help the counties and sort of clean up the playing field, but the ultimate decision very clearly will go back to our Utah Supreme Court for a decision as a result of the cases that are pending. And they are the ones that'll probably have the final say in the issue.

Now these are the issues that the Utah State Tax Commission is considering this spring: "What is a nonprofit entity within the guidelines of the state constitution?" Now those of us that are on the offensive here or on the defensive, if you will, are raising these kind of issues. "Is the organization organized for public purposes of health care for nonprofitable purposes?" Issues like assets dedicated to charitable public purposes and the extent to which and the destiny of the assets of the organization in case the organization liquidated. "If an organization, a nonprofit organization went out of existence, what would become of the assets?" "Would the assets be retained for public and charitable purposes?" "What is the nature of the governance?" Now, I'm just giving you a few of the kinds of things that are surfacing in the Tax Commission. "Is the governance structure such that the trustees are not investors, but are, in the case of many of these organizations, non-paid community volunteers?" "Does the organization exist for the community or are there other motivating reasons for the organization to exist?" These are the kinds of things that are coming out on the question of guidelines of the state constitution. "How are nonprofit entities to be distinguished from for-profit entities engaged in the same or similar activity?"

And again, the same kind of questions that I raised earlier are being raised here, in addition to some others, that is, there are certain distinguishing features. The small rural hospitals in the state of Utah are almost all owned or operated on a not-for-profit basis and they're struggling. Is this or isn't this a community gift, particularly if there are subsidies involved?

Another issue that I noticed was raised in the literature in front of you is the nature of the programs that are offered in nonprofit organizations as opposed to their for-profit counterparts; the extent to which the services go beyond the emergency needs for all. "Are there unique services being provided by nonprofit organizations that may not be provided by their tax-paying counterpart?"

Another issue is the reliance on public and private financial donations, the extent to which they're received and the uses to which they're put. Involvement and commitment in the teaching activities in the health science area, again, is being declared a legitimate gift back to the community. It's very clear that nonprofit organizations in

our state are carrying almost all of that burden and in some cases directly subsidizing state universities and colleges in the health science training arena. The spectrum, as I mentioned, of services of one entity compared to the other.

"What standards should be adopted to assure that qualifying institutions make reasonable payments to employees, officers, vendors, et cetera?" And here's another issue that has surfaced: "Are the payments for the staff any evidence of private inurement?" "Are the compensation and benefit levels within reasonable limits of market standards?" Those are the kinds of issues that are going to be put to the test.

And then, lastly, in the area of finance, the extent to which there is annual disclosure of net revenue together with the uses of that revenue, both from operations and revenues that are generated by donations. Nonprofit entities have done a pretty poor job nationwide in disclosing financial results.

So those are the key issues. I really feel that the Tax Commission is going to improve the playing field, because anything they do would only be an improvement. The question is of more appropriate guidelines to be used at the local level, but as I said earlier, I think very clearly the key issue will go back to the supreme court and I'm convinced that when the supreme court renders its decision another time, it will not be as nebulous a decision as it was the first time. It'll be a much more informed court, one that's likely to do its homework, resulting in a much more prescriptive type of decision than the one they rendered the first time around.

Now, let me just conclude on lessons learned. What are some of the responses that organizations have made, and how has behavior changed as a result of the question of tax exemption? I think that's something that this symposium deserves to hear. First, I think that there's been evidence that organizations have done a better job in disclosing what their mission statements are and what their commitments are to the communities. In our own situation, there hasn't been a word of our mission statement changed since it was written ten years ago, but a great deal more has been done in making the community aware of what that community mission statement is. We've had to become much more aggressive in making sure that we stake ourselves out, and other organizations are doing the same thing relative to the things that we intend to do in serving the community in a unique way. And as I say, the actual statement hasn't changed a bit, but the dissemination of that statement has been far greater than anything we've ever undertaken before.

Organizations have, as ours has, taken exhaustive steps in going back and examining our business practices to make sure that we're fair in our dealings in the competitive marketplace. That we're dealing fairly with the individuals and organizations that are complaining in addition to the government, particularly the competitors. Are we using tax exemption in an unfair way over our competition?

An example of this is the third item here and that is taking steps to assure that taxes are paid on appropriate segments of the business. And those are activities that are more commercial in nature. For example, the operation of medical office buildings and the leasing of space back to physicians—far more commercial in its nature than the traditional services that hospitals provide to the communities. Even services such as laboratory services that are not geared for general patient populations, but are geared for specific industries, in our case large industries, like the steel industry that are buying specific services on a commercial basis. Taking steps to segment that kind of business away from the mainline and make sure that we are operating those kinds of services on a taxable basis.

The next response is to take steps, very deliberate steps, to segment charity care from bad debt and other deductions from revenue. Nonprofit organizations have been

very passive about this across the country. They may have been giving a good deal of charity care away, but many of them haven't done it in the proper way and that is to make sure that it's understood that it is charity care before the service is given, to document the extent to which it is charity care and then exempt the family or the individual from the payment and then account for it in an appropriate way. Traditionally, much of this service has been included in the area of bad debts. Some organizations, including our own, I think perhaps we're the only one, have gone a step further and that is we've made it very clear that we will not turn anybody away for lack of resources. And now that kind of statement is prominently found in our literature. It's found in statements on the walls, prominently posted in appropriate places in our hospitals. And I think this has helped. Even though that had been our intent all along and the only exception to that is in very high-cost, high-tech services such as heart transplant, and again, charity care is offered, but in many cases, there's a little deeper discussion relative to the extent that other resources can be found, in order to avoid an enormous cross-subsidization.

Review of potential trustee conflicts of interest is important. I think it's very clear that in some parts of the country, fortunately not in Utah, this issue has raised its head. We've also examined compensation and perks for employees and management for appropriateness.

Nonprofit organizations must document all forms of community gifts. The key forms that we are declaring include charity care, health science education, and subsidized rural care. We think there's some obligation for us to try to change the nature of the way in which rural care is provided, make it more efficient and less subsidized. We need to be efficient in the way we provide rural care and make sure that the way we provide it is appropriate with community needs. That one's a little nebulous, but I'm sure it's going to surface as an issue.

Let me just conclude by saying I feel that organizations in the state of Utah, as well as elsewhere, that wish to maintain exemption are going to have to document and demonstrate and adequately prove their case or they should be denied. Thank you very much.

THE UTAH SITUATION ON TAX EXEMPTION

1. Major Environmental Factors

   - Challenge on exemption is being raised in many states—in most cases the issues are similar.
   - Some of the issues are legitimate—tax exemption shouldn't be in place to provide a competitive advantage.
   - Nonprofit hospitals have aggressively responded in a pro-competitive market
     - Additional technology
     - Diversified health care services
     - Health insurance plans
     - Tough contracting strategies/negotiations
     - Etc.
   - Tax payer coalitions to reduce tax rates
   - Tax revenue shortfalls in many communities (e.g. Pittsburgh)
   - Private competing businesses concerned/angry
   - Investor-owned competitors feel they are in an unfair position and speaking out
   - Public perception that costs are too high
   - Excessive margins and unwarranted spending
   - Public perception that some organizations are not meeting essential public responsibilities
   - Evolution of large health care provider systems
   - Lack of documentation on fiscal value of community services/gifts.
   - Tax exemption challenge is occurring in many states and communities (30 to 40 states). There are many variations on the intensity of the circumstances. (e.g. percent of tax exempt property in Pittsburgh)

2. Utah Situation - Key Events

   - Utah County vs. IHC

- Supreme Court ruling (result was a "gray - non-black and white" one: Under certain circumstances, nonprofit hospitals *may* be taxed)
  - Organization for charitable purposes (extent to which?)
  - Operation for charitable purposes (extent to which?)
  - Question of private inurement/commercial activity

    Extent to which?
    Is there any?
  - Total gift to community/nature of recipients

    Extent of? (implying how much relative to value of taxes)

    Extent to which recipients represent individuals who would go without?
- Annual test by each county/no guidelines specified
  - Legislative support on constitutional change was quickly achieved
  - Proposition #1 (1986) narrowly defeated by 1300 votes (50.1% to 49.9%)
  - 20 exemptions granted
  - 4 exemptions denied
  - Appeals pending
  - Costs involved
  - Implications for additional taxes

3. <u>Key Issues Which Have Surfaced/County Hearings</u>
   - Do people needing care get it regardless of ability to pay?
   - Does the organization's total exceed the value of tax exemption?
   - Does the public understand the charitable nature of the organization's commitment?

4. Utah State Tax Commission's Analysis/Key Issues

- What is a "nonprofit entity" within the guidelines of the State Constitution?
  - Extent to which organized for public purpose of health care—not for profitable purposes
  - Assets dedicated to charitable public purpose/assets to other nonprofit on dissolution
  - No share holders/investors
  - All earnings retained for public/charitable purpose
  - Governance by non-paid community trustees (not investors)
  - Organization exists for the community—not for any other reason
  - Nature of governance
  - Commitment to rural areas or other areas of need that might not otherwise be met
  - Care commitment beyond emergency needs for *all*—including indigents
  - Reliance on public-private fiscal donations
  - Involvement/commitment in teaching activities/health science.
  - Spectrum of service compared to community need
- How are nonprofit entities to be distinguished from for-profit entities engaged in same or similar activities?

Some Points to Consider

For Profit	Not-for-Profit
1. Can't qualify for property tax exemption	1. May qualify.
2. Owned by private investor-shareholders	2. Not owned by private interests/ assets are held in public trust
3. Organization basically driven by profit motives	3. Motivation is public charitable purpose—objective is health care provision on permanent basis

4. Organization pays dividends or makes other distribution	4. No dividends paid—no distribution of profits or earnings to anyone: all earnings retained to further the basic purpose
5. On dissolution, the net assets are distributed to shareholders	5. On dissolution, assets go to another nonprofit or public entity

- What standards should be adopted to assure that qualifying institutions make reasonable payments to employees, officers, vendors, etc.?

  Issues here:

  1. Private inurement
  2. Reasonable market-related compensation
  3. Annual disclosure of net revenue together with uses (revenue from both operations and donations)

5. Lessons Learned

- Broadened disclosure on mission/commitments
- Examine business practices for fairness
- Assure taxes are paid on appropriate segments of the business
- Segment charity care from bad debt and other deductions from revenue
- Review for potential trustee conflicts of interest
- Make sure compensation/perks are appropriate
- Document all appropriate forms of community gifts
- Organizations that wish to have exemption must demonstrate/document and adequately prove their case—or they should be denied.

PROPERTY TAX EXEMPTION: LOCAL RESPONSE FOR A LOCAL CHALLENGE

JOHN O'DONNELL. Much about the situation in Vermont is very similar to what Mr. Jeppson has talked about in Utah, and that is not surprising. What is surprising was that the result was so different. At least it has been different so far.

In June 1987, the city of Burlington, Vermont, sent a tax bill of almost $3 million to Medical Center Hospital of Vermont. As in the Utah case, the action was totally out of the blue. For some reason city assessors' offices seems to think that ambush strategy works in these situations. Burlington's theory was that MCHV no longer met the Vermont statutory definition for a charitable tax exemption. I emphasize *statutory* rather than a constitutional definition, as contrasted with Utah.

The Vermont definition says that a property tax exemption is to be granted for "real or personal estate granted, sequestered, or used for public, pious, or charitable uses." The city contended that MCHV no longer met any of those criteria for a public, a pious, or a charitable use. MCHV conceded the "pious." It did not concede the others.

MCHV responded by seeking a temporary restraining order in Chittenden Superior Court, the civil court of Chittenden County in which MCHV and Burlington are located. The parties agreed to a consolidated hearing on both the request for an injunction as well as the merits because MCHV was facing a review of our budget by the Hospital Data Council, the state voluntary budget review body, scheduled to take place in the end of August. MCHV felt that if it had to include a three-million-dollar item in its budget, the issue should be decided before rates were set for the year.

The benefit of the consolidated hearing was that things moved along rather quickly. In fact, this whole case went much more quickly than did the Intermountain case in Utah. The drawbacks to a consolidated hearing on that schedule was that all legal discovery in the case was done in five weeks and that the trial testimony had to be developed and prepared for in that period of time. There was a great deal of discovery during that five-week period. What this case showed, of some surprise to the hospital, the board, and the administrators was that for a hearing like this, a discovery request can ask for just about anything and everything, and that is what the City did. A large number of documents and other material the hospital never expected to see the light of day were examined. Regardless, the trial was started within five weeks of the original hearing. The five-day trial involved a number of expert witnesses and a fair amount of rhetoric, all of which seem to accompany these types of cases.

A month later the decision handed down by Supreme Court Judge John Meaker found for MCHV on all points. Judge Meaker found that the hospital was a public use, although that issue was never really fully developed at trial and neither side developed all the arguments of what a public use should be. The judge also found, however, that MCHV was a charitable use and did go into great detail as to what constituted a charitable use according to Vermont law.

The Intermountain case was cited heavily in the trial by the city. In fact, the city at one point, as a fall-back position, urged that the Utah test, the six-criteria test Dave Jeppson detailed should be adopted for Vermont as well.

The city of Burlington appealed the decision and the case was sent to the Vermont Supreme Court, the court for direct appeal. Briefs were filed in December 1988 and oral argument on the case was held on April 20th. There is no timetable for the Supreme Court decision. Both parties are anxious, however, since one of the

stipulations in the case back in the summer of 1987 was that the tax would not be paid awaiting the outcome of the final decision. A tax bill, therefore, has been accruing at the judgment rate of interest since the summer of 1987 and now is approximately eleven million dollars. Were MCHV to lose, that tax bill would come immediately due.

Why the focus on property tax? Why does this issue come up in the form that it did for MCHV and for Intermountain? The general issue of tax exemption, regardless of the taxing authority or the type of tax, is the one that many hospitals are facing now. These remarks will concentrate on the property tax aspect. Of much more concern in a state like Vermont, and probably in many states around the country, is whether or not a hospital or a not-for-profit health care facility maintains its property tax exemption.

For illustration, there was little chance in 1987, and for years into the future, that MCHV would be liable for a $3 million income tax bill. There are ways to lower income tax, the obvious being deductions and credits. Property tax occurs in one fell swoop. There is very little way, generally, to avoid that tax. Virtually no credits offset it, and it comes as a direct expense over which hospitals have little control. For magnitude of the tax alone, property tax exemption should be a major concern.

Second, property tax is by definition a local tax. It is generated as the result of the state taxing authority, but it is a local tax designed to generate revenues for local purposes. The needs of localities differ across the country. Therefore, the needs for revenue differ. How one state or municipality will attempt to raise that revenue may be quite different from how another may do it.

Further, the base for property tax is just that—property. The amount and type of property in a community will determine the ability of a municipality to generate revenue from property tax. In Burlington, for example, over 40 percent of the grand list is tax exempt. That is due in part to the presence of the University of Vermont and Medical Center Hospital of Vermont, two separate but affiliated institutions. It is also due to the fact that Burlington itself, although the center of a region of about 140,000 people, only has a population itself of less than 40,000. Much of the city, as I say, if not tax exempt, does not include large amounts of commercial property.

The legal basis for property tax and property tax exemption is similarly local. Because it is the subject of state and municipal law, there is not a uniformity of interpretation across the country about what certain aspects of property taxing statutes mean. How the attorneys or the courts in Burlington, Vermont, view the word *charity* is different than how the justices in the Utah Supreme Court view charity. That is both good and bad. The bad part is that you cannot translate results or interpretations across state lines, because it is based on different state statutes. As inconsistent or convoluted or, often, contradictory as federal income tax law interpretation is, both by the Internal Revenue Service and by courts reviewing IRS actions, at least it works with a common statutory scheme.

Finally, property tax exemption is an issue that has real immediacy for individuals in that city. What happens with your federal tax? Given automatic deductions and a myriad of spending programs, federal tax issues are often not immediate to individuals. What is immediate is that the city cannot afford to buy a new fire engine or that one's tax rate goes up well in excess of one's salary adjustment. As municipalities lose federal revenue-sharing funds and as they face increased demands for funding of social-service agencies and capital-intensive projects, they look to the tax base because there is not much else available. When a potential taxpayer is able to avoid property taxes, it literally hits home with an immediacy much greater than federal tax law changes.

As an example, in the year that the tax was assessed against MCHV, Burlington's total tax base generated revenues of approximately 24 million dollars. If MCHV were

suddenly liable for three million dollars of that, there are individuals who would have said, "Wait a minute, my taxes are gonna go down by a prorated amount." They were right, the individual tax bills would have been decreased. And the effect would have been considerable.

For those reasons the property tax exemption issue remains very much a local one. Therefore, local standards and local interpretations should be used. "Local," in most cases, means "state," because the taxing authority comes from the states and it is devolved down on to the municipalities. Theoretically, it differs in 50 different jurisdictions.

What were the city's arguments as to why MCHV was no longer a public or a charitable use? In its trial brief the city made certain points. The first was that MCHV cannot prove that it derives its funds mainly from public and private charity. Public or private charity, according to the city, were donations or philanthropy. The standard the city argued was that more than 50 percent of hospital revenues should come from charity. MCHV could not show that, and there are virtually no other hospitals in the country that MCHV could determine met that standard with the possible exception of the Shriner hospitals.

At one point, the predecessor hospital to MCHV, the Mary Fletcher Hospital, founded in the 1870s, had met such a standard. It could show that philanthropy was responsible for the operation of the facility. The city referred to that situation and agreed that a property tax exemption was appropriate in 1879. It was appropriate, the city conceded, even back in the 1940s, when 47 to 53 percent of revenues were generated from philanthropy for the operation of this hospital.

Currently, however, the figure for charity and bad debt is something on the order of 3 to 5 percent. The city stated that 3 to 5 percent just is not charity. In the trial brief the city argued, "MCHV cannot prove that it provides a substantial amount of care free of charge or at reduced rates so as to relieve government of a burden it would otherwise be forced to undertake." As Dave Jeppson discussed, MCHV, like other hospitals, simply did not have good records concerning free care and bad debt care provided. That is something that has since been addressed.

What the city attempted to show was that the amount of free care that MCHV gave was primarily to individuals outside the city of Burlington. Therefore the city of Burlington should be able to tax the hospital, because the benefit to the city of Burlington was not commensurate with the tax advantage that the city gave to the hospital through its exempt status. The way that the city attempted to show this was to request from MCHV the names and addresses and diagnoses of all Burlington residents who had received free care in the previous year. MCHV refused to provide that information.

There were several separate hearings on that particular discovery request and an evidentiary ruling. MCHV would not turn over that information because of the problems with patient confidentiality and because the list was on the order of 500 to 700 individuals. In addition to the difficulty of generating the lists, MCHV did not feel that it would be appropriate to turn the list over to attorneys and investigators who would immediately attempt to confirm that individuals did in fact get free care and did get the care for the diagnoses that were listed.

Because the city did not have the opportunity to cross-examine those individuals, the judge ruled that the amount of free care rendered by MCHV was not admissible at the trial. Therefore, at the trial and in the decision there was no evidence in the record that showed that MCHV provided any specific level of free care. The decision was made independent of that determination. That is the biggest difference between the

approach taken by the Chittenden County Superior Court and the cases in Utah and in other areas, where the actual amount of uncompensated care was a large, in some cases deciding, issue.

The city argued that MCHV cannot demonstrate a "spirit of charity." MCHV never found out exactly what that was, but what the city argued, again in a fair amount of courtroom rhetoric and press conferences on the courthouse steps, was that it would bring forth individuals who had been turned away from care at the emergency room, individuals who had been discharged from the hospital earlier than they should have been, individuals who were refused treatment because they could not pay. In fact, no witness was ever brought forward who was able to testify to that. The city attempted to put a couple witnesses on who had heard about friends who knew somebody who had relatives who did not get this care or had been hounded by collection agencies on behalf of MCHV, but the judge very quickly stopped all such testimony, since it was obviously hearsay. No witness was brought forth that could indicate from personal knowledge that he had been denied care at MCHV.

Finally, in its trial brief, the city argued, "MCHV is operated so as to inure private advantage, gain, or profit to persons who manage or control it." The city argued that there were really three indications of this. The first was the compensation paid to executives at MCHV, which they claimed was far out of line with what other not-for-profit organizations paid their executives, and further that there was a form of dividend hidden in the salaries. Second, there were conflicts of interest and benefits to members of the board of trustees or spouses of the board of trustees from their service on the board. Third, physicians received private benefit from the hospital by their connections with the hospital. The city used as examples the fact that the surgeons did not pay rent on the operating rooms at the hospital. That particular fact came as a surprise to the city attorneys.

On the issue of executive compensation, the city attempted to show through a multiple-linear-regression analysis, that over the last five years the top three executive salaries were correlated with how well the hospital did in terms of its bottom line. The regression figure came out to something on the order of 60 percent. The testimony, though from an expert witness, was somewhat confusing and ultimately not persuasive. MCHV challenged the assumptions on which the analysis was based. For example, the city had the timing for the salary adjustments and the bottom line performance exactly the same. At the time the salary adjustments were made, however, MCHV did not know what its bottom line would be. There may have been some incidental correlation, having to do generally with performance of the organization, but one was not dependent on the other.

Further, in its trial brief, the city attempted to show that MCHV was not a charitable institution because none of the executives or other administrative staff at the hospital had taken a vow of poverty. In fact, that was true. None of the staff *had* taken vows of poverty, but what came out of that was an interesting discussion about the reasonableness of executive compensation. The court found MCHV's relevant market for comparison to be other New England teaching hospitals and MCHV fit approximately in the middle of such a comparison.

The court expected the city to present evidence on all this. The city did present evidence, not on all of it. When the court ruled, it, in effect, defined a charity under Vermont statutes as an organization that has a not-for-profit status, that has 501(c)(3) status for income tax purposes, that uses excess revenues over expenses for the charitable purposes of the institution, that admits patients regardless of their ability to pay, and that provides no private benefit or inurement from the operation of the facility

to managers, directors, or others in control of the facility. The amount of free care was not a consideration. The gift to the community was detailed in the decision by a listing of the types of services that MCHV offered that would not be offered if MCHV were a for-profit institution. Two examples used, based on expert testimony by MCHV, were the burn service and the intensive-care nursery.

The case is currently on appeal. Judge Meaker's decision is interesting for purposes of discussion, but is not yet a definite statement of Vermont law. That is up to the Vermont Supreme Court, which is expected to rule before the end of this year.

In spite of local differences, a number of issues were common in the legal determination of "charitable." Before listing those, however, a review of the public-use issue is appropriate because it emphasizes more than anything else the local nature of these types of challenges. The Vermont exemption is based on public, pious, or charitable use. Not a great deal of the MCHV decision dealt with the issue of public use. However, in February 1989, the Vermont Supreme Court did address property tax exemption for public uses. It addressed the issue in the context of a case dealing with a challenge to the public use exemption for the American Museum of Fly Fishing in Manchester, Vermont. The museum said that it was a public use. The town of Manchester said it was not. The case went to the Vermont Supreme Court. The finding for the town of Manchester was that a fly fishing museum was not an essential government function. Fly fishermen may dispute that, but most people would recognize that regardless of the subject of a museum, it is probably not an essential government function. Much to the surprise of many people in Vermont, however, a divided Vermont Supreme Court expressly overruled the "essential government function" requirement for a public use. It said that there is a three-part test for public use in Vermont. The Vermont Supreme Court said: "Before a property is entitled to tax-exempt status as a public use, it must meet certain criteria as follows: the property must be dedicated unconditionally to public use; the primary use must directly benefit an indefinite class of persons who are part of the public and it must confer a benefit on society as a result of the benefit conferred on persons directly served; and third, the property must be owned and operated on a not-for-profit basis."

This case helped MCHV. It helped in particular in that it was three months before oral argument of the MCHV tax case. In fact, the question was asked by the justices to the counsel who represented the hospital during oral argument, "Couldn't we decide this case simply on a public-use decision and not deal with the charitable issue at all?" The answer was yes. The problem for MCHV is that the composition of the court that decided this public-use definition without an essential government requirement is not the same court that heard the MCHV case. Only two justices of five were the same and one of those justices wrote a stinging dissent to the fly fishing museum case. Further, this case opened up a great deal of discussion of what a public use actually was, and the legislature immediately addressed the issue. The Vermont legislature is still in session; however, there has already been a bill passed in the House of Representatives that would insert the "essential government function" as part of the statutory language for a public-use exemption.

This case is an illustration not so much of the vagaries of statutory and case law interpretation, but an indication of one supreme court, admittedly in a small state, developing a wholly different view of public use from that of another state or another municipality interpreting similar statutes.

Some common issues were important in the determination of charitability—a second basis for exemption. The most important, far and away, was a clear statement of the mission of the hospital. MCHV's mission statement was not particularly unique. It

simply stated that the primary mission was to provide high quality primary, secondary, and tertiary health care at the lowest cost consistent with the maintenance of high standards of care, prudent uses of advanced methods of technology, and needs and expectations of constituents served. MCHV will not restrict the availability or compromise the quality of essential care on any basis.

What helped MCHV was not so much the language, but the fact that the board of trustees had gone through an extensive effort to review, rewrite, and reaffirm that mission statement in January 1987, just six months before the assessment of the tax bill. MCHV was able to say, "Yes, it's still our mission. We've just looked at it. We have reaffirmed it. That's what we are today, all we've done is updated for the changed environment."

A second factor is that MCHV has concentrated on that mission. In part, it has been able to do this because it is the only game in town. The next largest hospital in Vermont is about half the size of MCHV. MCHV is the regional referral center. The closest hospital offering equivalent services is in Albany or Boston. It is a major teaching hospital. It offers a large array of high-tech services. There are no for-profit hospitals in Vermont. There are very few hospitals at all in the rest of the state that are in excess of a hundred beds. MCHV, therefore, was required, but also allowed, to concentrate on being a tertiary-care and secondary-care referral hospital. It has not been involved in insurance programs to any great extent. It has not been involved in many free-standing facilities. It has not really gone far afield in terms of medical office buildings or travel agencies or anything else that is different from offering acute-care services. Because of that, MCHV has avoided much of the concern about using hospital resources of management, funds, facilities, and so on to go into competition with other health care providers in the area. MCHV's few for-profit activities are scrupulously segregated from the hospital not-for-profit activities; taxes, property and otherwise, are paid on all those activities.

Perception of operational practices was another factor in the determination of charitability. The hospital was a little surprised to have so much of that questioned. It really was not surprising, however, when one looks at what has gone on in the last couple of years with issues like executive compensation, board conflict-of-interest policies, and physician involvement. MCHV was in a good position since it has none of the executive or management compensation policies in place that some hospitals have. As many as 30 percent of not-for-profit hospitals have some type of incentive program tied to the performance of the bottom line for executives. MCHV does not. It would have been very difficult in Vermont and in the climate that MCHV was in to defend such an arrangement. MCHV does not have physicians on staff. MCHV has no joint ventures with physicians. It has very few situations where physicians' services are provided on anything other than fee-for-performance basis. MCHV maintains an open medical staff, somewhat unusual for a hospital of its type. This policy has caused a fair amount of discussion in the past. As a major teaching hospital as well as a community hospital, MCHV felt that it had to balance the requirements of the two. An open medical staff, as opposed to a closed medical staff, was viewed as a necessity.

Finally, in terms of community awareness, MCHV found—both formally and informally—that the community was not as aware as MCHV thought of the mission of the hospital—how it operated, what services were available, and how such services would be made available. MCHV actually seized the opportunity of the trial to reinforce this message and it has spent a significant amount of time since then on this effort. Further, it has developed a relationship with several providers in the community (a community

health center, for example) that provides health care resources and primary care services to low-income residents.

Would any of these factors work in other situations? What should be apparent is that most of the factors are the same as in the Intermountain case. What was different were some of the environmental factors. Again, Vermont is a small state. MCHV is a decent-sized hospital, but there are few other hospitals around that provide a competitive aspect to the environment. There are no public hospitals in the state. There is no real competition in terms of certain types of health care activities as there are in other parts of the country. There are no for-profit hospitals in the area. In fact, there are very few for-profit health care organizations of *any* type in Vermont. That combination of environment and institution is by definition unique, and so was the definition of charitability.

What MCHV faces is probably a situation that is quite similar to many, if not most, of the other hospitals throughout the country. The competitive aspects, the environment, the factors that are typical in a Chicago area, or a Provo area, may not be the same as the situation in the middle of Montana or the middle of Mississippi. Yet, property tax remains an issue for all of these. How the law will be interpreted and what the effect of different factors will be on those assessors' offices and judges reviewing those actions is dependent on the environment and how those particular institutions are responding and acting charitably or publicly in that environment.

One final point emphasizes the difference between the Intermountain case and Vermont. The Vermont case stands on one side as opposed to the Utah experience on the other. In Vermont, charitable status was a permanent aspect that one had to work to lose, rather than work to gain each year. The lack of specific financial value, the amount of fiscal gift, at least according to the law as it stands now without the Supreme Court decision, was not determinant. The *availability* of the gift was a determining factor, but if a hospital operated itself as a charity and nobody walked through the door, it would still be a charity in Vermont. That is the difference that marks the boundaries of the debate.

QUESTIONS FOR MR. JEPPSON AND MR. O'DONNELL

QUESTION. I understand now that you in Vermont have made some affiliations to provide limited primary care. Do I recall that in Utah you have become engaged in providing care and shelter for the homeless as well? I believe that is how it is worded.
JOHN O'DONNELL. Well, MCHV is not. We're involved with a primary-care facility for which we provide some financial assistance and some resources. I think the situation is a little different in Utah, though, Dave, isn't it?
DAVID JEPPSON. Prior to the time the issue was raised in Utah, we had provided out-patient care and referral in-patient care directly in our transient shelter. We had a clinic in two of our large shelters. And that has continued. One of the things I should have mentioned, in addition to staking ourselves out loud and clear now to take all comers, we've also increased the access. We added four or five clinics that were primarily for charity. We now have seven. We'll have nine by the end of the year. We're trying to get out-patient care out in the communities. I think that's been another very strong commitment that we've made to increase the access, but it was there before. We've just intensified it.
QUESTION. Does Utah or Vermont have a sales tax?
DAVID JEPPSON. Utah has a sales tax and thus far we've been exempt from sales tax.
JOHN O'DONNELL. Same with Vermont. We have a sales tax, but it is only for goods rather than services, with some exceptions. If there were a service tax that came in, like there was in Florida some time ago, the question of whether it would extend to health care facilities or not is an open one.
QUESTION. Has there been any deliberate steps to protect yourself by giving direct contribution, I guess fiscal or other, to specific needs of tax-paying entities?
DAVID JEPPSON. In Utah we haven't. When I presented a paper last fall on the same subject in New England, I found in the state of New Hampshire that there have been a number of hospitals for years that have been making direct financial contributions to police entities and also fire districts. They were smart enough to feel like they ought to go an extra step besides just taking care of all comers, they ought to directly contribute to and subsidize governmental entities. And I think that's paid off for them. Some of their hospitals have been at that for a lot of years.
JOHN O'DONNELL. The best defensive mechanism we've been able to determine, if we were to lose our case, would be to immediately become church-affiliated somehow. The situation in Vermont is such that religious hospitals would not be taxable. That raises some interesting constitutional questions on its own about separation of church and state, but that's probably for another conference.

In terms of payments in lieu of taxes, we were approached about this by the city soon after the tax bill was issued. I should tell you that part of the background in Burlington at that time included a Socialist mayor who did not like the U.S. health care system and did not like the hospital in Vermont in particular and did not like the physicians who practice in that hospital at all. The negotiations really were not fruitful. In fact, they were rather confrontational. At the same time, the hospital felt, and this was the strong feeling of the board of trustees, that a payment in lieu of taxes was a tax. If there was a difference, it was in the discount from the *ad valorem* calculation, but it was a tax nonetheless. Whereas the city of Burlington did provide certain services to the hospital in terms of fire and police protection, the response was that the hospital provided to the city of Burlington substantial benefits, perhaps less quantifiable than the number of fire runs, but no less real. So we have not proposed a payment in lieu of

taxes. I can understand and to some extent empathize with situations in other areas, but in our situation it was not a good alternative.

DAVID JEPPSON. But before we leave that question, one other therapy that we're undertaking that is somewhat along that line. When we set up our organization, we set up a foundation that was organized primarily to meet broad community needs. We've never felt a need to fund it. We've felt like the needs that we ought to address are ones that we ought to handle right out of our mainline operation. In the last year or two, we've reconsidered that whole question. We have a foundation now that we're adding community leaders to that's going to be at arms' length and we've taken steps to see that it is funded.

One of the things we did several years ago was to spin off some of our high payout shared services into a tax-paying entity and sold those services to other organizations. And one of the services has been data processing software. We've installed data processing software through this little tax-paying entity in about 200 other hospitals across the country.

As we examined whether or not we ought to continue that and what that does to our image and what it does to our management energies, we decided the best thing to do would be to sell it, so we sold it to the General Telephone Company. They paid us, after we paid off our debts, in excess of about 15 million dollars. That went into the Foundation and that money will be used exclusively for community purposes. We also had a joint venture in one of our Idaho facilities where we've been in a two-hospital town competing with HCA. We merged the two hospitals, continued the joint venture, and we sold that joint venture to the HCA Corporation, then took the proceeds from that, put it in the Foundation. And so, I think those will be new forms of gifts, if you will, that will serve the community in ways perhaps broader and different than anything we've done before.

QUESTION. Do you think that nonprofit hospitals are the tip of the iceberg for the scrutiny of other nonprofit organizations, like colleges and universities, by tax commissions?

DAVID JEPPSON. That's a very good question and it is very clear, as we've gone back and examined what the tax commission and the assessors in our part of the world have been up to. They indeed have been doing a great deal of research on all of the tax-exempt organizations. I really feel that, because of the nature of what we do and the aggressiveness with which we've done it, we've been one of the early targets. But there has been and is research going on on many other forms of organizations that have had this exemption. Very clearly it is an activity in our part of the country and I'm assuming elsewhere as well.

JOHN O'DONNELL. I agree.

QUESTION. How do the individuals questioning the amount of private or public charity view contractual allowances associated with certain types of reimbursement programs?

JOHN O'DONNELL. In Vermont, the court recognized that Medicare and Medicaid services were provided, in particular instances and overall at less than cost and recognized that that was a gift or a benefit to the community. In the case of the Medicaid program in Vermont, the Medicaid program pays about 62 percent of our charges. It is a considerable gift to the community. However, the conduct of the case and the rhetoric surrounding the case concentrated on the fact that there was something less than 2 percent of actual philanthropy developed by the hospital in any given year. The city felt that was the appropriate comparison—to the hospital 50 years earlier when well more than half of all income was generated from philanthropy.

DAVID JEPPSON. I'd like to comment. John indicated that in his situation the opinion was held that 50 percent of the revenue ought to be from charitable sources. In the one county in Utah that has denied four organizations, where the rhubarb is really occurring right now, the county attorney and one of the commissioners have stated publicly that no organization should be exempt that bills its patients or its clients for anything. They've staked out themselves saying that the only hospital that really should have complete immunity from property tax is the Shriners' Burn Hospital, a small 24-bed hospital that doesn't ever send out bills.

QUESTION. My question relates to in either of your two cases under discovery were there any issues raised about the aggressiveness of your institutions in communicating with the community, advertising, direct mail programs, the dollars that have been spent on advertising?

JOHN O'DONNELL. Absolutely. I believe the question was, "Was there a concern raised about how public we were about communicating our free care policies?" This was one of the major arguments that that city made: "Look, you have this free care policy, but nobody knows about it. We asked you a year ago to run ads about the policy and you didn't do it." MCHV developed arguments in response to that saying we didn't think we needed to, the policy was well known. It was a very large part of the case. In response to some community surveys, we are now more aggressive in this sort of advertising. That is one outcome of the case.

QUESTION. I'd like to redirect. Was there any criticism about taking advertising dollars and advertising open heart programs as opposed to charitable care?

JOHN O'DONNELL. Well, in our situation in Vermont (again local responses for local interpretations), we do not advertise. The only thing we advertised was a series of health promotion and health education programs. We do not need to advertise right now. If you need a heart procedure in Vermont, you come to MCHV. The only other hospital in the area is a 100-bed Catholic hospital that does not offer obstetrics or pediatrics, for example. So it wasn't a problem for us.

DAVID JEPPSON. In our situation, there was thought in some of the counties that we should do more to declare our mission. We've had, I guess, the good fortune or the public relations people had the good judgment to make sure that our advertising has been along the lines of vital information that people ought to have. It's been much more community service-oriented type advertising.

Recently, in the last few years, we've had eight or nine free-standing psychiatric hospitals come into our marketplace, and the advertising has been highly commercial. Here, again, we've kind of laid back and our advertising has been more public information. The issue's been raised, but not in a very severe way, because of the nature of the way we've disseminated public information.

QUESTION. I think our students generally get the idea that joint ventures with physicians and compensation according to performance are not such bad things in many instances. Does this mean that they're going to have trouble maintaining tax-exempt status when they go to work?

JOHN O'DONNELL. Well, on the program for later today, I notice Mr. McGovern, who is assistant chief counsel for exempt organizations in the IRS. I think it would be a good question for him to answer—whether or not the entities that your graduates will be going to will be able to maintain tax-exempt status in light of these practices. I think joint ventures with physicians are going to become increasingly difficult to maintain in a tax-exempt environment, simply because the physicians involved almost always are looking for some level of inurement, some level of benefit. We have decided to go extremely slow in terms of going into ventures with physicians in anything other than a

situation that is clearly not-for-profit for both sides. In terms of compensation programs, again I think that they raise questions in people's minds, "Are you being paid for what you do or are you being paid as a part of the bottom line?" In certain localities, and Vermont is one of them, I do not think that the population is going to accept easily a compensation program that involves some level of payment that looks like a dividend.

DAVID JEPPSON. When we commenced our operations back in the early seventies, our board introduced a subject to us that was foreign. None of us had had any involvement in incentive payments, but they had had a good deal of experience with it in their private industries and private businesses. So they proposed to management that they would pay us a competitive salary, but they'd reduce our salaries in terms of our annual base pay by a certain percentage that we'd have to earn back in stretch goals in the form of incentive payments. We gulped and said, "Let's give it a try." And so traditionally we've had incentive programs both on a long-term and an annual basis that have been fairly aggressive and they've been based on stretch goals. The goals and the requirements have been very broad. They have dealt with issues such as quality and achievement relative to budget. Appropriateness questions have been raised in our very conservative state by our competitors. We're not sure just exactly how it happened, but there's a little mystery in Utah in that bank records were stolen and information was disseminated to the media relative to salaries for executives. That occurred last fall and, as a result of that activity, questions have been raised. Our feeling is, as long as incentive payments are a part of and do not exceed competitive salary rates, but are based on stretch goals that are broad in nature, they are appropriate forms of compensation.

EVOLUTION OF LEGAL STANDARDS FOR HOSPITAL TAX EXEMPTION

PAUL HATTIS. It's quite an honor for me to be invited here to participate in the Bugbee Symposium on the question of tax-exempt status for our nation's nonprofit hospitals. It's also a very special pleasure for me to be paired with Bob Sigmond on this topic. I very much believe that Bob's thoughts and comments, both reflected in his remarks today as well as in his recent writings, will help lead all of us to a more enlightened view of what it means for a hospital to be a tax-exempt community benefit organization.

As we have already heard this morning from David Jeppson and John O'Donnell, the tax exemption issue means different things to different people. In many ways the tax exemption debate represents a legal manifestation of the frustration over a number of concerns about hospitals and the functioning of our health care system. In particular, the tax exemption discussion has re-ignited the desire of many people to redefine what it means for a hospital to be a charitable organization truly working in the interests of its community.

To continue this discussion, I'd like today to first give you my brief overview of the political issues behind the tax exemption debate. I then want to discuss the evolution of the federal standard for granting tax exemption to hospitals and briefly comment on some of the legal standards for state and local tax exemption as well.

Background

As exemplified by laws regulating charitable use of property which were first enacted in England in 1601, the concept of granting tax exemption to entities engaged in charitable endeavors is solidly based historically in law and policy. Similarly, from a national historical perspective, nonprofit hospitals have enjoyed a favored status under federal and state tax laws for most of the history of the United States.

Even though the granting of tax exempt status to charitable organizations is deeply rooted in our history, the continuance of tax exemption for nonprofit hospitals has today become a policy issue attracting interest at federal, state and local levels of government. While the not-for-profit hospital sector, like the health care industry generally, is accustomed to regulatory scrutiny, tax exemption challenges represent a new focus of governmental examination. Isolated challenges have resulted in discussions, and in some cases legislative or court actions, which seek to redefine the traditional concept of charitability as it has been historically applied to tax exempt hospitals. These discussions about not-for-profit hospitals' tax exemptions have been shaped by a number of political factors and represent a confluence of societal concerns which have been channeled into the tax exemption debate.

First, the concern by government bodies for generating adequate revenues to provide needed services has reached new heights. Facing monumental federal budget deficits, Congress has been looking for untapped sources of revenues in order to address the national fiscal crisis. Additionally, at the state and local level, activity has been increasing to find revenues to meet budgetary needs. This activity is most acute in municipalities where it is not uncommon for over 40 percent of real property to be exempt from tax.[1]

A second factor which has focused attention on the tax exemption issue is the concern raised by the small business community about unfair competition. Small business representatives (e.g., durable medical goods suppliers, lab owners) have argued

that not-for-profit hospitals maintain an unfair competitive advantage over investor-owned entities engaged in similar business activities. These small businesses complain that not-for-profit entities, with increasing frequency, use their exempt position to sell products or services at below market prices or engage in activities which not-for-profit hospitals traditionally have not performed as part of the scope of their exempt function.

A third major factor driving the tax exemption issue is an emotional one. This issue concerns the medically indigent, or the thirty-seven million people in this country who lack adequate insurance to fully cover their health care service needs. Stories in both the electronic and print media have focused on the plight of the medically indigent and specifically on instances of patient dumping and inappropriate transfers to public hospitals. In this regard, one study which received some Congressional attention suggested that not-for-profit hospitals in California provide amounts of free care which are less than the value of the taxes they would be required to pay if they were not exempt.[2] While this California study was incomplete in its analysis of the charity care issue, it nevertheless raised questions concerning the extent to which not-for-profit hospitals provide for the medically indigent when the government has failed to do so.

The fourth factor which has caused some individuals or groups to bring the issue of hospitals' tax exemption before legislative and judicial bodies is the belief that there are no significant organizational, operational, or clinical outcome differences between not-for-profit and investor-owned hospitals. Over the last few years, a number of studies conducted by various researchers have tried to address some of the comparative differences between investor-owned and not-for-profit hospitals. While no conclusive results have been reached, a number of authors have attempted to promote their results and have made questionable assertions that one form of organizational form is superior to another in regard to a specific operating or organizational characteristic. The effect of these assertions has helped move the tax exemption and related issues debate to center stage.

Evolution of the Federal Legal Standard

While political factors are fluid—raising concerns which ebb and flow from time to time, the legal basis for tax exemption has firm historical roots which have allowed for stability and continuity of service provision by the not-for-profit hospital sector. The current federal standard for income tax exemption could be summarized by stating that a nonprofit hospital, the assets of which are devoted to the care of the sick, where operations are free of any private benefit, and which promotes health in a manner that is beneficial to the community, is a charitable organization deserving of tax exemption.

Ever since the passage of the first federal act to impose a tax on the income of profits of corporations generally, Congress has provided for exemption of certain organizations.[3] Included among this group are those organizations which are defined as "charitable."

Defining what sort of purposes have throughout time been recognized in law as charitable is a task which many have found quite difficult. As Professor Scott has stated, "The truth of the matter is that it is impossible to frame a perfect definition of charitable purposes." (A. Scott, *The Law of Trust*, (3rd edition 1969 Section 368)).

Lack of consensus on a definition of "charitable" has not been a problem for Congress. The grant of income tax exemption to "charitable" organizations has been maintained in every major statutory revision of the Internal Revenue Code (IRC), including the present Section 501(c)(3) of the 1954 IRC. In 1956, the Internal Revenue Service in Rev. Ruling 56-185 first declared that the definition of charitability for

hospitals was to be governed by a financial ability test: a hospital "must be operated to the extent of its financial ability for those who are not able and expected to pay ... It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services." Rev. Ruling 56-185; 1956-1 C.B. 202[4].

In 1959, the Treasury regulations which interpret Section 501(c)(3) for all charitable organizations were amended comprehensively, to provide, in part, that: "the term 'charitable' is used in Section 501(c)(3) in its generally accepted legal sense." Treasury Regulation Section 1.501.(c)(3)-1(d)(2), 24 *Federal Register* 5217 (1959).[5] This allowed the IRS to more broadly define a "charitable" organization consistent with the law as developed by judicial decisions.

After promulgation of revised regulations in 1959 and 13 years of uncertainty on how to apply the "relief of poverty" standard, the IRS in 1969 expressly modified Rev. Ruling 56-185, and created an alternative definition of "charitable" based upon a hospital's provision of community benefits. Such a standard for tax exemption is based upon the legal and conceptual notions that "charitable" purposes must be broadly defined to include all purposes which promote man's well-being and which are beneficial to the community. This standard enunciated in Revenue Ruling 69-545 remains in effect today. Its general thrust is of a broad nature—allowing for tax exemption of a nonprofit hospital which is free of private benefit and which is engaged in the promotion of health in a manner which is beneficial to the community. Acknowledging that the charitable hospital had evolved into a facility that delivered health services to a broad range of beneficiaries, with rich and poor alike benefitting from a not-for-profit hospital's charitable activities, the IRS distinguished the contemporary nonprofit hospitals' institutional need to respond to the needs of its entire community and not only be operated to benefit the poor.

Thus, under the community benefit standard, while it remains essential for all hospitals to share in the provision of care to the medically indigent commensurate with the needs of their community and the availability of resources, the *grant* of tax exemption is based on a not-for-profit hospital's providing public benefit to the entire community, rather than only a limited focus on how the hospital's activities benefit the poor.[6]

Defining "Community Benefit"

This recognition that the "promotion of health" is a distinct purpose of the general law of charity has its origins in 17th century England.[7] Since the enactment of the Statute of Elizabeth (a.k.a. the Statute of Charitable Uses), Stat. 43 Eliz. 1, c.4. (1601), certain specific purposes have come to be widely regarded in the law as charitable. Nevertheless, because of the difficulty of enumerating every purpose in the ever expanding catalogue of charitable purposes, great weight has been given to Lord MacNaughten's definition in *Commissioners v. Pemsel*, [1891] A.C. 531, 583, 3 Tax Cas. 53, 96, which identified three basic charitable purposes and a fourth charitable category of other purposes beneficial to the community.

Justice Burger in *Bob Jones University v. United States*, 461 U.S. 574, 587 (1983) made reference to Lord MacNaughten's definition of charitable purposes:

> In 1891, in a Restatement of the English law of charity which has long been recognized as a leading authority in this country, Lord MacNaughten stated: 'Charity' in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the

advancement of religion; *and trusts for other purposes beneficial to the community*, not falling under any of the preceding heads. (emphasis added)

As far back as the Statute of Elizabeth's classification of the "relief of aged, impotent, and poor people" as a charitable purpose, it has been recognized that, as a matter of law, the relief of the suffering and distress of sick and aged persons is a charitable purpose.[8]

Although relief of the distress of the sick and aged has often been subsumed under Lord MacNaughten's fourth category of purposes beneficial to the community, it has more frequently been separately treated as a fifth heading of charitable purposes in English and American law.[9]

It is now "well settled that the promotion of health is a charitable purpose." A. Scott, *The Law of Trusts* Section 368, at 2853 (3d ed. 1967); *id.* Section 372, at 2893 and cases cited at 2894-97; G. Bogert, *The Law of Trusts and Trustees* Section 374, at 107 (2d ed. 1964).[10]

The true significance of the treatment of promotion of health as a separate charitable purpose in the law of charity is that it forms an independent basis for the underlying principle that a nonprofit health organization, free of the taint of private benefit or profit, qualifies as a charitable organization without regard to providing free care for the poor. Nevertheless, the federal standard does not take such a "liberal" approach for granting tax exemption to hospitals. In order to make sure that a charitable hospital does, in fact, provide "public benefit," the federal government has created an additional requirement. This requirement mandates that such promotion of health activities benefit an indefinite class of persons which must not be so small that its relief is not of benefit to the community and encompasses a number of concerns.

First, such a requirement attempts to reinforce a fundamental principle in charitable trust law, that in order to qualify as charitable, an organization must not only operate in furtherance of charitable purposes, but must also be free of any private benefit or inurement.[11] With respect to hospitals,

> [t]he test [for tax exemption] is not whether the patients of the hospital pay more or less for their services, but whether those charged with its operations were conducting it for their private profit or advantage.[12]

This specific concern is also embodied in a federal treasury regulation which states

> an organization is not organized or operated exclusively for one or more [exempt]...purposes...unless it serves a public rather than private interest... [and may not be] organized or operated for the benefit and private interest such as designated individuals, the creator [of the organization] or his family, shareholders of the organization, or persons controlled, directly or indirectly, or such private interests. Treasury Regulation Section 1.501(c)(3)-1(d)(1)(ii).

Second, in addition to this concern about private benefit and inurement, the requirement of benefiting an indefinite class of persons also stems from a fear that the benefits provided by a charitable organization may, in fact, only be made available to a "limited" number or class of persons. Thus demonstration by an exempt hospital that it provides access to its facilities by operating an "open" emergency room, and/or that it

participates in Medicare and Medicaid, still remain important indices for identification as an exempt community benefit hospital.[13]

This community benefits "concept" which is applied to the exemption evaluation of a hospital was reaffirmed in a 1983 Revenue Ruling (Rev. Ruling 83-157). There, the IRS granted tax exempt status to a hospital similar to the one described in Rev. Ruling 69-545 except it did not provide emergency services (as a specialty hospital it did not operate an emergency room). The Revenue Ruling noted that many specific factors may be considered in determining whether a hospital promotes the health of a class of persons broad enough so that the community benefits. Accordingly, under the current federal standard, no characteristic is in and of itself determinative of whether or not the hospital is providing enough community benefit to be granted exemption. (Rev. Rul. 83-157)

Various welfare organizations unsuccessfully attempted to challenge the legality of the IRS 1969 Revenue Ruling. In *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278 (D.C. Circuit 1974), *reversed on other grounds*, 426 U.S. 26 (1976), the Court of Appeals found that the term charitable in Section 501(c)(3) may be broadly interpreted so as to allow these institutions to qualify as exempt without requiring them to admit and provide free or reduced service rates to persons unable to pay. The definition of "charitable" was not to be restricted to its narrow sense of relief of the poor. The appellate court noted that the interpretation promulgated in Revenue Ruling 69-545 was not contrary to any express congressional intent:

> There is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social, and technological precepts and values of contemporary society. *Id.* at 506 F.2d 1278, 1288.[14]

State Tax Exemptions

Recently, a few state and local tax boards, for the reasons described earlier in this paper, have begun to challenge the tax exempt status of nonprofit hospitals. In these actions, advocates of removing tax exemption from hospitals often assert that the challenged hospitals are not providing enough free or reduced care to the indigent, or in other ways not providing enough "community benefits" in order to justify the continuance of their property tax exemption (Utah, Tennessee, Lehigh County, Pennsylvania). In other communities, not-for-profit hospitals are being asked to make payments for municipal services which local governments provide (Pittsburgh, and Erie, Pennsylvania and Wisconsin legislative effort). Citing the need for revenue in communities where substantial amounts of property are exempt or where a tertiary hospital provides substantial amounts of health services to people who reside outside the local property taxing district, these local government officials are currently seeking payments from not-for-profit hospitals to help meet the costs of local government (Burlington, Vermont and Pittsburgh, Pennsylvania). Also, concerns of the small business community (e.g. clinical labs, medical equipment suppliers) have been channeled into efforts to forbid hospitals from engaging in certain business activities or to pay local taxes on their unrelated business income (Pennsylvania and Virginia State Legislative Proposals).

All of these initiatives reflect a concern that current state laws are inadequate in the way they distinguish between those organizations who deserve tax exemption and

those that do not. Much of this activity follows a 1985 Utah Supreme Court decision which denied property tax exemption for two not-for-profit hospitals for one year. In that case the Utah Supreme Court created a six-part test to be used to annually review the tax exempt status of all Utah not-for-profit hospitals.[15] Similarly, recent challenges to hospitals in Tennessee,[16] Vermont[17] and Missouri[18] have followed the Utah initiative with government officials attempting to convince the courts of the need to develop definitions of "charitable" which include some sort of "free care" criterion. Thus far in these cases, the courts have declined to adopt such criteria and have decided that both legal precedent and statutory interpretation require continuance of tax-exempt status for the challenged hospitals.

This effort to collect local and state taxes from not-for-profit hospitals is a recent change which is without much legal precedent. Like the federal basis for tax exemption, state governments have historically recognized that their local community not-for-profit hospitals have returned substantial benefits to their communities and accordingly have granted not-for-profit hospitals tax-exempt status.

Local taxation in our nation's history dates back to American colonial government, with provision for tax exemptions to charitable institutions firmly in place even during that time period in our nation's history.

> From the Revolution until the end of the 19th century, the development of the tax exemption law for religious and educational organizations was largely the work of state government and courts.[19]

As our nation further developed and secular institutions for relief of poverty and distress arose in great numbers, legislation was enacted at the state level exempting these charitable organizations' property from state and local taxation as well.[20]

Current state law regarding not-for-profit hospital income tax exemption for the most part follows the federal standard, as approximately 29 states plus the District of Columbia either directly link state income tax exemption of nonprofit organizations, including hospitals, to the grant of federal income tax exemption, or essentially have income tax exemption statutes stated almost identically to the provision under IRS Code 501(c)(3). In addition, some 18 additional states either directly exempt the income of charitable and benevolent organizations or tax only corporations organized and conducted for profit.[21]

Similarly, nonprofit hospitals are usually exempt from sales or service tax for all proceeds related to their exempt purposes, although some states recently have considered legislation which would impose these taxes on nonprofit hospitals. In addition, Florida requires its nonprofit hospitals to provide a reasonable amount of free care in order to be granted sales tax exemption.[22]

Property tax exemption has also been universally available to not-for-profit hospitals. Currently, all states and the District of Columbia have either constitutional or statutory provisions exempting the property of non-profit or charitable entities, such as voluntary nonprofit hospitals, from taxation. Seventeen states and the District of Columbia have enacted an express statutory provision which recognizes that the delivery of hospital care services in a nonprofit corporate format (with or without some minor conditions) is a specific purpose which alone qualifies hospitals for exemption from property taxation.[23]

Prevailing State Standards for Property Tax Exemption

Beyond these seventeen states, the remaining statutes on constitutional provisions have been interpreted by the courts regarding the circumstances under which a nonprofit hospital is entitled to tax-exempt status. The prevailing view of a "charitable hospital" based upon a review of cases interpreting the various state constitutional or statutory exemption provisions is that a nonprofit hospital which is engaged in the promotion of health in a manner beneficial to the community should be granted tax exempt status. For example, the Supreme Court of Nebraska in *Evangelical Lutheran Good Samaritan Society v. Gage County*, 181 NEB. 831, 836 151 N.W. 2d 446 (1967), stated that nonprofit hospitals have been universally classified as charitable institutions.

> Formerly all institutions furnishing services of this nature, including both hospitals and nursing homes, were providing care for many patients without compensation and extended charity in the sense of alms-giving or free services to the poor. With the advent of Social Security and Welfare programs, this type of charity is not often found because assistance is available to the poor under these programs. (181 Neb. at 836)
>
> [T]he courts have defined 'charity' to be something more than mere alms-giving for the relief of poverty and distress, and have given it significance broad enough to include practical enterprises for the good of humanity operated at a moderate cost for those who receive the benefits. (*Id.*, 181 Neb. at 836, 151 N.W. 2d at 449 quoting *Youngman's Christian Association of Lincoln v. Lancaster County*, 106 Neb. 105, 111, 182 N.W. 593, 595, 34 A.L.R. 1060, 1064-1065 (1921).

In Massachusetts, the community benefit standard has been adopted as the standard for property tax exemption by Massachusetts courts, in *Harvard Community Health Plan v. Board of Assessors at Cambridge*, 384 Mass, 536, 542-543, 427 N.E. 2d 1159, 1163 (1971). The Massachusetts Supreme court noted:

> [W]e recognize, too, that major changes in the area of health care, especially in the modes of operation financing, have necessitated changes as well in definitional practices. The term 'charitable,' as applied to health care facilities, has broadened since earlier times, when it was limited mainly to almshouses for the poor. As a result, the promotion of health, whether through the provision of health care or through medical education and research, is today generally seen as a charitable purpose.

Also, the Supreme Court of Virginia in *City of Richmond v. Richmond Memorial Hospital*, 202 VA. 86, 116 S.E. 2d 79, 82, 84 (1960), in granting tax exemption to a nonprofit hospital stated that:

> The nature of these institutions, the purpose and use to which they are put, all combine to show that they are operated 'exclusively as charities'...
>
> Non-profit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science are and should be regarded as charities.

Clearly, the prevailing view across the country rejects the relief of poverty approach to tax exemption and instead embraces a community benefit concept. A commentator describing the trend in granting tax exemption to charitable organizations perhaps best summarized the state of the law as follows:

> The general trend of authority in cases determining the charitable character of institutions for tax exemptions moves away from the old concept that charity is confined to the 'free' care of the indigent, and toward the idea of charities comprehending all humanitarian activities even though recipients may be able to pay at least in part for the benefits. Thus, the charitable institution does not lose its character and consequent tax exemption as such merely because recipients of its benefits who are able to pay are required to do so, or funds derived in this manner are devoted to the charitable purposes of the institution. (37 A.L.R. 3d 1197)[24]

The prevailing view of a "charitable hospital," based upon a review of cases interpreting the various state constitutional or statutory exemption provisions is that a nonprofit hospital free of private benefit, which is engaged in the promotion of health in a manner beneficial to the community should be granted tax exempt status. Nevertheless, some states provide, in addition, a statutory focus on either the nature of the beneficiaries who benefit from the organization's charitable activities, or on specific hospital financial issues including the sources and uses of hospital revenues and the financing of care for the indigent.

The seminal state case in recent times that has received much attention for reviving the "financial issues" focus for the grant of hospital tax exemption is the *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985) (*Intermountain*) decision. In that case, the Utah Supreme Court, in denying tax exempt status to two charitable nonprofit hospitals, applied a rigid analysis, looking for a "substantial imbalance between the value of the services it provides and the payments it receives." *Intermountain*, 709 P.2d at 274. Finding no such "substantial imbalance" or "gift to the community" under a court-created six-part test,[25] the Utah Supreme Court denied the two hospitals property-tax exemption even though they admitted patients without regard to their ability to pay.[26] Justice Stewart in his *Intermountain* dissenting opinion, stated succinctly how the majority differs from traditional and prevailing notions of charity:

> The majority's ruling represents a sharp and singular break with traditional legal principles. It is black letter law that nonprofit hospitals which are operated for the benefit of the public at large, and not for the benefit of any individual or group of individuals, and whose revenues are used for the charitable purposes of the organization are charitable institutions. (*Intermountain*, 709 P.2d at 281)

The *Intermountain* decision has not only been criticized for its aberrational view of charitability, but some commentators have noted that the Utah Supreme Court utilized a form of cost-benefit analysis which is fundamentally flawed and nearly impossible to apply.[27]

Perhaps this realization prompted the same Utah Supreme Court to essentially reject its reasoning in *Intermountain* when, in *Yorgason v. County Board of Equalization of Salt Lake City County*, 714 P.2d 653 (Utah 1986), it granted tax exemption to an

apartment complex for the elderly and handicapped which charged all tenants rent based on their ability to pay.

The difficulty for Utah counties to understand and apply the six-part test has resulted in the state tax commission now attempting to establish uniform standards for all Utah counties. One issue will certainly be whether or not a certain quantitative "free care" test should be defined. Even in those states which have adopted some form of a standard which includes a specific inquiry about service to the poor, there has been little discussion of how much service (in a quantitative sense) is required. This fact is really not that surprising, since there is no agreement as to how much care hospitals should be giving away in order to be "charitable." Most often, rather, courts look to see that the organization has a sort of open-door policy: that it will not turn away anyone needing its assistance for want of financial resources, e.g., *Lamb County Appraisal District v. South Plains Hospital and Clinic*, 688 S.W. 2d 89 (Tex. App. 1988).

Conclusion

In conclusion, recent efforts to remove the tax exempt status of not-for-profit hospitals comes about today as a result of concern over four factors:

1. The need to raise revenues to run the operations of the government;

2. The desire to placate individuals from the small business community who assert that not-for-profit organizations, including hospitals, unfairly compete against small businesses;

3. The desire in the face of government's failure to provide adequate insurance for those who are medically needy, to find short-term solutions to the inadequacy of health care service accessibility to the poor; and

4. The response to a growing perception that not-for-profit hospitals are organized and operated like any for-profit business and, similarly, should be required to pay taxes.

While a number of theoretical rationales have been proposed for justifying tax exemption, no one rationale seems capable of explaining why nonprofit hospitals have been granted tax exempt status. Nevertheless, the fundamental question of what value does society receive in return for the grant of tax exemption is one that will be continually asked as the debate over the continuance of tax exemption for non-profit hospitals is considered.

Since 1969, the federal standard for providing income tax exemption to nonprofit hospitals has been based on the promotion of health for people through provision of community benefits. This broader concept of "charitable purposes" as applied to hospitals has provided our nation with a pluralistic health care delivery system. It takes into account the realities of each hospital's situation, and recognizes that society can be benefited in many different ways that will depend upon the specific context of the hospital and community that is served. Accordingly, like the definition of charitable purposes, the distinguishing characteristics of the community benefit hospital will vary from community to community and will evolve over time.

To this end, some commentators have articulated some basic characteristics which define the broad community benefit standard. These characteristics flow from the nonprofit hospital's charitable mission, organizational structure, operating process, and activities which provide important benefits to its relevant community. In today's world the structure, process and outcome characteristics of nonprofit hospitals which may constitute community benefit may be as diverse as the communities nonprofit hospitals serve. The challenge for all of us is to better understand and define those important characteristics.

ENDNOTES

[1]E.g., Pittsburgh - 48.9% (Pittsburgh Press, March 21, 1988); Boston - 51.9%, (Annual Report of the Tax Exempt Steering Committee for Fiscal year 1987, City of Boston, Massachusetts).

[2]Simpson, James B. and Less, Diane M., *Nonprofit Community Hospital Tax Exemption: Issues For Review*, Western Consortium for the Health Practitioners, 1987.

[3]The Revenue Act of 1984 (Act of August 15, 1894, Chapter 349, 28 Stat. 553) stated that "nothing herein contained shall apply to ... corporations, companies, or associations organized and conducted solely for charitable, religious or educational purposes, ..."

As summarized by Justice Burger in *Bob Jones University v. United States*, 461 U.S. 574 (1983), "The background against which Congress enacted the first charitable exemption statute in 1894 is as follows: charities were to be given a preferential treatment because they provide a benefit to society."

[4]By embracing the relief of poverty theory of exemption, Revenue Ruling 56-185 was consistent with the then applicable definition of charitable contained in the pre-1959 Treasury Regulations. The Regulations, in effect at that time, defined "charitable purposes" as follows: "Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor." Treasury Regulation 118, Section 39.101(6)-1(b) (1953).

The "relief in poverty" standard from Revenue Ruling 56-185, while easy to describe in theory, apparently was extremely difficult to apply in the field because of its inherently factual nature. No cases subsequent to Revenue Ruling 56-185 provided any meaningful insight as to the affirmative criteria nonprofit hospitals had to meet in order to obtain exemption. (See also, R. Bromberg, *Tax Planning for Hospitals and Health Care Organizations*, 7-26 (Warren, Garham & Lamont: Boston, Mass. (1977).)

[5]The legal basis for this amendment was set forth in Reiling, *What is a Charitable Organization?*, 44 A.B.A.J. 525 (June 1958). Mr. Reiling was Assistant Chief Counsel of the IRS when the article was published.

[6]In the 1969 Revenue Ruling, the IRS did not specifically define what community benefits a hospital must provide in order to be awarded tax exemption. In the substance of the ruling, however, the IRS, in granting tax exempt status to the hospital in question, relied on several characteristics of this institution, including the fact that the hospital:

1. Operated emergency rooms open to all persons.

2. Provided care to all persons in the community who could pay either directly or through third-party reimbursement.
3. Promoted the health of a class of persons broad enough to benefit the community.
4. Used the surplus receipts over disbursements to improve the quality of patient care, expand facilities, and advance the hospital's medical training, education, and research programs.
5. Was operated to serve a *public*, rather than a *private interest* because:

   - The Board of Trustees was composed of individuals who are independent civic leaders.
   - The hospital maintained an open medical staff with privileges available to all qualified persons.
   - The rent the hospital charged for space leased to active members of its medical staff was comparable to commercial rent in other buildings, and hence no private benefits inured to those individuals.

The IRS also made clear, however, that:

In considering whether a nonprofit hospital claiming such exemption is operated to serve a private benefit, the service will weigh all the relevant facts and circumstances in each case. The absence of a particular factor set forth above or the presence of other factors will not necessarily be determinative. (Revenue Ruling 69-545, at 118.) (emphasis supplied)

[7]In *Ould v. Washington Hosp.*, 95 U.S. 303, 311 (1877) the Court said:

A charitable use, where neither law nor public policy forbids, may be applied to almost any thing that tends to promote the well-doing and well-being of social man.

A similar broad treatment is applied to the nature of charitable purposes in Restatement (Second) of Trusts Section 368 and Comment (b) (1959):

A purpose is charitable if its accomplishment is of such social value to the community as to justify permitting the property to be devoted to the purpose in perpetuity.

[8]Another classic and widely cited definition of charity is Justice Gray's in *Jackson v. Phillips*, 96 Mass. (14 Allen) 539, 556 (1867):

A charity is 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 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. (emphasis supplied)

[9]Brunyate, *The Legal Definitions of Charity*, 61 L. Q. Rev. 268, 281 (1945):

> [T]he relief of distress, that is ... 'the relief of any form of necessity, destitution or helplessness which excites the compassion or sympathy of men,' could with advantage be moved out of the fourth head. It is charitable not because of the immediate benefit to the public but for reasons of human sympathy akin to those which make relief of poverty a charitable object ... The relief of distress could, if desired, be treated as a separate fifth head of charity or it might well be combined with relief of poverty, which is in truth one among many forms of distress. (emphasis supplied)

[10]"[T]he promotion of health is a valid charitable purpose in all American jurisdictions." E. Fisch, D. Freed and E. Schachter, *Charities and Charitable Foundations*, Section 322, at 275 (1974); *See also id.* Section 322, at 275 n.18. Restatement (Second) of Trusts Section 368 (1959):

> Charitable purposes include
> (a) the relief of poverty;
> (b) the advancement of education;
> (c) the advancement of religion;
> (d) *the promotion of health*;
> (e) governmental or municipal purposes;
> (f) other purposes the accomplishment of which is beneficial to the community. (emphasis added)

[11]"The controlling feature is whether the institution was built, organized, and/or is maintained with an intent to make a private profit...." *State v. Browning*, 192 Minn. 25, 255 N.W. 254 (1934). *See* discussion in Bromberg, *The Charitable Hospital*, 20 Cath. U.L. Rev. 237, 251 *et seq.* (1970).

[12]*So. Methodist Hosp. and Sanitarium v. Wilson*, 51 Ariz. 424, 77 P.2d 458, 462-63 (1938); *Benton County v. Allen*, 170 Ore. 481, 133 P.2d 991 (1943); *McDonald v. Mass. Gen'l Hosp.*, 120 Mass. 432, 21 Am. Rep. 529 (1876).

[13]Rev. Ruling 69-545.

[14]The Court of Appeals also noted that Revenue Ruling 69-545 did not expressly overrule Revenue Ruling 56-185, but rather, simply provided an alternative method whereby a non-profit hospital can qualify as a tax exempt charitable organization. Thus, a hospital may demonstrate charitability by either meeting the requirements of Revenue Ruling 56-185 or Revenue Ruling 69-545.

[15]*Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985).

[16]*Downtown Hospital Association v. Tennessee State Board of Equalization*, Appeal No. 88-88-A, (1988). (Maintaining hospital's right to continue as tax exempt).

[17]*Medical Center Hospital of Vermont v. City of Burlington*, No. 87-501, filed 1988. (Lower court decision in favor of the hospital. The case is on appeal to the Vermont Supreme Court).

[18]*Calloway Community Hospital Association v. Ronald Craighead and Melvin Tate*, 759 S.W. 2d 153 (C.A. Mo. WD) (1988). (Appellate Court ruled in favor of hospital. State Supreme Court has refused to hear any additional appeal).

[19]Wellford, W.H. and Gallagher, J.C.; "Unfair Competition?: The Challenge to Charitable Tax Exemption," The National Assembly, Washington, DC, 1988, p. 120.

[20]Ibid, p. 120.

[21]Ibid, pp. 121-122.

[22]Florida Dept. of Revenue Rule 12-A-1.001.

[23]Unfair Competition, op. cit., p. 122.

[24]*See also Evangelical Lutheran Good Samaritan Society v. County of Gage*, 181 Neb. 837, 151 N.W. 2d at 450; *Evangelical Lutheran Good Samaritan Society v. Board of County Commissioners*, 219 N.W. 2d at 908-909; *Southern Methodist Hospital and Sanitorium of Tucson v. Wilson*, 77 P.2d 458, 462 (1938); *City of Richmond v. Richmond Memorial Hospital*, 116 S.E. 2d 79 (1960); *West Allegheny Hospital v. Board of Property Assessment*, 500 Pa. 236, 455 A.2d 1170 (1982); *Lamb County Appraisal District v. South Plains Hospital-Clinic*, 688 S.W. 2d 896 (Texas appeals 1985); also *Eastern Kentucky Welfare Rights Organization, et al. v. Simon, supra.*)

[25]The six-part test includes:

(1) Whether the stated purpose of the entity is to provide a significant service to others without immediate expectation or material reward;
(2) Whether the entity is supported and to what extent, by donations and gifts;
(3) Whether the recipients of the "charity" are required to pay for the assistance received, in whole or in part;
(4) Whether the income received from all sources (gifts, donations, and payment from recipients) produces a "profit" to the entity in the sense that the income exceeds operating and long-term maintenance expenses;
(5) Whether the beneficiaries of the "charity" are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objectives; and
(6) Whether dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests, and whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones.

[26]In addition to Utah, there are a few other states which, by statute or judicial decision, require hospitals to provide some unidentified amount of free or reduced cost medical care to those who cannot offer to pay for it themselves.

Nevada, Section 361.140.1(b) (1986), (requires that indigent persons must be able to receive medical care without regard to costs); Texas Tax Code Section 11.18(c)(1) (1987) (states that charitable purposes includes the provision of medical care "without regard to the beneficiary's ability to pay").

In West Virginia, the Tax Commissioner in a Ruling 82-2T at 11, *State Ex Rel Cook v. Rose*, 229 S.E. 2d 3, (West Virginia 1982) continues to follow a 1916 principle enunciated in *Reynolds Memorial Hospital v. Marshall County Court*, 78 West Virginia 685, 90 S.E. 238 (1916), that for a hospital to achieve tax exemption as a charitable institution, it must provide "free and below-cost services, under reasonable rules and regulations, to those unable to pay for hospital services." Recent regulations have been promulgated to enforce this notion of charitability. Iowa also requires that there be some aspect of gratuitous service to qualify for property tax exemption. Thus, in *Iowa Methodist Hospital v. Board of Review*, 252 N.W. 2d 390 (Iowa 1977), the Iowa Supreme Court denied exemption to a nursing home operated by a hospital where all patients were paid for, either privately or by governmental welfare payments.

[27]Perhaps, the next example demonstrating the impractibility of performing this sort of cost-benefit calculation comes from a speech by Professor Netzer. In a talk before the National Tax Association in October, 1972, Professor Netzer noted:

> [T]he costs of tax exemption are:
>
> (1) the tax rate times the assessed value of the property,
>
> times (2) The probability that, were there no tax exemption, either the existing use and value could be sustained or the land and buildings would be used for another purpose with an equally high market value,
>
> plus (3) the incremental costs of the public services actually provided to the tax exempt user of the property and financed from local general revenue (i.e., not from user charges or external grants dependent on the volume of service provided).
>
> Paralleling this, the benefits in any given case can be said to be:
>
> (4) the social worth of the services provided by use of the tax exempt property,
>
> times (5) the percentage reduction in the volume of services provided if the organization had to pay property taxes, or the probability that the services would be discontinued entirely, or the percentage increase in charges levied against users for services that, although subsidized are partly fee-supported (e.g., the Post Office),
>
> plus (6) the incremental costs, if any, of the additional public services that would have to be provided if the tax exempt user of the site were supplanted by the likely tax-paying user (e.g., replacement of a church by private housing occupied by families with school-age children).

THE FUTURE OF COMMUNITY BENEFIT STANDARDS FOR HOSPITALS

ROBERT SIGMOND. It's a pleasure to follow a presentation like Paul's, which was so clear, and made a distinction between the regulatory aspects of community benefit standards, as contrasted with the standards of those of us who are actually involved in providing community benefits and services at hospitals.

It's also a pleasure for me to be back on a Bugbee Institute program again. I can remember being on these programs years ago. These programs were not even formally named the Bugbee Institutes then. But George Bugbee was in charge, and always pacing up and down nervously, wondering whether these folks that he had brought in from around the country to speak were going to do what he had asked us to do, and whether we would keep on schedule. It is nice to see him in the audience there, apparently comfortable and relaxed and able to enjoy the program.

It is also good to be back to follow up on the theme of my Michael M. Davis Lecture at your 1985 session, which first floated the notion of community benefit standards for hospitals. In that lecture, I pointed out that "Today [this was 1985], a hospital can meet every legal and accreditation standard without giving any consideration to the community: without knowing the health indices of the community, such as the leading causes of death or disease, or whether the infant mortality rate has bottomed out or is rising. No one within the hospital governing body, medical staff, or management is charged with responsibility for assembling and analyzing basic health indices.... Accordingly, the typical hospital today does not know whether the services it provides are appropriate, necessary or even desirable from the community's perspective and whether the services, individually or collectively, are contributing to the health status of the community or to the affordability, accessibility and effectiveness of the community's health resources."

The standards that hospitals have been operating under since Malcolm MacEachern developed the original standards for the American College of Surgeons 70 years ago no longer relate to most of the key issues that are bothering people about hospitals at this time. So, I'm glad to be back here, to follow up on the need to develop community benefit standards, which can be relevant not only with respect to tax-exemption, but more importantly, with respect to the very identity of the hospital as a community institution.

My assigned topic is the future of community benefit standards, which means that I have been called upon to make predictions. That is a very risky business in the health field, but at my age, I'm not likely to be around long enough to have to face the truth, in case I am wrong. So here are my eight predictions.

My first prediction is that the development of community benefit standards for hospitals will follow the history and patterns of standards development in the health care field in this country over the last century. In the health care field, standards have played a very important role, not only with respect to hospitals and other institutions and organizations, but also with respect to professional and other healthcare manpower. Usually, we have developed both voluntary and governmental standards. Historically, the voluntary standards have usually preceded the regulatory standards. The voluntary standards usually have been designed to encourage continuous improvement, as contrasted with identifying the bad apples in the barrel. The regulatory standards have tended to make use of the state's police powers, and have been designed to identify and punish those who are lagging too far behind. Generally, voluntary standards have been tougher but less flexible than regulatory standards. Historically, up to the current

period, it seemed very clear that voluntary standards have been more influential. In particular, the hospitals always paid more attention to accreditation standards than to licensing standards. Similarly, physicians pay more attention to board certification standards and medical staff requirements than to licensing standards. That has been the normal pattern, and I assume that will be the pattern as we move ahead with community benefit standards, which we do not yet have. As Paul indicated, community benefit is the declared standard for federal tax exemption, and the American Hospital Association supports the Position of the Internal Revenue Service in this respect. But neither group to date has spelled out the notion of community benefit standards in the way that the JCAHO has spelled out other standards. My first prediction, then, is that, with respect to community benefit standards, voluntary standards will probably precede governmental action.

My second prediction is that the development of credible, community benefit standards is not inevitable, but without them, autonomous community hospitals, as we know them today, will be only historical memories in the twenty-first century. In the absence of community benefit standards, hospitals will continue to exist, but will likely become purely body repair shops (Rosemary Stevens' term) or technology centers, controlled by some health system authority, responsible for community health and medical care. Such health authorities might succeed the failed health systems agencies. They might be similar to their counterparts in Great Britain, where the hospitals are now essentially sub-units of a larger managerial structure, lacking any significant planning capability, governance structure, formal management structure, or identity of their own. In this country, too, hospitals will almost inevitably lose their governance authority, and exist simply as technical resources—if they don't systematically address community health issues and attempt to benefit their communities.

Systematic approaches will be required to coordinate the complex health care services that a community requires. Either the hospital will assume leadership in developing coordinated health services for its communities, as called for in the AHA Ethical Guidelines, or hospitals will lose their identity and autonomy to some other new community mechanism, that will be invented.

We would then not have community hospitals as we know them. Now, of course, I am defining "community hospital" in a much different way than the American Hospital Association's definition for statistical purposes, which includes any non-federal, short-term hospital, irrespective of whether it has any community commitment or not.

The time has come for a more precise definition of a community hospital, focused on service to specific communities, focused on the benefit the hospital provides to those communities. A hospital has traditionally been defined in terms of four goals or missions, of which only one is a requirement for any hospital. The first goal is patient care; that is the required goal. Without patient care, more specifically inpatient care, an institution is not a hospital. The other goals are optional: education, research and community service. That's the standard litany.

Now, patient care, education and research are not community goals as such, unless they are designed to serve and benefit a specific community, which most are not. Community service or community benefit is one of the optional hospital goals, like education and research; the hospital does not have to have a community service goal or a community program, any more than it has to be a teaching or a research hospital. As with education and research, we can expect that many hospitals will not want to bother with a community benefit goal or program. So, I don't believe that community benefit standards will be incorporated into our most basic hospital standards, but rather will be developed for use only by those hospitals which have this particular sense of mission.

Such standards will, in all likelihood, be developed and administered as supplementary to the basic hospital standards, just as we have developed standards for hospitals which want to have recognition of a third level emergency service. So, I predict that community benefit standards for hospitals, if they develop, will not be incorporated as a basic element of general hospital standards, but as a special feature for those hospitals that are attempting to serve their communities systematically and earn the right to maintain some degree of self-determination as a community hospital.

My third prediction is that it will become important to define explicitly what is meant by the terms "community benefit" and "community"; these will be more controversial matters than might at first seem likely. In my own work, I've based my definition on the American Hospital Association's Guidelines on Ethical Conduct for Health Care Institutions (Catalogue no. 058749), which incidentally were just revised by a distinguished committee chaired by Paul Hofmann and approved by the Board of Trustees in 1987. These Guidelines have an explicit section on the institution's community role, which specifies that the hospital "...should be concerned with the overall health status of their communities while continuing to provide patient services." Right at the beginning, then, a clearcut distinction is made between the patient care goal and the community benefit goal. The Guidelines go on to say that the hospital is "...responsible for fair and effective use of available health care delivery resources to promote access to comprehensive and affordable health care services of high quality. This responsibility extends beyond the resources of the given institution to include efforts to coordinate with other health care providers...."

Now, these are dimensions of ethical conduct that a hospital can disregard, and some will, but such hospitals can hardly be defined as community benefit hospitals. As indicated above, it seems safe to predict that some hospitals will meet traditional accreditation standards as they transform themselves more and more into body repair shops, and others will go much further in the direction of community benefit programs. It is fascinating to speculate on the proportion of the hospitals that will fall into these two categories. Personally, I am optimistic that the majority will eventually opt for recognition as community benefit hospitals.

Using the AHA Guidelines, it is possible to get more specific, and to define a community benefit hospital as one in which the mission statement includes, among other things, an emphatic commitment to playing a leadership role in improving the health status of all of the people in carefully defined communities, and also in enhancing the cost effectiveness of their health services. That's what, it seems to me, community benefit is all about.

Other definitions of community benefit do not seem to be of value for the period just ahead. For example, it does not seem to be feasible to define community benefit as whatever the hospital does that loses money. Or as uncompensated care. Or as education or research, unrelated to the health problems of the hospital's communities. Or as anything that the hospital does that makes it feel good. Or anything that the hospital does not charge for. All of these alternative definitions don't seem to fit a systematic approach to the community's health services.

Up till now, we have had very clear definitions of patient care, education and research, and fairly explicit standards for these three hospital goals, but not so for community service. It is time to get on with that, and to develop explicit standards for dealing with the community benefit issue in the framework of today's health care issues and of modern management techniques.

This means that to be a community benefit hospital, it should have an explicit community benefit program. That program should be organized and managed like any

other hospital program, using such techniques as management by objectives. At this time, few if any hospitals deal with community benefit in this way. Virtually all hospitals today are in about the same status with respect to community benefit programs as most hospitals were with respect to traditional hospital standards in 1919, when Malcolm MacEachern developed the original American College of Surgeons approval program. Many of them were doing most of the right things, but not in a very orderly or systematic way, and not in a way that anybody could formally certify conformance to systematic standards.

At this point, we don't even have consensus on a clear definition of the term "community." Traditionally, in the health field, the term "community" has always had a geographic component, and has meant "all of the people and all of the organizations and institutions in a more or less precisely defined geographic area where the people feel some degree of belonging and interdependence." In referring to community, for purposes of development of community benefit standards, it seems necessary to get back to some variation of the traditional definition of "community" in health. That may present major problems for many teaching hospitals and other hospitals in metropolitan areas. In the development of standards in the hospital field, the tradition has been to attempt to use the same standards for all hospitals, and that approach should be attempted with respect to community benefit standards. I predict, however, that it will be necessary to develop some alternative definitions of "community" to fit a variety of situations.

With understandable definitions of "community" and "community benefit," it will not be difficult to develop community benefit standards and methods of assessing conformance with the standards, similar to the approaches being undertaken by the JCAHO. Any hospital will be able to meet such standards, if it has the necessary community commitment, but a series of incremental steps will be required before most hospitals today will be able to assume a genuine leadership position in their communities with respect to community benefit. The guidelines with respect to tax exemption and community benefit that the AHA has recently distributed to the membership, as Paul mentioned, represents a good starting point for most hospitals.

My fourth prediction is that before the end of next year, credible community benefit standards will be developed and brought to the attention of every hospital. Major foundations will support this effort, which will involve major universities. An explicit accreditation program will be developed to function as a supplement to the JCAHO program, and hopefully eventually incorporated into the JCAHO. Those hospitals that join in this effort and are accredited as community benefit hospitals undoubtedly will be able to maintain their tax exemption, and should also gain many other advantages.

This brings me to my fifth prediction: a credible community benefit standard will attract a wide spectrum of financial and non-financial incentives, so that such hospitals will be able to compete effectively with the "body repair shop" hospitals.

For example, such hospitals should become eligible for differential payment from the government, Blue Cross, and other financing agencies. Medicare has always made differential payments to so-called "sole community hospitals." Currently, the definition of a sole community hospital is purely in terms of geography and distance from the nearest hospital. Of course, when the real meaning of a community hospital is better understood, it becomes clear that to be a sole community benefit hospital in an isolated town is much easier and has much less financial strain than to be the sole community benefit hospital in a town with five or six other hospitals. One of the obvious things that I predict will happen as soon as we have a credible community benefit standard, credibly

administered, is the notion of a differential payment for *all* community benefit hospitals; not just sole community hospitals, but all hospitals that have a soul. If such a differential were to be shaped in the currently popular "budget neutral" mode, (that is, pay the community benefit hospitals a differential with funds subtracted from the payments to the other hospitals), there would be sufficient funds to support significant community benefit activities.

Also, a credible community benefit program will provide the basis for considering appropriate anti-trust exemption for such hospitals. Blanket anti-trust restrictions make no sense at all for community benefit hospitals. Remember that there's never been a law passed that specifically says that hospitals should be under the anti-trust laws. That's been an interpretation of the courts. Congress can change that, as has been done with baseball, for example. Appropriate anti-trust exemption is essential for community benefit hospitals to function effectively; in fact, anti-trust exemption is even more important than tax-exemption in the development of the most effective community benefit programs.

Other incentives that will be built around community benefit standards include:

- involvement in the best preferred provider networks, when it becomes evident that people and many corporations will not want to sign up with networks that don't consist almost exclusively of community benefit hospitals.
- greater access to block grants, community funds, corporate gifts, and other forms of philanthropy and community support.
- continuation of eligibility for tax-exempt bonds and tax-exempt gifts.
- continuation of support of community trustees, who are not likely to maintain much dedication to hospitals that continue to turn their back on their communities.
- eligibility for participation in medical education programs that appropriately stress community approaches to improved health status.

In this context, tax exemption continues to be much more than avoidance of certain tax obligations, but rather a symbol of a special identity, deserving of very special respect and rewards, not available to hospitals that do not meet community benefit standards.

My sixth prediction is that, initially, important national hospital organizations and many, if not most, important hospitals will not strongly support explicit community benefit standards. Standards will appear to be excessively cumbersome, threatening to medical staff relationships, to the bottom line, and to the status quo, and not worth the bother. That will almost certainly be the initial reaction.

Now, if Malcolm MacEachern were alive today, he would probably say, "That's right. Except for the strong support of the Catholic Hospital Association, that's the way it happened with me 70 years ago." But a number of outstanding institutions, I predict, will adopt community benefit standards, seek recognition for their achievement, and clearly demonstrate the resulting benefit to society as well as to the institution. Whether most hospitals then follow their lead, in my opinion, will not depend on tax exemption, but rather on the degree of recognition that community benefit standards are given by society as a whole, especially by the payors, by hospital trustees, and by other community leaders. Personally, as I have said, I am guardedly optimistic.

My seventh prediction is that within the next decade, public policymakers in the health field will begin to see clearly that the issue of equitable health services and outcomes for the poor and disadvantaged requires not only (a) universal entitlement and adequate financing, but also (b) explicit community programs by hospitals reflecting special initiatives to respond to the unique needs of these population segments of the hospitals' communities.

The issue of uncompensated care must and will be resolved by a new financing program, such as universal entitlement, that does not rely at all on tax-exemption. Conversely, any effort to rely on uncompensated care to defend tax-exemption is obviously a strategic error, bound to fail. If this approach is taken, tax exemption will be doomed as soon as we adopt a decent national financing scheme, as appears to be inevitable to me.

But those of us who worked on the various poverty programs during the 1960s know that adequate financing, as important as that is, by itself is not enough to assure decent health care results for the disadvantaged. In addition, a second major thrust is required: the kind of humane, caring, affirmative action community programs that will be the special responsibility of community benefit hospitals. We learned a great deal about the elements of such programs during the OEO days in the 1960s, much of which has been forgotten. We learned about the importance of involving people in designing health programs, of considering problems of transportation, of language problems, of accessible hours, of adapting to different cultures, and much more. Such programs go far beyond entitlement and really have nothing to do with entitlement; they have to do with whether the hospital has a heart and a soul, and a commitment to and effective relationships with the community.

My eighth and final prediction, to which I have already made some reference, is that community benefit standards will require solid, modern management techniques and modern organizational structure, to assure that community benefit programs go beyond idealism and rhetoric to yield concrete outcomes for the communities. This means special emphasis on such notions as management by objectives, community outreach and involvement of the community in the design of programs, and recognition that an individual hospital can't do the job by itself, but will require collaboration with other institutions and organizations.

In addition, the community benefit hospital will require continuous reappraisal of the structure of the hospital to assure that as the hospital manages, plans and works through its multiple goals of patient care, community service and possibly education and research, that the community benefit programs are getting their fair shake in a balanced approach to allocation of resources and of governance and executive energy. That involves some significant reexamination of the composition of the governing body, how it functions, how many open meetings it has, and how much attention the board devotes to community problems. There are also major implications for the medical staff and how it functions in relation to both the health problems in the community and the cost effectiveness of the community's health care services. There are strong implications in terms of the management structure, and who's in charge of the activities explicitly related to community benefit, and especially for the strategic planning function. Remember, the patient care activities will always get—and must always get—priority in terms of day-to-day operations. I don't ever want to go to a hospital where that isn't true; I don't want my wife to go to a hospital that puts community benefit activities ahead of service to her as a patient.

But when it comes to strategic planning, community benefit programs should get top priority. Assuring the appropriate balance among community benefit goals and

other hospital goals both in planning and in operations is a special responsibility of both the management and the board of trustees.

In conclusion, the development of community benefit standards will highlight some important missing elements in most hospitals today, missing elements involving governance, management and the medical staff, as well as missing programmatic elements. In many respects, in terms of the current challenge to hospitals, we are just about where hospitals were in relation to the challenges of the post World War I period when MacEachern developed the original ACS standards. As at that time, a new era in hospital development is dawning. Those of us who always had community benefit goals built into our genes or simply our way of looking at the world (which I think includes most of us at a Bugbee Institute) have a lot to do, a lot of excitement and a bright if stormy future ahead of us. In this current competitive environment, it's time for all of us to come out of the closet and declare ourselves for community service.

QUESTIONS FOR MR. HATTIS AND MR. SIGMOND

QUESTION. Bob, are you suggesting that hospitals will take over the public health departments?

ROBERT SIGMOND. No, but I strongly support closer coordination between hospitals and public health departments. As indicated in a paper by David Seay and myself in the Spring 1989 issue of *Frontiers of Health Services Management* (p. 26), we believe that new community benefit standards for hospitals should incorporate Recommendations 113 through 122 of the report of the Commission on Hospital Care (*Hospital Care in the United States*, the Commonwealth Fund, 1947). There are 10 recommendations that essentially call for a very close working relationship between the hospital and the public health department, with the health department preferably housed at the hospital.

By doing so, the hospital will be much better off in terms of fulfilling its community service responsibilities, and this will also greatly strengthen the health departments in this country, most of which are quite weak because of their separation from the mainstream of medical care. So, we are suggesting very close cooperation. Now, that's not something that the hospital can achieve in time for the initial community benefit accreditation site visit inspection, but it can begin to make initial practical moves in that direction.

QUESTION. Paul, you stress that we can't measure the benefits simply in the dollar terms that will be required. Can you elaborate a little bit on the units that are appropriate, and also respond to the question as to whether you feel (although you don't believe it can be measured in dollar terms), that hospitals might be required to measure benefits in dollar terms?

PAUL HATTIS. The "total" measurement of community benefits or the value that society receives for granting tax exemption cannot be readily reduced to specific units. In our AHA Community Benefit and Tax Exempt Status Self-Assessment Guide, we identified a number of characteristics which help to define a community benefit hospital. These characteristics flow from a nonprofit hospital's charitable mission, organizational structure, operating process, and activities which provide important benefits to its relevant community. Issues such as how the organization is structured; how the governing board is selected and prioritizes its decisions; how the hospital relates to various community groups, employees and the medical staff; and what sort of community service activities are engaged in by the hospital, represent some of the areas of inquiry for community benefit evaluation. It is perhaps this latter category which best lends itself to quantitative evaluation and measurement.

While the totality of community benefits cannot be completely reduced to specific units, certain service and activity components can be measured. Nevertheless, I do not believe that dollars and cents represent the most appropriate measure.

For example, in evaluating a hospital's uncompensated care activities, there is often a singular focus on a hospital's expenditures for free care and bad debt. Such a narrow perspective of what a hospital contributes to the poorer members of its community is truly unfortunate. Further, there isn't at this time uniform agreement across the country on how to best define "uncompensated care." Larry Lewin, et al. have written recently in the *New England Journal of Medicine* about their notion of a better definition for measuring charity care costs. I can't get into a discussion now about what Larry's group has proposed, but the difficulty in reaching agreement on how to measure uncompensated care exemplifies the problem of trying to determine whether or not a hospital is a charitable organization by making a single calculation.

That brings me to the last part of your question of whether it is reasonable to try to make some objective evaluation of a hospitals' community benefit activities. I guess the answer to that question is yes. However, rather than making absolute measurements of how much in dollars and cents this hospital provides as part of its community benefit activities, it probably makes more sense to have the institution prospectively identify certain measurable goals and evaluate how effectively the hospital performs in achieving those goals.

ROBERT SIGMOND. I agree with what Paul said, and I believe (as outlined in the aforementioned *Frontiers* paper) that there are basically three types of indices for measurement of community benefit progress. The first and most important are various *health indices* per 1,000 population, whether infant mortality rates, premature low birth rates, various other measures of health status per 1,000 population involving disability, chronic disease, and so forth. In many respects, it's actually easier to gather those data and measurements than the kind of data that the Joint Commission is trying to get at with its Agenda for Change, which focuses primarily on individual patient outcomes. Gathering health status data isn't that much different from what many hospitals are now spending a lot of money on in "marketing research."

The second and third types of indices are *healthcare expenditures* per capita and various measures of *patient satisfaction*. We think that hospitals need to work up these kinds of measures, and then set specific goals each year for providing leadership in various programs to move these indices in the right direction. Then, the accreditation body can evaluate both the goals that were set, as well as the amount of progress achieved. Were the goals reasonable? Were they set at a level too easily achieved? If they didn't succeed, what changes are being made or contemplated? The notion is not some single measure, like some magical single measure for deciding whether the University of Chicago is doing its job effectively. As with standards for any complex organization, it is necessary to identify specific activities that should be undertaken, requiring the management to have quantitative goals, and assessing their success in designing programs and carrying out programs to achieve those goals.

QUESTION. Do you think the development of community benefit standards will take some of the pressure off the so called "safe harbors" and other problematic areas that hospitals have gotten themselves into as they try to increase their revenue base and begin to look more like for-profit businesses that do things for the benefit of physicians and other private parties?

PAUL HATTIS. Do you mean by your question to talk about the technical and legal aspect of the Medicare Fraud and Abuse Provisions?

QUESTION. Yes.

PAUL HATTIS. Well, I'll discuss the technical and legal issues, and Bob can deal with the big picture aspects of this question. I also think Jim McGovern from the Internal Revenue Service, who is sitting in the back of our audience, may be commenting on this issue this afternoon. I think the criticism of hospitals for engaging in sound business practices (and there are critics out there who don't like any aspect of a hospital being more businesslike or efficient in their operations) is unjust. To say that a hospital shouldn't be efficient in operations and in setting managerial goals is ludicrous. I think all hospitals should be more businesslike in that sense.

However, I think your question is attempting to get at the issues of physician/ hospital joint ventures and the appropriateness of those activities. I don't think you can easily establish any absolute guidelines which state that if you engage in this kind of joint venture activity, than per se, the organization has evolved from a charitable one into an organization whose goals are purely profit maximization. Nevertheless, from a

regulatory perspective, the government needs to be able to deal with egregious behavior. Under either the Medicare Fraud and Abuse statutes or the Internal Revenue Act there are guidelines in place to deal with the concerns about physician private inurement and Medicare program abuse. There are no data at this time which indicates that hospitals have been engaging in inappropriate activities. The insubstantial transactional components of a hospital's operations and its venturing with physicians do not necessarily change the character of the organization. Nevertheless, I do believe that hospitals that are identified as community benefit organizations will be better situated to defend the totality of their business activities.

ROBERT SIGMOND. I call your attention to the fact that the Guidelines for Ethical Conduct for Health Care Institutions of the American Hospital Association (AHA Catalogue no. 058749, 1987) on which our community benefit standards are based, are *not* limited to nonprofit or government hospitals. Those guidelines are appropriate for all hospitals, and spell out the community role for all hospitals. I am not at all opposed to (as a matter of fact I favor) investor-owned hospitals conforming to these guidelines, trying to benefit their communities. My own sense is that in one-hospital towns, they do that as well as the nonprofits. The fact that they can't get tax-exemption has nothing to do with community benefit, but rather with inurement issues, as Paul pointed out. I believe strongly that the community benefit standards should be applicable to all hospitals, whether or not they are tax-exempt or investor-owned, or whatever. If intelligently carried out, adherence to community benefit standards should help to make the hospital a key element of its community, and consequently protected from external forces by its community.

QUESTION. Should we use the same criteria to answer the tax exemption debate and for distinguishing the operational meaning of being a good hospital?

ROBERT SIGMOND. Well, the key point is that the investor-owneds have voluntarily opted, in terms of the marketplace, to put themselves at a disadvantage, requiring them to strive not only to get the money to meet the total costs of running the institution and serving the community, but also to strive to contribute some money to the stockholders. They made that decision. So they start out, in terms of income requirements, at a real disadvantage right here, but then they seem to think that this extra economic requirement somehow puts them at an advantage. That is the corporation's own decision, which isn't easy for me to understand, whenever there is all this talk about a level playing field. Of course, I would like to see investor-owned hospitals give as much attention to community benefit as institutions that were organized from the beginning to serve their communities without any profit distractions—but I don't have high expectations for most of them. The mere fact that some of them *might* do it, doesn't seem to me to be an argument for taking away the kind of recognition that society can be giving to those nonprofit hospitals that have historically organized themselves to serve their communities. The much more important issue is not how does a tax-exempt nonprofit hospital compare with investor-owned hospitals, but how does it compare with society's expectations of how a community benefit hospital should perform. It is obvious that many nonprofit hospitals have lost their way in recent years, and the key issue is how to get at least some of them back on track, through tighter standards for tax-exemption and other incentives.

So, I say, sure, let the investor-owned hospitals qualify for recognition as meeting community benefit standards, but I don't have high expectations, and I don't see why that theoretical possibility should interfere with the basic traditions of having the major sector in our field, the nonprofit sector, have some very specific inducements to do right.

PAUL HATTIS. Let me answer your question this way. The fundamental question, I think, when looking at the issue of tax exemption is what does society receive in return for granting tax exemption to government and nonprofit hospitals? The issue is *not* how do nonprofit hospitals compare to for-profit hospitals.

I'll describe for you an analogous tax and social policy question. Charitable contributions are made to various organizations from donations by both individuals and corporations. These two groups may have very different motives for their giving. The fact that the largest and most successful corporations in their country make charitable contributions doesn't negate the societal value of the contributions that are made by individuals. We don't compare the contributions of corporations with those of individuals and decide tax policy for encouraging donations on the part of individuals. I am trying to use this analogy to show that nonprofit and proprietary organizations can have distinct motives and purposes which require different sets of social policy encouragement. Whether a proprietary hospital is ultimately motivated to maximize its rate of return or instead chooses to give up some income maximization to pursue more community benefit activities—that's its own decision. Society has not granted it a tax subsidy with some sort of expectation of a societal *quid pro quo*. Accordingly, it is irrelevant to the question of what society does expect from nonprofit and governmental hospitals to make comparisons to proprietary hospitals.

ROBERT SIGMOND. It won't convince them, and it also probably won't even be very convincing to economists, who find these investor-owned/non-investor-owned studies fit their methodologies, so they like to do them. But I don't think that the difference between the nonprofits and the investor-owneds (after all, the investor-owneds are a very small portion of our system and showing increasing signs of instability in terms of communities being able to count on them) is the real driving force. The driving force is the difference between (a) the legal and public expectations of the nonprofit hospitals and (b) the way so many of them are (mis)behaving as they compete with the investor-owned hospitals on their terms (in the absence of explicit community benefit standards). Just look at what has happened to so many of them, and ask, why aren't they functioning the way they ought to? Why are they not responding to the social issues of the day? That's the key issue; not how they compare to the commercial institutions. it is true that whether the nonprofits are performing better or worse than the investor-owned hospital group is a measurable question, but that is like focusing on a pimple instead of the basic malaise.

Until now, we never had an explicit community benefit standard, and never even thought about developing such a thing. Today, the nation is beginning to understand that it needs such a set of standards in order to monitor the extent to which the health system is responsive to community needs. Let me give you just one of many examples.

Part of my time I spend working for another organization that has tendencies of losing its way: Blue Cross/Blue Shield. The Blue Cross/Blue Shield Association monitors what's going on all over the country in the development of PPOs and HMOs and other forms of so-called Alternative Delivery Systems (ADS), and all of the plans are moving in this direction. It has become clear to me that all of these ADS initiatives start by trying to get the lowest price for services. Next, they recognize that the lowest price doesn't mean very much in the slippery marketplace; they've also got to have effective management of utilization. The next thing they realize, after some experience, is that they can't be changing the hospitals in these ADS networks every year, based on competitive prices and utilization management experiences; that people want to know if the preferred providers are responsible institutions. As you look around the country in terms of the time sequence of this development (and different communities are in

different stages in different environments), it appears that they are all moving in one direction: they all need a community benefit standard to help identify those hospitals that should be permanent elements of the network. They are all going to want hospitals that not only give a decent product for a decent price, but also have stability and connection with their communities.

You can see that happening all over the country, and that is another reason that we are beginning to move in the right direction. My sense is that the pendulum swing away from a community service emphasis to a commercial product emphasis has now gone so far that it is beginning to swing back.

STRATEGIES FOR KEEPING ONE'S TAX-EXEMPT STATUS

ROGER NAUERT. I'd like to begin with an overview of the problem of preserving tax exempt status from the perspective of the multi-hospital system. As a beginning point we would all make the assumption that tax-exempt status is a very valuable thing.

It has certainly been a major source for prudent providers to develop funded appreciation reserves and to otherwise assist in the capitalization of projects and initiatives that, but for tax-exempt status, might have been very difficult. As we live in a day of shrinking demand for in-patient care, and marketing becomes more a matter of taking patients and physicians away from the competition, it's nice to have cushions that allow for diversification of revenues and pursuits of other lines of business that can grow with the system and assure access to capital in the future.

As we look around, we note that there has been enormous growth in tax-exempt organizations in the United States. Today we're approaching almost 900,000 tax-exempt organizations and that's more than twice the number that existed in 1963.

The tax-revenue losses that are produced as a result of the wide recognition of tax-exempt organizations are truly awesome. I've seen estimates in the range of ten to fifteen billion dollars in lost tax revenues at all levels, because of the proliferation of tax-exempt organizations. And in a day of trying to reduce the deficit at the federal level and develop a stronger tax base at the local and state levels, it's obvious that the pressure is clearly on.

Some of the numbers that I've heard are that just in Federal income taxes alone, we're looking at annual losses in excess of six billion dollars. About 2.5 billion dollars lost as a result of tax-exempt bonds. And tax consequences in the vicinity of 1.4 billion as a result of charitable deductions.

I think you've read some of the case law, such as the Intermountain case and others. It is notable that there has been a very special focus on the commitment of tax-exempt hospitals in providing charity care for the indigent population, especially in the inner cities and the rural parts of America. Boards and senior management are looking with greater scrutiny at the levels of care that are provided to the poor. And there may have been some retrenchment and some back-tracking all across the country.

As I mentioned, revenue diversification has been a major keystone of the health care industry. The movement to out-patient care to escape the cost pressures of prospectively determined pricing for in-patient care is especially noteworthy. Being just in the business of in-patient care is a fool's mission for most hospitals. The need to diversify is very apparent. As a result of that a number of healthcare organizations have consciously or unconsciously backed into some serious competition with local business enterprises, thus raising the hackles of a number of local small and midsize businesses who are increasingly crying "foul" on those activities.

Just a couple of further overview comments. I'm presenting to you today a partial list of items that I would urge those of you in the hospital and health care business to carefully consider. But beyond that, I think it's very important that you have substantial resources available to you to review and monitor on a continuing basis the decisions that you're making in the areas of revenue diversification and for-profit business development. At the Detroit Medical Center, for some time now we have had a full-time in-house tax person to remain current with what is coming out of the IRS and evolving tax law. It's a very important screen that we take very seriously as we review board decisions, policies, and strategies.

In addition to that, the DMC has taken very active steps to make sure that we have regular and continuing access to tax partners from our outside audit firm and from the law firms that represent us. It's an important consideration that must be thought of at every turn along the road.

I think another thing that the DMC and some of the other larger multi-hospital systems have done is to create some sort of a vehicle to pursue for-profit business development activities. That entity for the DMC is called Radius. And I'm sure you're familiar with other entities such as Arc Ventures, which is operated by Rush Presbyterian St. Luke's Medical Center here in Chicago. A number of guidelines, I think, are apparent in the use of vehicles like Radius and Arc. And that is to consider that some of the things you're going to choose hopefully are going to be very profitable. That they will be able to produce a very substantial positive cash flow. So much, in fact, that there is the potential jeopardy of having the appearance of a not-for-profit organization. In that connection there are certain activities that might be viewed as "inherently commercial" and so far removed from providing care to in-patients that it is not a good idea to include them within the major corporate entity as an operating division. Congress is beginning to focus on a number of "inherently commercial" activities that should be housed in a separate corporate entity.

What I'd like to do now is just to go through what I have boldly called a management checklist of some of the things that you ought to be thinking about. As I indicated, it's only a partial list.

To begin with, times have changed very dramatically. And if you haven't done so, it's a very good idea to review all of your corporate documents, many of which, for older organizations, may have been filed with the secretary of state's office and other entities many years ago. In fact, perhaps decades ago. Those documents state for all the world to see what your corporate purpose is. I would wager that there are some institutions represented in this room that may have strayed just a tad from some of the missions that were established perhaps in the 1920s or even beyond that.

It's appropriate to recognize the paradigm that has changed in health care. If you have moved away from just being in the hospital business to a much broader health care business orientation, it would be a good idea to revisit those corporate documents and make sure that you filed them and that you are acting in a way that is clearly in conformity with your corporate purpose.

I think your finance department would do well to perform certain financial ratios, particularly those relating to your net income and your ability to generate cash and profitability as a ratio of your assets to debt. To see whether or not, notwithstanding, you have a tax-exempt status under the Internal Revenue Code; whether or not one or more of your lines of business that equate to being a business are in fact becoming so profitable that it would be a good idea to think about a change in corporate status for that particular line of business. Either creating a separate for-profit business entity or, perhaps, lumping it under a general for-profit business development corporation division.

I sense from the comments prior to this that you know all about private benefit and inurement. These are concepts that you need to watch carefully, carefully considering the independence factors of the members of your board. Considering whether or not you are involved in contracts and paying fees to individuals who are in fact on your board and may have participated in those decisions. It's very important to have the appropriate levels of disclosure, and to disqualify those individuals from any consideration of those items on which they are consulting or providing counsel. Perhaps a partner from a law firm happens to be chairman of the board and has controlling decisions to produce fees for his law firm. Perhaps you have a board member who has

a construction company that you're using with great regularity. There's a problem there and you need to address it.

I think you also need to review the perquisites and salary levels of your top management. If you get into litigation they will take a very conservative approach to looking at those salaries and benefits. They tend to compare salaries and benefits to small and midsize businesses and even to people in public life.

I was involved in a case in Iowa where the president of a multi-nursing home system was regarded as being similar in function to the administrator of the local school district. And, of course, the compensation level for this individual was several times higher than that for the school official and had a number of perks that were significantly beyond what this public servant was earning.

Look at your wage scales and your perks in line with industry norms and trends. And consider that as a part of the total circumstances. The totality of these items is the thing you need to worry about as you look at an IRS audit. Not any one of these particular items can necessarily produce a loss of tax exempt status. With the exception of private benefit. If they determine that, even if it's only one dollar—that is a fatal mistake to allow to occur.

For the most part, these should be read as being a series of factors, no one of which is necessarily fatal. But taken as a whole, if you're violating several of these items on the checklist, you have a serious, serious problem. As mentioned, the positive cash flow needs to be watched to make sure that profitability is appropriate to a not-for-profit entity. And related to that, if you are a multi-institutional system that may have a home office substantially outside the region in which you are doing business, it's a very good idea to make sure that those dollars stay in your community and are not forwarded back to Louisville or Denver or Nashville or wherever the home office might be. That is clearly a red flag that the IRS and local governments will look at to determine that you are not making your contribution to the community.

And that suggests the overall need to publicize fully your commitment to the community. The public relations department and the marketing department need to be aware of how important it is to preserve and defend tax-exempt status. The use of open houses, mailings, and things like that make your community aware of your sense of service to that community, not just in taking care of the indigent, but your involvement and your participation in providing a broad range of community services.

Political and legislative activity is also a no-no. But that is also governed by a totality-of-circumstances test. That kind of activity cannot be a substantial part of your operation. And you are well advised to keep that activity focused on items that have an impact on more facilities and more entities than just yours. I would focus on the generic items that have to do with Medicaid reform and uncompensated care, malpractice, issues like that where your position may be very close to the hospital's position. And that you not get into pure political activity where you're actually paying money as contributions to specific candidates. You need to keep a fairly high plane of activity in that regard or else there is the threat of losing tax-exempt status. And I know it's hard to do because in many institutions you have special problems where your interests may be somewhat oblique from what the hospital association is pursuing. That is, again, to use my organization as an example, the case with the Detroit Medical Center. And as a result, we have a very active government-affairs program. In fact, we have an office in Lansing to represent our interests to the Michigan legislature. But it's obviously very closely scrutinized and kept on a very high plane.

As you go about this business you don't necessarily build your own entities. You often get an opportunity to acquire another business that may already have a

management in place, a good track record, and a market position. It's a part of common sense and good business judgment that if you have such an entity, it's a good idea to consider the acquisition, particularly if it makes good sense to the core business.

Keep in mind, though, that as you look at the historic financials and consider the ability of that entity to fit into your system, it makes sense in the continuum of care and diversity you're looking for, that many of the better opportunities are going to be inherently commercial. And that term *inherently commercial* is becoming a term of art in the Bush administration. I sense there's an awful lot of interest in looking at certain things such as out-patient cataract surgery and the like that are substantially distanced from the business of in-patient care.

Charity care. It's important for you to honor at least your Hill Burton requirements. And to go, I would say, significantly beyond that. To do your best.

Someone was talking about the premises on which tax-exempt status was granted. It's very much a premise, going all the way back to the time of Queen Elizabeth I, that government felt that certain forms of charity care were simply too broad and too extensive for government to play a role. And, thus, the vehicle of tax-exempt status was created with the expectation that hospitals, churches, universities and the like would provide various forms of charitable services in return for freedom from taxes. That equation is being heavily scrutinized today and you need to be aware of that.

A lot of scrutiny is occurring these days in the potential and actual misuse of foundations. Foundations created for the purpose of attracting dollars to sponsor research and other public benefit activities. But largely for reimbursement reasons and other factors, some organizations have moved a number of activities into the foundation, such as public relations and communications that also really don't fit with the charitable purpose of that foundation. And that should be watched. You may have to bring some of those functions back into your organization even though you're not going to get reimbursed for them.

Tax documents. We all file tax documents whether we're for-profit or not-for-profit. Those documents need to be filed on a timely basis and need to be accurate. Again, the need to have strong, in-house capability and to monitor that with your outside law firm and your external CPA firm. Consistent reporting. There have been a number of horror stories that have started to pop up around the country. And I think you can imagine what that means. As you look at new and diverse revenues and you file your certificate of need, you may put one face on those prospective financials in the CON. Maybe those prospective financials look a little different in the feasibility study that you are pursuing for the tax-exempt bond issue. And perhaps they look even more different if you're going for an equity contribution. Thus there might be a substantial range in expected profitability depending on who you happen to be talking to at the time. Don't do that.

Make sure, as you put together your forecasts and determine management's most likely results of operations and activities, that you stick to a single story and don't appear to be wildly profitable to one organization and barely breaking even to another. With the invention of the Xerox machine and because of the Post Office, those documents tend to get exchanged.

And after the fact keep in mind that you made certain representations to the outside world and when you prepare your cost reports and begin to then start thinking about how you can move some costs around and maximize reimbursement. That consistency must remain in place. You don't have the luxury of changing your mind and performing accounting magic to make the numbers convey different things to different audiences.

Competition. I think you need to be very, very careful in local business competition; particularly if you're pursing new lines of business that are inherently commercial and that are definitely competing with local businesses. The Bush administration is making this a very, very high priority. We use the term *level playing field*, to discuss the feeling that some large health care providers have gotten into lines of business that are inherently commercial and are reaping the benefits of unfair competition with small and midsize businesses. This is not an administration to fool with any more than the Reagan administration was. When you add all that together, there is the potential threat of what some people have called a "feeding frenzy" for new tax revenues. As the hurdles become lower and lower and as the federal government and the various state and local governments try to balance their budgets and go after dollars, there is the fear that a feeding frenzy could erupt and some very, very untoward consequences might result.

So I would read the *Wall Street Journal* regularly and see what's going on in Washington because there are some scary, scary things being talked about. I thought I might just toss out a couple of things that are under consideration. Surely not all of these things will happen, but maybe a few of them will.

There are a number of congressmen who believe that tax-exempt status should apply only to in-patient care. And none of the other services should qualify. They are simply too far removed from the historic purpose of hospitals. And there's just too much confusion in terms of what's appropriate for a hospital, what's appropriate for physician's office practice, and the like.

À la carte payments for government services is already a reality. Most communities in Pennsylvania have maintained their tax-exempt status, but they are asking for à la carte payments to cover utility costs, fire protection, police, and the like. So if you haven't already received one, you can expect a phone call at some point from your local revenue director to talk about what you're doing for the community and whether it might not be a fair thing to come up with direct payments to the municipality or the county in lieu of losing tax-exempt status.

I think as the backtracking continues, as we begin to limit services to indigents and restrict use of emergency rooms and other activities, it's going to reach a breaking point. And I wouldn't be surprised if at some point we, in fact, did have some mandatory requirement for charity care. Probably stated as a percentage of revenue.

Pete Stark and others have, for several years now, felt that investment income is clearly unrelated to the hospital's core business. And that no compelling public purpose is served by not taxing investment income. I think that taxing investment income is a real possibility in the next two or three years.

As mentioned before, as the local auditors and revenue directors get together (as they often do through national associations), this is a major focus. Especially in cities that have lost their tax base because of urban blight. Or loss of the working population to the suburbs. The pressure to balance those local budgets is going to be enormous and they're going to be looking at entities that are basically multimillion-dollar businesses that may have extensive real estate holdings and the like.

So the pressures are going to mount dramatically and thus the need to pay close attention to that checklist. There are already a number of audits underway—including at the Detroit Medical Center. Literally hundreds of audits are in process as we sit here today. To aid and embellish that activity, there are going to be much more disclosure requirements; forms, and the like, as the government tries to gain better understanding of the business of health care. Your work is going to get much more difficult as you go along.

And I guess the real bad news, as I said before, is that this is only a partial list. This is going to get worse and worse. Tax exempt status has become a planning and financial factor for all nonprofit healthcare providers. It has become a major part of policy making and business decision making in hospitals all across the country. It's importance will loom ever larger as the search for new revenues goes forward in the decade ahead.

CHALLENGES TO THE TAX-EXEMPT STATUS OF TODAY'S NONPROFIT HEALTH CARE SYSTEM

JAMES MCGOVERN. It is good to be here in Chicago and I am pleased to be part of this symposium. For some reason this turned out to be my Chicago week. As Paul indicated, I was here earlier to speak at the Fifth Annual Health Care Tax Law Institute sponsored by DePaul University and the American Academy of Hospital Attorneys. Earlier this morning I finished a presentation at the Chicago Kent College of Law's Eighth Annual Conference on Nonprofit Organizations. Perhaps it was some historic force that beckoned me to Chicago at this point in time. We celebrated a special anniversary yesterday. It was on May 4th in 1932 that Al Capone, the crime boss of Chicago, entered the federal penitentiary in Atlanta. As many of you know, he entered the penitentiary not for his obvious and principal crimes, but for tax evasion. Despite this historic connection, I must admit that as I finished my presentation on Tuesday afternoon, I felt more like public enemy number one than Elliott Ness.

There are some interesting developments that occurred last week in our discussions with the Department of Health and Human Services. This is a topic that is going to be of significant interest, so I will mention it along with several points that I made in my paper.

This conference is focusing on the issue of who profits from the nonprofit hospital. Is tax-exempt status justified? I have been asked to review the legal basis for tax exemption and to review the arguments challenging tax-exempt status. I will address these from the perspective of the Internal Revenue Service. In addition, I will address the challenges that I see in the future.

As you know, nonprofit community hospitals do not pay federal income tax because they are considered charitable organizations within the meaning of Section 501(c)(3) of the Internal Revenue Code. The origin of the statute goes back to 1894 when Congress was attempting to enact our country's very first income tax. Up to that time we raised revenue through a system of excise taxes. Perhaps you remember the Boston Tea Party or the Whiskey Rebellion? These were citizens' protests over excise taxes. In 1894 Congress looked for a broader-based way to raise revenue, and devised a fair and simple income tax: a two percent income tax on individuals and corporations. However, Congress had to make some value judgments. Congress decided that they would not tax religious, charitable, or educational organizations. Although the 1894 tax law was subsequently declared unconstitutional, it formed the basis for today's section 501(c)(3).

The law says that a section 501(c)(3) organization must be organized and operated exclusively for a charitable purpose, and that no part of the net earnings may inure to the benefit of private persons. In essence, these organizations are charitable trusts. The private inurement provision in the law says that proceeds of those trusts must be used for public purposes and not for private benefit.

There have been major changes in the exempt sector, and the hospital industry in particular, in the past decade that impact on the issue of section 501(c)(3) organizations and private benefit. In the exempt economy, there has been high inflation. There has been declining federal revenue. Federal revenue was down $4.5 billion between 1980 and 1984 for the nonprofit sector as a whole. There has been increased demand for services and as a result exempt organizations on the whole have moved into the commercial arena to survive. There have been new ventures and joint ventures. There

have been deals structured by investment bankers. There have been significant partnership deals between exempts and partnerships that simply didn't exist 10 years ago.

With this change in the economy has been the evolution of the health system. In order to survive in this changing and heavily regulated environment, nonprofit hospitals diversified by reorganizing into multi-entity structures that are often called health systems. A typical reorganization involves the conversion of a single nonprofit hospital into a more complex structure in which a tax-exempt parent, the holding company, controls through interlocking directorates a series of corporations, both exempt and taxable. The evolution of these new systems has raised concern at the federal tax level about how they are doing business.

There has also been concern at the local level. I know you've heard from the Intermountain system and from the Vermont Center Hospital. I have participated in programs with other representatives from those institutions and their message, I think, is a very important one. I heard Paul Hattis talk on Tuesday about the American Hospital Association's self-assessment guide and the community benefit guide. And I think that his message is also an important one. There are challenges to today's healthcare institutions based on the fact that they are doing business in ways they've never done business before. I think if they are going to survive in these new structures, they have the burden of showing that they really do serve the community. You might recall in the Intermountain case that the court couldn't distinguish the nonprofit system from the for-profit one.

My concern is not so much whether nonprofit hospitals deserve tax-exempt status as it is with respect to whether these new systems adequately are regulated by today's tax statutes. I outlined in the paper that I did for this presentation three basic concerns. They are really more of a technical nature, that is, of concern to tax lawyers. I'm going to quickly run through them on a basic level to try to demonstrate to you what is bothering the tax administrator.

Point number one is that Section 501(c)(3) corporations are in two camps. The first camp is what we call the publicly supported camp. These are institutions that get their support from the public and are thus theoretically responsive to the public. The second camp is the privately supported Section 501(c)(3) organizations. In 1969 Congress changed the law dramatically and said that these privately supported organizations have diversified into the business community. There were concerns about unfair competition. And there were also concerns that they may not be in the business of charity but in the business of business. As a result Congress enacted a very comprehensive scheme of rules that apply to privately supported charitable organizations.

Hospitals have always been in the publicly supported camp and have had special status in the Internal Revenue Code. With the evolution of the health systems, however, the classification of the parent, brother, and sister corporations becomes critical. If these systems are going to work from a tax perspective, the parent, brothers, and sisters that are tax exempt need to be classified in the publicly supported category. If they lapse into the privately supported side, the systems won't work. The first part of my paper addresses this issue. While many of the parent, brother, and sister corporations have been classified as publicly supported organizations, it is not a neat fit. The health systems simply didn't exist when Congress wrote the tax law in 1969.

The second concern is whether the rules that are in the Internal Revenue Code that deal with the issue of unrelated business income tax work when dealing with health systems. In 1950 the concern was that exempt corporations were using their exempt status to unfairly compete with the private sector. The famous story involves the New

York University School of Law running the Muller macaroni factory. Congress reacted and changed the law so that exempt organizations will be taxed if they carry on unrelated business within the corporate entity. The strategy after the law was changed was to drop the unrelated activity into a subsidiary corporation where it pays tax. Congress, however, was concerned with *active* business income. Thus, it wrote exceptions into the law for passive income. Congress wasn't interested in taxing dividends, interest, rents, and royalties. As might be expected, a scheme was devised to characterize unrelated activity in a subsidiary corporation as passive income (such as rent or royalties) so that payment to the parent would not be subject to the unrelated business income tax.

The UBIT rules changed in 1969 to deal with this. The new rule provided that if an exempt corporation that controls a subsidiary corporation (owns 80 percent of it) and passes income up in passive form to the parent, that income will be subject to UBIT.

The problem, of course, is that these rules don't work with respect to health systems. In 1980 the district director in Detroit called this to our attention. The rules work well in situations involving parent and subsidiary corporations, but not particularly well when dealing with the myriad of brother and sister corporations that exist in health systems. There is a current initiative in Congress that will address that particular issue and drop the control test from 80 percent to 50 percent. Whether it will be enacted or not, I don't know.

The third concern can be characterized in a few words—how much is too much? The typical hospital reorganization involves a conversion of one nonprofit entity into a system of entities. As I mentioned, there is the parent and the interlocking subsidiaries which are both taxable and exempt. Some hospital systems have evolved beyond the basic system into megastructures involving 20, 30, or more entities. One system, for example, that we discussed recently with the oversight subcommittee and the House Ways and Means Committee, evolved from one tax-exempt hospital into a system of organizations including one tax-exempt parent, three tax-exempt subsidiary corporations (one of which is the hospital), and 33 taxable subsidiary corporations. This development raises a question of how many taxable subsidiary corporations can be spawned by one exempt corporation without changing the character of the whole system from a nonprofit system to a for-profit system. This concern is also being considered by Congress, at least as an option to amend the unrelated business income tax. This would involve the aggregation of the activities of an exempt parent and its subsidiaries to test whether the system is a for-profit system or a nonprofit system.

The ability to evolve from one tax-exempt entity into a 37-entity system, 90 percent of which are taxable corporations, raises another basic policy concern for the tax administrator. How much of the tax-revenue dollar should be spent to administer multi-entity health systems? Historically there was one hospital, and the revenue agent came to the one hospital. Today there are systems, and revenue agents have to deal with a myriad of corporations. One of the suggestions that I have made to deal with this issue (and it is a personal recommendation), is that some type of gross receipts tax is needed to help pay for the administration and oversight of these very complex systems.

The final area that I want to talk about is not discussed in my paper because the developments occurred just last week. It pertains to the evolving relationship between the nonprofit hospital and its physician. It goes to the issue of private inurement and private benefit that Roger and many of the earlier speakers have talked about this morning. Hospitals are currently engaged in intense recruiting wars for both new physicians and established physicians who can supply a steady stream of paying patients. Physicians are being wooed by a number of inducements, often called physician

enhancements. With as many as a third of the available hospital beds reportedly empty, this tactic is theoretically deemed necessary for survival.

We read with interest a February 12, 1989, article in the *Chicago Tribune* entitled "Hospitals Woo Doctors to Win Their Patients." Reportedly competition is fierce in Chicago, particularly on the North Side where there are 16 community hospitals within a five-mile radius. The manager of practice enhancement at Michael Reese Hospital was described in this article as saying that it's war in the city of Chicago. In the same article, an unidentified hospital marketing director said that he gave some physicians payments for services to the hospital that were inflated by a couple of thousand dollars a month. A tax attorney told the story of one physician who was given $10,000 to $15,000 to present a paper. This compensation was a disguised gratuity for admissions.

A recent article in the *Denver Business Journal* also talked about physician recruitments in the west. I don't want to unfairly single out Chicago. In that article it was noted that some medical management consultants and hospital regulators believe nonprofit hospitals are walking a very fine line between enhancements and inurement. Many of you probably saw the recent articles in the *Wall Street Journal*. The lead headline on page one was captioned "Warm Bodies. Hospitals that Need Patients Pay Bounties for Doctors' Referrals." The practice is questionable but it appears as profits from care are threatened. The physician-hospital relationships that I just mentioned are areas of concern to us because of prohibited private inurement.

As I mentioned earlier, the Section 501(c)(3) status of tax-exempt hospitals provides a number of tax benefits. That status is predicated on the fact that the hospital is a charitable trust, and that the assets of the trust are used for public and not for private purposes. Simply stated, the inurement prohibition prohibits the siphoning off of those assets for private purposes. The same issues that concern us in this regard, also concerns the Department of Health and Human Services. Federal laws governing fraud abuse and kickback in the Medicare Program prohibit hospitals from paying doctors either directly for referrals or in any way meant to induce referrals. The concern of the Department of Health and Human Services is over-utilization of medical care and siphoning off of the government's Medicare trust funds. It appears to us that both of our agencies, IRS and HHS, may be looking at the same issue from a different perspective. Indeed we may be looking at the very same transactions involving the very same dollars. With this in mind, we met last week with representatives of the Inspector General's office of the Department of Health and Human Services to begin a dialogue about the overlap between Medicare fraud and abuse and potential abuse of the tax exemption. Within the constraints of applicable disclosure laws (and that is an area that we have to be very careful with because there are strict prohibitions on sharing information with respect to taxpayers), we are looking for opportunities to coordinate and share information among our respective agencies.

One of the major concerns that remains with respect to the issues of unrelated business income, unfair competition, and evolution of the hospital systems is the fact that there is a lack of data at the state and federal levels. Governmental entities at all levels are in the process of revising information returns in an effort to get a better handle on the scope of the commercial activity in the exempt sector. I think it's going to be a while before that data comes in. I can't prejudge what that data is going to say, but I think if it confirms what some of us think it is going to confirm, there probably will be pressure in the near future for significant change. And of course that's my final point. What would be the model for significant change in this sector?

Recently, in February of this year, the Internal Revenue Service released a study on civil penalties in the Internal Revenue Code. There has been so much tax legislation

in the past 10 years that the penalties in the Internal Revenue Code have grown dramatically. The concern, from our perspective, is that penalties are to seek compliance, not to punish or raise revenue. A group of IRS employees, outside lawyers, outside accountants, and other interested individuals took a look at the penalties throughout the Code, including those that apply in the exempt-organizations area. It was noted that more stringent rules apply to privately supported than to publicly supported Section 501(c)(3) organizations. It was also noted that these rules are more effective in dealing with perceived abuses of tax-exempt status. Right now, if we find prohibitive private inurement, our sanction is to revoke exemption. We have to punish the community health facility because of self-dealing between an individual or a group of individuals and the trust. That is something that we are reluctant to do, and it's something that the courts are reluctant to uphold. The penalty study talked about that, not in the hospital context but in the overall context of exempt organizations, and suggested that this is something that has to be given serious thought. I think the debate on that issue has started. I think it's a long-term issue, and that change won't occur overnight. In my opinion, if anybody's going to be in the forefront of the debate, it's the hospital community. Those are my thoughts from Washington. Again, I appreciate the opportunity to participate in this program.

QUESTIONS FOR MR. NAUERT AND MR. MCGOVERN

QUESTION. It seems to me that the basic purpose of health systems was, in fact, to develop revenue centers that would contribute to the basic functions of the organization in terms of in-patient care. They could be for-profit centers. Do I hear you saying that given that they are for-profit, they do pay taxes, and they return revenues after taxes to the in-patient hospitals that this still may, in fact, become a problem?

JAMES MCGOVERN. Ron, I think what I was trying to articulate here is if you create a subsidiary corporation and it pays taxes based on the profit that it makes, that is fine. What I'm suggesting—and the tax laws are very sophisticated—is that the tax laws right now may not adequately reach that result. There are ways to structure transactions so that the unrelated business income tax rules don't effectively work. Congress is taking a shot at some piecemeal approaches to this problem right now. At least they're discussing options. These may or may not get enacted into law. But if they are enacted and they're not effective, we're going to have to take a look at a long range solution.

I've done a lot of health care programs over the years. I have frequently asked this question: do your taxable subsidiaries pay tax? And the answer, usually with a smile, was "not if I'm doing my job properly." You don't hear that anymore. That's the concern.

We need to get data to confirm whether or not this is a problem. The information returns of hospitals, and all Section 501(c)(3) organizations, is public information. Taxable subsidiary corporations, however, are private entities that are entitled to the disclosure protections of the Internal Revenue Code. We do not yet have a good picture of how these entities have been operating in relationship to the hospital and whether any of them have been paying tax. That's the piece of data I mentioned earlier that simply isn't in yet.

ROGER NAUERT. Just a reflection more than an answer to Ron's question. I guess one of the thoughts that I had is that systems were not created solely for the purpose of diversifying revenue from a business standpoint. There are many other reasons. Providing a continuum of care and trying to produce some efficiencies that can go with vertical and horizontal integration. In many of the systems, certainly the Detroit Medical Center and Presbyterian St. Luke's and others, a common feature is a substantial commitment to the inner city and care for the indigent. As you go about the decision-making process and implement strategies, a key rationale for this whole process is to subsidize programs that you could not otherwise operate without the financial success that you're enjoying from other business operations. The easy answer is to sequester the more promising or profitable ones into a for-profit sub. But in the real world it's not that easy.

QUESTION. There's a lot of evidence, for example, from the national health insurance experiment that consumers are price sensitive with regard to hospital care and even more so as to probably which hospital they receive their care from. My question is that if a hospital lowered its prices either directly or by not charging for certain services, and as a result its staff physicians were able to raise their prices either directly or by charging for services that were previously billed by the hospital, would that constitute inurement?

JAMES MCGOVERN. In the question as I understood it, we have two situations. One where the hospital reacts perhaps to occupancy rates and reduces the fee that it charges for services. And at the same time perhaps the physicians note that more people are coming into the hospital and the physicians raise their rates. I see no problems with

private benefits whatsoever unless there is collusion between the hospital, its administrators, and the doctors to do just that.
QUESTION. You talk about the legal problems of collecting better information in terms of the IRS's own efforts to study the whole issue of the use of subsidiaries, for-profit and nonprofit. Are you going to try to collect that information also to try to get some idea about taxable corporations within those systems and put all the data together in some comprehensive fashion at some point?
JAMES MCGOVERN. The question is whether the service is going to try to get a better picture of the operation of a system involving both exempt and taxable organizations. The answer is yes. One of the early options raised by the oversight subcommittee a year or so ago was to direct the Service to do a study of reorganized hospital systems to focus on the interrelationship between exempt and taxable organizations. In addition, we recently proposed a revision of our forms to get a better picture of organizations that operate in tandem with exempt organizations.
QUESTION. How do you deal conceptually with university hospitals that have salaried faculty that use that vehicle, if you will, to draw the cream of the crop away from community hospitals?
JAMES MCGOVERN. That's a good question. In terms of the tax laws, I don't know if there is a way to distinguish that. I mean unless there is some type of financial package incentive, etc. If it's simply the prestige of the organization, the ability to be on a faculty of a teaching hospital, etc., they've got an advantage.
QUESTION. How do you relate taxability and inurement to practice plans?
JAMES MCGOVERN. It's not uncommon for the faculty of a big medical center to have a faculty practice plan. We have not successfully litigated the issue of whether certain types of faculty practice plans are entitled to Section 501(c)(3) status. We lost a number of cases in court.

We are concerned right now about recent reports that some physicians are trying to run their practice of medicine through a Section 501(c)(3) corporation. A doctor may have a title at a hospital, such as head of a department, and set up an exempt corporation. The corporation has these ostensible purposes of promoting the health of the community. In reality, however, the only thing that it does is to run the practice of that individual physician through that particular corporation. The corporation doesn't pay tax, and the doctor gets paid salary and bonus arrangements. We've alerted our agents to these alleged transactions.
QUESTION. Maybe it goes without saying, but I think it's a mistake that from almost the onset the trade literature has emphasized legal and financial motivations for establishment of healthcare systems. My own personal situation involved a seven-year process to develop a long-term care system. We identified nine what we call general management reasons for doing so. Three additional legal reasons. Three financial reasons. We would have done it just for the nine general management considerations. Even if there had not been legal or financial advantages as well. And the benefit that we're getting at the present time is clearly more in the area of general management motivation than it is in the legal and financial. Because the diversified entities haven't had an opportunity to get out of their initial stages. One significant general management consideration was to reduce to the extent possible the negative impact of the large not-for-profit boards of directors.
ROGER NAUERT. I strongly concur with that. There are other features as well. The more successful entities also have significant teaching and research functions and may be affiliated with a medical school. So there are very broad reasons to diversify and form systems. Long term, I think the preeminent reason is by force becoming a competitive

system. Because there are certain economies of scale, access to capital, and other features, integration will go forward. But you're exactly right. The health care industry is riddled with horror stories about what were intended to be for-profit entities that were going to produce all this money and there have been some absolute disasters that have produced major financial losses for hospitals all across the United States.

JAMES MCGOVERN. Let me make sure I leave you with my concern over health systems. My concern is whether the tax statutes that were enacted 30 years ago are adequate to deal with today's health systems. I am not passing judgment in terms of a health system as to whether the economics of the industry or the management practice make sense. But there is real concern as to whether the proliferation of these systems is regulated. In an article that I wrote with respect to the subsidiary corporations, I pointed to a couple of private letter rulings that we issued which indicated that the educational institutions are beginning to look at systems. We know some fraternities, non-section 501(c)(3) organizations, are looking at systems. And I think the tax lawyers who understand the tax law would be very honest about it, perhaps in a closed forum. But they would say that the laws we have today don't adequately fit. And that's what I'm worried about.

A RESPONSE TO THE MORNING SESSION

WALTER FACKLER. It seemed to be a very good morning. Or a very interesting morning. I learned a lot. And I hope you did, too.

Let me make a few comments on some of the things I thought I heard. And some of the things I didn't hear.

The issue of tax exemption basically boils down to two sort of analytical arguments that make sense. And most of the rest of them are sophistry. One is that an organization is providing something in addition that would not be provided by the marketplace. That is to say there are some positive externalities, to use the jargon. We rely on that because we work for a nonprofit organization. We use that argument all the time, I can assure you, at the University of Chicago. Basically, there's a free-rider problem. We produce knowledge. We produce research. We do things that the market wouldn't produce by itself because you can't appropriate knowledge very well. Sometimes you can patent things, but sometimes you can't. And so we're producing something "in addition" that the market wouldn't be producing. There is a positive external benefit widely distributed—the classic case of the free-rider issue. In all public education, the argument for it really comes down to that base. That some people would under-invest in education. They would under-invest in knowledge. And so we have these positive externalities where the market doesn't produce enough because the private benefits are not sufficiently great for a particular person to undertake them without a subsidy. So education falls in this category.

You know, we regaled this morning about the definition of nonprofit as public, pious, and charitable. Well, I don't know where the pious comes in, but the public certainly comes in. Education is traditionally one of the organizations that have merited or presume to have merited tax-exempt status.

Second, the other argument for tax exemption is there are charitable agencies. People this morning talked about going back to Queen Elizabeth; we have always had charity. That's been with us because the market doesn't produce a just distribution of income. And nobody ever said it did. It's on an efficiency standard. And so we have both private and public transfers. And in a sense, then, the tax-exempts are minigovernments. And the courts have said this many times. If these people weren't producing these things then the tax payers would have to produce them. And that's certainly an option. So those are the two things that we need. Transfers because the market doesn't produce enough of something. Or, and, in these cases, either income transfers or subsidies for these positive externalities. And I haven't run across any other arguments in the literature that really lead me to say that there are any other sensible reasons for tax-exempt status. So the question then is, what are we getting for the tax subsidy? If tax-exempts are mini-governments, as is the University of Chicago, making these income transfers, producing this great fount of knowledge or fund of knowledge. What are we getting, as tax payers, for our tax-exempt status? That seems to me an important question and the right question and one that's been addressed here by various members of the morning panels.

I thought Dave Jeppson did an absolutely superb job on the Utah case. And with all the problems of standards and the local jurisdictions and those kinds of questions. Basically, the people there were asking the right question about charitable organizations or charitable purposes, organization and operations: the charitable trust concept or model with no private benefits. Not blatantly commercial activities. And how do you measure the total gift to the community? Now, there's the crux of the matter, it seems

to me. How do you measure that total gift to the community for which we are paying as tax payers? And it's not easy. One of the speakers this morning said we can't measure these things in dollars and cents. And that's true maybe. That's a lawyer's view. But it's certainly not an economist's view. We have to make judgments all the time. Is something worth something or is it not worth something. Should we spend more on defense or no more on defense. Is a B1 bomber worth as much as a hospital or two of them as much as a torpedo boat? And so on. We're always making judgments of whether something is worth doing.

Now, it's true, it's hard to measure outcomes in charitable organizations, nonprofit organizations, hospitals, universities. How much value-added did we add? But to say you can't measure in dollars and cents means you can't put a value on something, which means that you're really back to the labor theory of value: the more you spend on input, the more you're producing. And we all know that's baloney. That, I think, is just wrong. It's true it's hard to measure output. It's true it's hard to make value judgments. But we will have to do it. So I think the questions are right.

And I detected a little schizophrenia here this morning too about what is charity. And I thought that was pretty interesting. And I learned some things about it. Charity, taking care of the poor. That's a myth that was squashed. Is charity taking care of the indigent? Well, what about the rich drug addicts? Somebody raised that point this morning. The question of social service and the gift to community is a very hard one. And people will arrive at a lot different answers, Mr. Sigmond notwithstanding. They'll arrive at a lot of different estimates of what the gift to the community really is. And I have a little problem with his notion that you're going to have these community standards along with other standards for accreditation and so on because I don't see how you're going to have in all cases these very explicit goals. In the hospital in a declining neighborhood where drug addiction is rising, are their goals being met? Infant mortality is increasing or decreasing. Maybe they're doing a splendid job even though the certain kinds of health problems are getting worse. And I think that's going to be a very tough problem, this question of goals. And we're going to have a lot of difference of opinion on it. Another point was how to handle the public good issue. As Paul from the American Hospital Association pointed out this morning, you don't really need tax-exempt status as a way of doing something. There are different ways to skin a cat. And you *can* have direct subsidies. So the public good argument by itself isn't sufficient. And we do have some of those direct subsidies. We have a lot of them, as a matter of fact—a lot of them in addition to our tax-exempt status. But then you have the problem, of course, in all these cases that controls are going to follow the dollars.

I didn't hear anyone mention directly this morning the problem of moral hazard. Maybe only economists and lawyers talk about moral hazard. I don't know. But it's terribly important when you have third-party payers. That's one case where you have moral hazard on the part of the physician. And you have moral hazard on the part of even the insurers. And it's the same problem we have in the S&L bailout now where the taxpayer's going to pick up $150 billion because the problem of moral hazard wasn't recognized by the Congress. And we didn't have a regulatory presence in the S&L's. The same problem we have in the hospitals. Where do the subsidies go? Do they go to increasing the medical care? The quantity of medical care? The price of medical care? The income of the doctors? The quality of medical care? It can go various places. And so that is a problem that people in nonprofit management have to deal with: the very important problem of moral hazard.

Another thing that wasn't mentioned this morning was the problem of agency. And that seems to me is the thing that goes to the heart of the difference between for-

profit and nonprofit organizations. There is a question of for whom are the managers trustees? Who are the owners? Or who are the responsible people? Who are the residual claimants? And so on. On the agency problem there's quite an interesting literature now. How do you make sure that the management are really doing all these things that they're supposed to be doing that Mr. Sigmond talked about? How do you settle up? You say in the private sector, or the for-profit sector, there's a settling-up process. There's a capital market. The stock goes down. New management comes in and throws out the other management. And it takes over. And so the capital market. There's a settling-up. There's a settling-up through the labor markets. That happens, too, in the not-for-profit people. But in the profit sector there's a settling-up process; that's basically the difference, and it works continuously through the capital markets and through the labor markets.

So what is the mechanism by which managers of nonprofit enterprise are called to account? And so deserve their nonprofit status that Mr. Rice talked about? Those are some questions that weren't addressed.

I was really surprised to find out that fly fishing in Vermont doesn't serve a public purpose. I thought that was just heresy if I've ever heard it. But another question that came up I thought was the right question: the uncompensated care issue. I don't know that that's an easy one unless, as someone mentioned this morning, you tell people in advance that this isn't going to cost them anything. But, my God, if we started taking credit for uncompensated care at the University of Chicago, we would look like we were very virtuous simply because we don't know how to keep our accounts receivable. How to keep track of them and how to collect them. So we do a lot of uncompensated care, but it's through inept management. Not through any charitable, or intended charitable purpose.

I am interested, though, to note that sometimes what seems to be profitable also coincides with public service. A problem that wasn't really addressed. But we all know what it is. You try to go into things that are going to be nominally profitable. How do you explain the great increase in alcohol and substance-abuse units around the town and around the nation. Trying to find new niches where there is a real demand. Shows there's a reflection of the demand for those services.

Well those are some observations on the morning. As I say, I thought it was a splendid session. I learned a lot. I thought the presentations were, on the whole, extremely good. The conference focuses on a terribly important issue. And I think that, as I go back to what I said at the beginning, Mr. Jeppson put his finger on it. You may merit tax-exempt status, you may not. And it's up to you to prove that you do.

KIRSTEN GRONBJERG. One of the advantages of being a second commentator is I feel no obligation to summarize anything or necessarily try to comment on all the arguments that were raised this morning or yesterday afternoon about the tax-exempt status of nonprofit hospitals.

I do have three points that I believe provide the context within which this debate is occurring. The forces that drive the discussion relate to whether or not there is a subsidy; concerns about cost containment; and consequences of competition and the particular way in which the health services field is structured financially. The legal issues that we have heard about today provide the context for that debate, but a whole series of moral issues and issues of perception overlay the legal debate. Somebody said there is a lot of rhetoric in that debate. The rhetoric is where those issues surface and why some of these forces need to receive careful attention.

Two closely related issues have become part of the public debate about and public perceptions of nonprofit hospitals. In a technical sense they relate to non-redistribution constraints—whether hospitals meet the legal financial test of engaging in for-profit activities; and whether they use mechanisms for structuring payments in ways that do not show up as profits, although they have that effect. These issues surface most explicitly in the public debate on hospitals simply because of the sheer size of the hospitals. Thus we found a couple of years ago that nonprofit hospitals constituted about 100 of the 4,000 or so nonprofit public benefit—501(c)(3)—types of organizations in the Chicago metropolitan area—about 2.5 percent of the total. But they accounted for 49 percent of the revenues, or $4.1 billion out of a total of $8.4 billion. When you have something that large, that institutionalized, it is not surprising that hospitals receive a great deal of attention. Moreover, hospitals do not look like poor struggling organizations to the general public. They look fairly plush to most people. The size of bills that people receive does not convince them that hospitals are struggling financially. Hospitals also operate under the mixed corporate structures that we heard about from McGovern—very complex structures that obscure their nonprofit status. These structures and the management and fiscal manipulations associated with them, developed for good reasons, confuse public perceptions. They question whether hospitals meet the financial tests that warrant their public benefit or charitable status.

In short, the foremost issue is that surrounding subsidized care, the charity care that people refer to. Hattis, I think, was explicit when he argued that hospitals, and nonprofit hospitals specifically, are not supposed to serve the indigent exclusively. That may well be the case. But when people hear charity they think about poor people and indigence of various forms.

For example, a content analysis of the Chicago *Tribune* and the *Sun Times* about five years ago showed that about three-quarters of references to nonprofit organizations explicitly linked those organizations to inner city residents, low-income people, or public aid recipients—all synonyms for indigent care. In many cases these organizations were not hospitals, but hospitals easily come to share in the general public perception, whether they should or not.

There are other public benefit purposes relating to wider benefits in the form of teaching, research, technology, the development of new models or new niches that are not yet marketable or profitable. Presumably, when these niches become fully developed, they will merge into the private sector and become the basis for new expansions there. There is also the more narrow public benefit in terms of community benefit. Mr. Sigmond talked specifically about the need to measure community benefit. I would like to suggest that, as difficult as that is going to be—if the sociologists have learned anything in the last 50 years or so—defining community is going to be no easier.

It is very, very difficult to define exactly what you mean by a community and therefore the definition of *community benefit* is going to be equally problematic.

The second major force we need to come to grips with is the fact that these developments have been occurring on the backdrop of the expanding role of government. But the expansion has occurred under a very particular type of administrative system, one in which government is using non-governmental agencies as a means of executing its own mandate. This becomes important for several reasons that I will discuss later. But let me just talk a little bit about the growth in health services.

You know as well as I do that the health field has grown both in terms of finances, professionals, number of new specialties, and technology. In short, it has become an especially *notable* public sector. Overall public welfare expenditures in the United States, adjusted for per capita and for inflation, have more than quadrupled since 1950, but inflation adjusted health expenditures per capita have increased by 7.6 times. Only various public insurance programs, such as Social Security and public employee pension programs, have surpassed the growth in health expenditures and increased by almost nine times the amount they were in 1950.

More importantly, the growth in these expenditures for health services occurred through a system that relies on the extensive use of non-governmental service providers both nonprofit and for-profit. The U.S. has chosen *not* to execute its health policy through direct public service provision, as we have seen in a number of other nations, such as the institution of public hospitals and clinics of a variety of sources. This explicit use of non-governmental service providers is a preferred model in the United States. It extends much beyond health care, although the education field is left almost entirely to the nonprofit and the public sectors.

In general, the public sector depends on the nonprofit sector for executing public policy mandates. Our analysis of public spending for the Chicago area showed that 54 percent of all broadly defined social service expenditures went to nonprofit organizations which, in fact, delivered the services. That was a higher percentage than the government delivered directly itself. The percentage was also high for health services and particularly in the hospital field. These patterns of growth and reliance on non-governmental agencies help explain the particular concern with hospitals.

These patterns also mean that different institutions now increasingly rely on similar income streams, particularly in the health care field. The growth occurred in the Medicare and Medicaid programs. As a result, a particular set of financial arrangements have come into existence and now dominate the way in which most health systems operate. These arrangements were based on a series of presumptions about shared goals between the nonprofit and public sectors that we now increasingly have come to question. The dividing issues relate not only to the traditional separation of church and state, but to controversies surrounding the expansion in health care costs and the related use of non-governmental service providers. We face the paradox of having one of the highest levels of expenditures for health of any industrialized nation in the world, but we have major gaps in health status as measured by a variety of indicators. The goals of the two sectors are no longer as easily reconciled as perhaps they were at some point. This, also, draws attention to the hospital field.

The growth in health expenditures and the extent to which they are channeled through non-governmental service providers, especially nonprofit hospitals, have become the driving forces behind the cost-containment effort. This in turn is forcing a number of hospitals and other provider organizations, into paying close attention to their bottom-line performances. The cost-containment efforts have indeed focused extensively on the health field. There are a number of reasons for that. Health has been the largest, most

rapidly growing field, except for income security programs. But cost containment is easier to execute in health than in income assistance or income insurance programs, because health organizations serve as institutional intermediaries between the cuts and the direct beneficiaries. We saw how difficult Congress found it to institute significant cuts in Social Security a couple years ago. There were not many cuts and they were not that significant. Public spending cuts came in places where there were institutional intermediaries.

Also, there are not many other candidates for cost containment. If you cannot touch Social Security, you are left with very few. Education accounts for about 34 percent of all public expenditures, but education is the first line of defense behind which the market system is supposed to operate for the general population. Education is as close to a sacred cow in the United states as you get. All the other social welfare fields take such small proportions of the total public pie that it doesn't do much good to try to cut them. For example, public income assistance—not Social Security, but AFDC, General Assistance, Supplemental Security Income, Food Stamps, that entire package—accounts for only 10 percent of total public welfare expenditures. All other forms of public welfare, social services, employment and training, and public housing account for about 3 percent. You are not going to get a lot of extra revenues from trying to cut there. It means an inevitable focus on the health area.

The third force that shaped the current debate is the fundamental problem of competition. One of the driving forces behind the concern about the status of nonprofits in the health field is that the public funding there has occurred through the adoption of an essentially commercial or proprietary model of payment. Partly, the field is dominated by direct proprietary interests in the form of individual physicians, laboratories, drug companies and nursing homes. True, hospitals are disproportionately public and especially nonprofit. But the remaining part of the health field has been significantly shaped by direct proprietary financial interests as opposed to charitable origins.

Partly as a result, the dominant payment systems in the health field operate on the basis of charges above and beyond cost in the form of private insurance programs, Medicare, Medicaid, and related public expenditure programs. I was interested to hear one of the speakers this morning mention that Medicaid paid less than full charges and even, in some cases, less than full cost. If you look at similar kinds of reimbursement systems in the education field, student loans and things like that, the educational institutions make no pretense that tuition pays for full cost. That is, I think, a significant difference between the educational and health fields.

The social services field provides a different contrast. Social services nonprofits also have a very significant dependence on the public sector for funding. But the reimbursement system does not operate in the form of a cash-or-credit-bearing client. It is in the form of direct purchase agreements between the government agency and the specific nonprofit organizations. That allows for much greater negotiation between the public and the nonprofit sector about what are community interests and what are community benefits. It also reduces the incentive for letting the fee-paying or the cash-carrying client become the basis for management decisions. Once you move into a model based on the cash-bearing client, then you must almost inevitably adopt a commercial type of operation. This is where gray areas develop between for-profit cash centers and nonprofit community benefits.

These three forces have driven much of this debate and help explain why it is occurring now, particularly in the health field. Of course, the rest of the nonprofit sector is looking to the outcome of this debate with a great deal of anxiety because it

feels itself under similar kinds of scrutiny but without the financial resources to manage those interactions as effectively as the hospital sector.

QUESTIONS FOR MR. FACKLER AND MS. GRONBJERG

DAVID DRANOVE. I would like to thank both discussants for adding valuable new perspectives to our topic today. I would like to just add a comment or two of my own. One of the themes that I observed running through today's session was that perhaps the legal requirements that are going to be facing health care institutions may outstrip the ability of the institutions to develop valid measurements of what they're doing. For example, a valid measure of improvement in community health outcomes. Or a valid measure of uncompensated care; I continue to be amazed that everybody measures uncompensated care by starting with *charges* when uncompensated care should start with what it costs you to deliver the care, not what you charge.

QUESTION. When we talk about uncompensated care are we talking from the view of the provider or the view of the prospective customer? If we are to subsidize the care of the indigent, I'd like to take it from the market perspective of the customer and start with charges. Having come from where I come from, I know the difference between cost and charges.

DAVID DRANOVE. I don't know what the charges are for any given customer. There aren't too many customers, for example, who pay the full charges.

COMMENT. In my business, half the customers pay full charges. And they pay terrific differentials to cover the difference between cost the lesser, which is government reimbursement. It's a disservice to the public not to take that factor into consideration.

WALTER FACKLER. That some customers are subsidizing other customers is what you're really saying. And we do it all the time, of course, with tuition. It's partly whether you're up front about it or whether you try to conceal it. In a university, the people that pay the full tuition subsidize the student aid for those that don't. And we do that in the hospital. The difference between charges and costs is everywhere. We do it at the Chicago Symphony; you don't get the tickets you want for the subscription price. You have to give them a little gift, too. But it's not under the counter. It's all up front.

COMMENT. It's more important to account for uncompensated care to the person that makes that differential payment.

DAVID DRANOVE. I think we're in agreement from the perspective of the hospital trying to document that they are providing charity care. Their charitability is the point to which they're saying we are going to admit someone for whom we believe the revenues will be less than the costs. And any other measure is not a measure of their charitability. But you have the same problem with both the insurers. Wherever you have someone else doing the paying, the third party, you have the problem of accounting to that third party for the uncompensated care you dispense. You have it in terms of what the physician charges. You have it in terms of the insureds, is it worthwhile. If they can pass it on to the employer. And so on. And so there you have that problem and I don't know how you get around it. But it's there.

QUESTION. Professor Fackler, I'm glad you agree with me, that the issue is how you value (putting it in your terms) the tax-exemption subsidy given those organizations. Or maybe one should look at that as some sort of a quick evaluation of the value of the subsidy that's returned. Where we differ is whether or not the value can be put into dollars and cents. You seem very much in support of that. Let me ask you a question. For churches, for example, how would you value their charity care in dollars and cents? What you seem to say is important in determining the value for the exemption of churches.

WALTER FACKLER. I'm going to let the sociologists value God, because I don't know how. If you say the reasons for tax-exemption are traditionally three: God, education, and income transfers (or charity), you still have to make judgments about them. The point I'm making is you can't just say "we don't know; is it worth a million dollars, two million dollars, five billion dollars?" Everybody has to make judgments about what things are worth. Now it's much easier to accumulate costs and say, well, we know what it costs but we don't know how much value has been added. We don't know what's the value that we've added to our students in the business school. I don't know. They're in the University of Chicago generally. Well, there are ways to get at that. You have to value the outcomes. But it seems to me, even though it's difficult, asking the question that they asked in the Utah case is proper, even when you get all kinds of weird jurisdictional differences and so on. As saying, yeah, what are you doing for us?
QUESTION. You need to measure charity care. You need to put it in dollars and cents. You need to recognize the implication of what you're saying. You can't see a way to accurately measure uncompensated care as a dollar amount but you're still confident that it can be done anyway, that a social policy can be built around it. I guess that's where I get confused.
WALTER FACKLER. Well, my response is simply that we have to work from unformed hypothesis in all kinds of social policy decisions. We work with incomplete research all the time.
QUESTION. Why?
WALTER FACKLER. Because resources aren't infinite.
DAVID DRANOVE. Let me give you an example. Suppose that you find that for five million dollars' subsidy to a hospital you can save one infant mortality per year. You have to make a judgment as to whether that's a valuable investment. I can identify five-million-dollar investments that the government can make that will save more than one life per year. For example, just going ahead and installing air bags in automobiles without making it an option for consumers. I mean, we can do it on a cost-effectiveness basis rather than a cost-benefit basis if it troubles you to put a dollar value on a life. So you do have to at least ask what are you getting for your buck.
QUESTION. One of the things I thought I heard this morning sounded like a redefinition of who should benefit from charitability. And something that may be related is the growing number of individuals who cannot pay, cannot qualify for public assistance, have no insurance. And I think this is a growing problem that may be one of the reasons why some of the hospitals feel the need to redefine. I only heard one person talk about indigents.
WALTER FACKLER. It was mentioned briefly but very tangentially. You're right. That when you say charity, what groups qualify and what groups don't, and so on? It's a very important issue.
KIRSTEN GRONBJERG. I think there's an additional side to that issue, which I tried to allude to when I said that we have one of the highest levels of health expenditures in the world, but have major, major gaps in the access and the quality of care that is available. We do have one of the highest levels of infant mortality of any advanced country. We do have many people without access to care, both in inner city areas and in rural communities. These gaps reflect physical problems of where services are located relative to where people live as well as cost barriers—whether or not you have the capacity to come in the door and ensure the health provider that you have the means to pay the costs.
QUESTION. But I think a subtle change that is going on in the public is that more people are becoming concerned about ability to pay, and are going to the support of

uncompensated care simply because more of the people who never thought they would have to even worry about that, are these days having to worry. And, I think, more people are beginning to identify with those who will need and won't be able to pay. It may or may not be a subtle change. But it's a change that is occurring and I think will increase until something is done about health care coverage and benefits.

KIRSTEN GRONBJERG. It's associated with the shift in the structure of the private economy, especially of the growth of service industries and of small businesses. Those tend not to provide fringe benefits or health insurance benefits. So I think you're right that there has been a growth in the population without covered benefits.

DAVID DRANOVE. I have an open question to anybody who may know the answer. It's another point that wasn't brought up. There's one stakeholder in this industry that wasn't mentioned. And that's the bondholder. Most nonprofit hospitals have substantial amounts of debt. And bondholders can place covenants in their bonds in response to perceived changes in hospital strategies. I was wondering if anybody's been involved in the lawsuits and so forth or familiar with bondholders' interests.

COMMENT. I can tell you one of the issues that came out of the tax exemption debate was a look at the bond covenants. And what those bond covenants talked about in terms of making sure of the fiscal responsibility of the hospital. The bondholders wanted to make sure that the hospital would not engage itself in so much free-care activity that its ability to pay back the bonds would be threatened. But I think, and I'm just assuming this, that the bonds became an issue in trying to challenge the fact that the hospital wasn't charitable and the court disregarded that concern.

INTRODUCTION OF THE MICHAEL M. DAVIS LECTURE

ODIN ANDERSON. I have the custom of telling people, particularly those that are under 40 years of age, who Michael M. Davis was. I learned that I had to do that about 10 years ago, because there were many blank faces when I said his name.

Well, Michael M. Davis was a very important person in the debate and study of medical care and health insurance, whether voluntary or governmental, particularly from 1916 on. He was born in 1879, and he died in 1971 at the age of 92. And was actually active right up to his death. A very bubbling person. When George Bugbee and I came here in 1962, friends and admirers of Michael M. Davis wanted to set up The Michael M. Davis Lecture Fund. Mike established this program in 1934. And I wish I had time to tell you about the story behind that within the University of Chicago. But, it is of interest to note that he went first to the medical school and wanted to base it there but he didn't get enough support. Only a couple of mavericks were in favor of having health service administration studied. So he went to the business school. He was a very pragmatic person. He didn't give a hoot where it was as long as it had a base. So he got it established in 1934 with about nine students to begin with. His style was to start something and, when it got going, to go on to something else. Since then there's been a whole series of directors, including even me and now Ronald Andersen. I think you might also say including even him. So this was started in 1963, and the first lecturer was Michael M. Davis. And he gave a very spirited lecture. He was then 84. It was a very touching experience. He got his Ph.D. in sociology in 1906 at Columbia University.

Well after 1934 he was working with the Rosenwald Foundation. The Rosenwald Foundation then liquidated and gave Michael M. Davis $100,000 to do with whatever he pleased as long as it was in the health field; and Rufus Rorem got $100,000 to do whatever he pleased as long as it was in the health field. And true to you might say the American political pluralistic style, and from the same source of funds, Mike set up a committee on research in medical economics, really to promote government health insurance. And Rufus Rorem began to work on the possibility of having voluntary and private health insurance the main vehicle, at least for most of the people. And they'd been working together. In fact, Mike hired Rufus. And Rufus wrote one of these classics on hospital capital and accounting, which is still worth reading.

That was for those under 40. And now I will introduce my friend and colleague, Theodore Marmor. I wanted his vitae, which he sent me, which is six pages long. But fortunately he also had an abstract. So I presume from the abstract, which he wrote himself, this is what he wants to tell you about most. Theodore Marmore received his A.B. and Ph.D. degrees from Harvard University and taught at the Universities of Wisconsin, Minnesota, and Chicago before coming to Yale (being in the Midwest I say *going* to Yale) in 1979 as chairman for the center for health studies. He is professor of Public Management and Political Science in the Yale University School of Organization and Management and Department of Political Science. And from 1974 to 1979 he was a colleague of mine in the center of health administration studies as research associate doing policy research and health insurance and so on and grants from the Johnson Foundation before he went to Yale. He is the author of *The Politics of Medicare* and numerous articles on politics and policies of the welfare state, particularly emphasizing social security, national health insurance, and health planning. A number of these articles have recently appeared in the volume of essays published by Cambridge University Press, *Political Analysis and American Medical Care*. He is an editor and

contributor to *National Health Insurance Conflicting Goals and Choices.* He was editor of the *Journal of Health Policy, Politics and Law* from 1980 to 1984. Professor Marmor served as special assistant to the HEW commission on income maintenance programs from 1968 to 1970, and served on the presidential commission on a national agenda for the 1980s. And was an advisor on health and other domestic policy issues to Democratic presidential candidate Walter Mondale. Professor Marmor is a founding member of the National Academy of Social Insurance and is a fellow of the Canadian Institute for Advanced Research. The title of his Michael M. Davis lecture is "Rhetorical Excess and American Health Politics: The Debate about the Tax Exemption of Nonprofit Hospitals." I am pleased to present my friend and colleague, Ted Marmor.

RHETORICAL EXCESS AND AMERICAN HEALTH POLITICS: THE DEBATE ABOUT THE TAX EXEMPTION OF NONPROFIT HOSPITALS

THEODORE MARMOR: Michael M. Davis was one of those reformers in the world of medical care who combined scholarly gifts and administrative knowledge in the most profound way. His final book, *Today and Tomorrow*, published in 1955, is, to my mind, one of the most probing and thoughtful guides to American medicine in the first half of the twentieth century. It places quite a burden on anyone giving a lecture honoring such a great figure.

My task here is to discuss both the broad study of American politics and the narrow but intense debate over tax exemption for nonprofit hospitals. After making some general points about public policy disputes in America, I turn to their expression in medical care politics over the past decades. With this as background, then, I address the struggle over tax exemption for nonprofit hospitals in American politics today.

I. American Politics

Disputes over public policy in the United States are notably noisy, messy matters. This is true whether the question is support for Star Wars or Supreme Court nominees, tax increases or prayer in the schools. The contestants in every case predictably swat at one another. The particular groups and particular advocates obviously vary, but there is clearly a recurrent process at work. Claims of crisis most typically are made to attract attention, and predictable charges of emotionalism and attention-grabbing soon follow. Appropriate statistical aggregates are trotted out: numbers of Soviet missiles, deficit levels here and abroad. Estimates of the number of homeless, fearless, fearful, or homely are all presented, in print and in speeches, as if their particular truth would entail some ensuing policy conclusion. Fact throwing begets a familiar form of policy analysis—ridicule for the other side and relief, expressed vocally, that one's own position is the right answer. The audience is told that there will be difficulties, of course, but with the political will and a modicum of good luck, the nation can choose the right course and move toward the desirable state of affairs—lower infant mortality, better education, more effective defense, more readily available therapeutic drugs, control over Alzheimer's disease, reduced levels of cancer, and on and on. I call this kind of policy talk "crisis mongering."

The supply of American problems is, by definition, enormous. The simple citation of facts can always establish a gap between aspiration and actuality. And compelling, appealing illustrations can be used both to demonstrate the character of the difficulty and to craft the appropriate remedy. "There ought to be a change. There ought to be something we can do about this," runs the familiar refrain. Precisely what change or what action is "right" is the real core of the dispute.

All of this, I should think, sounds pretty familiar to you. Particular disputes, of course, have their nuances and special differences. And in some cases, no doubt, there is a quite reasonable presentation of problems, options, and likely consequences. But the unruly, often feverish character of our policy disputes remains, as foreign visitors to the United States, from Tocqueville to Thatcher, have noted.

II. Medical Politics in America

Politics in the world of medical care are no exception to this pattern. My aim here is to set the context in medical care developments and disputes over the past twenty years in which the battle we came here to discuss is taking place.

The American medical care world is huge, relentlessly growing, and increasingly controversial. A Rip Van Winkle returning in 1989 would find startling the degree of dispute over the costs, efficiency, quality, and humanity of what it is that American medical care delivers. The nation spent some $600 billion for health care in 1988—distributing these funds to more than 7,000 hospitals, over 500,000 physicians, some 700,000 nurses, a small number of gargantuan pharmaceutical and hospital supply firms, and a large number of small organizations in bio-technical fields, let alone the nation's 140 plus medical schools.[1]

Twenty years ago, all the numbers were much smaller and the disputes centered far more on the opening up of access to a worthy service than on the quality, cost, and appropriateness of what medical care provided. When Medicare and Medicaid began in 1966, the United States spent 6 percent of GNP on health care and only experts worried about whether the national got value for money. Twenty years later, the picture is much different. We spend much more—over 11 percent of GNP—and, according to many observers, have come to feel worse about it. The costliness of this industry is one of the simplest indicators of massive alteration. Indeed, the theme of medical inflation—and the related use of crisis language—are the constants in an otherwise confusing picture of advance and decline, delight and dismay, hopefulness and fearfulness.

This period has also been one of great improvements in health status and increased longevity. Indeed, after modest changes in morbidity and mortality rates during the period 1945-65, both infant mortality rates and life expectancy at age 65 sharply improved. A variety of factors—diet, exercise, drugs, and surgery—contributed to the quite remarkable decrease in the age-adjusted death rates from one of the dread ailments of the 1960s, heart disease. Stroke, along with cancer and cardiovascular disease the three components of the deadly triangle of killers, declined sharply with the introduction of more effective drugs to reduce hypertension. Only cancer resisted this surprising development. The war on it—fought with massive research and clinical expenditures in the 1970s and 1980s—produced no dramatic breakthroughs, though the record of therapeutic improvement was impressive for particular cancers, especially Hodgkin's disease, colon cancer, and some others.

Technological advances, often quite spectacular in character and speed of diffusion, gave many Americans reason for optimism. The promise of medical miracles—the other side of the bargain for the great investment of medical research after the Second World War—seemed less fantasy than fact. The artificial heart became an operational tool—albeit a very disputed one—where once it had seemed only a figment of science fiction. The development of the CAT-scanner and, later, magnetic resonance imaging transformed radiology and made the X-ray machine seem like a model-T Ford. There were, of course, darker features of the medical marvels. Heart-lung machines not only permitted open-heart surgery, but respirators allowed brain-dead patients to live on and on, raising ethical and financial quandaries for doctors, nurses, administrators, insurers, and families that were as troubling as they were novel. Darker still were the fears that medicine, for all its vaunted progress, not only was unable to affect many environmental threats, but was dangerous itself, iatrogenic as Ivan Illich used to say.

Twenty years ago these cautionary concerns of the 1970s had not reached the broader public. The point of Great Society programs like Medicare and Medicaid was to include the aged and the poor in the mainstream of an esteemed world of American medicine. Their means was financial access, not organizational transformation. It was, in effect, something like a nationwide Blue Cross/Blue Shield plan available to the retired and the poor. In the language of the period, health care, like voting and civil rights, was to be guaranteed by law rather than permitted by more powerful others or rationed by ability to pay.

The advances in therapy, and the prospect of continuing medical improvement, were all part of this optimistic vision of American health policy. Looking back, they represented perhaps the last great period of postwar optimism, the conviction that, having won the great war, America could turn energies that had had martial outlets into secular, domestic improvement. Racial tension and urban unrest, the Vietnam War and its inflationary aftermath, and, in medical care, the explosion in costs—all contributed to a dismay at the end of the 1960s that was unforeseen by the enthusiastic backers of the Great Society.

The change in mood was readily apparent in the stance public leaders took toward the state of medicine at the end of the 1960s. There were claims of trouble in practically every quarter, from *Fortune* magazine to congressional finance committee, from Republicans to Democrats. Senator Edward Kennedy's *In Critical Condition: The Crisis in America's Health Care* symbolized the shift from celebrations of possibilities to prophecies of doom.[2] During the 1970s, then, the doomsayers debated not whether, but what form of national health insurance to choose.

In 1989, the picture could hardly be more different, politically, intellectually, and emotionally. Although a few figures of national prominence have recently begun cautious exploration of comprehensive medical coverage for the entire population, the deficits of the Reagan years dominate political discourse and set severe limits to what seems sensible to discuss. Intellectually we are living, to a considerable extent, with the debris of the reform mentality of the 1970s.

Attracted by the gold mine of funds flowing through a system of retrospective, cost-based reimbursement, the captains of capitalism came to see opportunity where the politicians had found causes for complaint. In the hospital world, small chains of for-profit hospitals grew into large companies through the 1970s, spawning nonprofit imitators along the way. HMOs shifted from an almost exclusively nonprofit form to a more mixed picture. Giants like Baxter-Travenol and American Hospital Supply took their conventional dreams of competitive growth and extended them to vertical and horizontal merger.

All of these changes in the structure of American medicine took place within the context of an increasingly anti-regulatory and anti-Washington rhetoric. Democrats and Republicans alike had been influenced by a generation of academic policy analysts—mostly economists—who ridiculed the costliness and captured quality of regulatory agencies—from state rate commissions to licensure boards and the like. The Civil Aeronautics Board and the airlines industry came to represent the distortions likely when government regulates an industry and, with time, the convention of describing any set of related activities with economic significance as an "industry" demythologized medicine as well. So even before the Reagan administration came into office the time was ripe for celebrating "competition" in medicine and getting the government off the industry's back. The irony of course is that the most consequential health initiative during the Reagan period was the introduction of the regulated prices we call DRGs (Diagnosis Related Groups). And the topic of this lecture—the fate of tax exemptions

for nonprofit hospitals—was a very special form of getting government off one's back, to put the point ironically.

So two decades after talk of a medical world "in critical condition," the problem of access continues to be serious, the relative rate of medical inflation continues to outdistance the CPI, and truly extraordinary changes in the rules of the health professional's life have taken place in the $600 billion industry we used to call medicine.

The perspective of crisis, moreover, has become commonplace. The nation's television programs, libraries, newspapers, and magazines literally overwhelm the public with portraits of trouble. Some of the change in the American medical sector is reflected in the site and volume of critical commentary. Whereas once medical care was a specialist's province, it now reaches the public as a topic of governmental or corporate policy in myriad ways. The television networks all have regular health and science reporters who review the most recent disputes over every type of health topic. The nation's newspapers cover the dumping of hospital patients as they once reported scandalous trials. Trade and scholarly journals monitor every nook and cranny of this immense world of medical care. Americans may or may not attend to their own health improvement, but there is no avoiding the subject on television, in the press, and in the publishing world.

The growth of the medical care industry and the commentary on it has not produced anything like an intelligent dialogue about medicine's promise and pitfalls. Quite the opposite. As the subject became more popular, the conventions of American public discourse turned a specialist's world into a series of crises claimed, panaceas presented, and turbulent fights. A content analysis of commentary over the past twenty years would undoubtedly show a precipitous rise in the use of inflammatory rhetoric. Public discussion, in this context, is bound to be bewildering. And indeed, in my view, it is.

III. Misleading Use of Dichotomies

Let me turn now to the debate over tax exemption, from my perspective as a political analyst wondering how to make sense of this subject. That debate, in my opinion, is a combination of complex issues in which the evidence, as we shall see, is inconclusive for drawing policy conclusions and the debate itself is exaggerated and misleading.

Before explaining why this seems so, let us examine how people talk about this issue. Despite the complexity of hospital behavior and the lack of conclusive evidence bearing on tax exemption, some participants in the debate come very quickly to firm but simple-minded policy conclusions.

There are many different ways in which simplistic discussion of American hospitals confuses the tax exemption debate. One is the tendency to confuse glossy brochures with institutional realities; both nonprofit claims of undeniable community service and for-profit boasting about their comparative efficiency are illustrations of what I mean. Another variant of this is the debate in which perfectly intelligent participants present only idealized and deidealized versions of the institution they want to defend or attack. In part this is the adversarial method taken to extremes, but we have had striking examples of this in the debate over the true meaning of the nonprofit form in American medicine. The published exchange of letters between Arnold Relman and Uwe Reinhardt in *THE AMA NEWS* produced caricatures, not coherent claims.[3] Relman found himself forced to defend medical and hospital professionals from the charge that they had nothing on their mind other than making money; he did so not by saying it was

obvious that making decent incomes was central to almost every professional and every nonprofit institution but by making it appear that decent doctors and decent hospitals always put the interests of their patients first. Reinhardt, on the other hand, went from the obvious point that health professionals cannot ignore financial considerations to the obnoxious point that they have nothing else on their minds. The prominence of financial considerations does not establish the absence of other motivations; the presence of serious professionalism does not allow one to ignore the obviously important role of commercialism in American medicine. All of us have a mix of motives between professional obligations and economic self-interest and physicians are certainly no exception. But any effort to describe medical care as either for profit or not is implausible. It is too bad that more attention has not been paid to Professor Robert Evans' effort to deal with this mixed state of affairs through the descriptive category, the not-only-for-profit world of medical care.[4]

This general problem is particularly acute when the economic implications are substantial and the underlying reality fits a spectrum of behaviors that defies dichotomous categorization. This is the case with the debate over whether the differences between the nonprofit and for-profit hospital warrant specially favorable tax treatment to the former. The evidence on the comparative behavior of hospitals—a topic to which I will return shortly to summarize the evidence—certainly supports two propositions. One is that there are systematic differences between for-profit and nonprofit hospitals in a number of areas, differences on average that remain when other causes of differences—like size, location, or patient load—are statistically controlled. The second proposition is that these differences on average emerge despite much overlap in behavior and evidence of growing convergence in response to similar financial incentives. All of this means at the very least that two airtight categories—nonprofit v. for-profit—do not describe well the range of behavior we find in the hospital world. And yet legal decision-making requires judgments of a yes or no character and lawyers are used to working with boxes like nonprofit v. for-profit. But, even if the result is placing hospitals in one or another such category, the important point to remember is what the underlying realities are and how they connect to the rewards and penalties of the legal categorization.[5]

There is a related point about the mismatch between the origins of the nonprofit form in American law and the realities of nonprofit hospital finance today. Hospitals grew up through donations; they were an example, in legal jargon, of donative nonprofit organizations, where charitable giving supplied the financial basis of operations. The modern American hospital, it is obvious, is radically different in sources of finance. Hospitals sustain themselves from the income patient care brings in, whether from private health insurance, public health insurance, or self-paying patients. On this basis, hospitals are excellent examples of commercial nonprofits, commercial in the limited sense that payment for services, not voluntary donations, is their major source of income. And by commercial I mean nothing at all connected with corner-cutting, financial zeal, or the like. In short, the changing realities of American hospital finance have broken the clear connection between donative financing and non-taxation of hospital income. To tax donations (either at source or at site) makes them less attractive to donors. But whatever can be said of museums, or even commercial nonprofits like private universities, decades have passed since the donative rationale for tax exemption made much sense for hospitals. The more important feature of the nonprofit form, to which I will return shortly, is its prohibition of stock ownership and private gain in that form. It is this aspect of nonprofit status, rather than tax treatment, that seems crucial to maintaining the links between hospitals and their geographical communities.

Let me review briefly some of the evidence about the effect form of ownership has on health care. With respect to cost, only small, inconsistent differences appear in reported costs of both for-profit and nonprofit hospitals, although for-profit nursing homes consistently have lower average costs than their nonprofit counterparts. With respect to quality of care, there seem to be few if any measurable differences in those facilities where physicians control delivery of care, regardless of ownership form. Where physicians play a less active role, however, the evidence suggests that lower quality care is found in for-profit settings. There is also fairly consistent evidence that for-profit facilities are disproportionately represented among institutions offering the very lowest quality care. In terms of access to care, it is clear that private nonprofit and for-profit health providers each engage in some screening of patients, by locating a facility away from low income areas, by not providing services used disproportionately by the underinsured and the uninsured, or by actively discouraging admission of those unable to pay for care. Evidence from past studies suggests that for-profit providers are more likely to use each of these methods, regardless of the degree of control exercised by doctors.[6]

Let me now give you a personal illustration of the kind of difference these data refer to. Several years ago a former student of mine from the University of Chicago, now working at Yale and married to a Polish graduate student, called me in tears with the most unbelievable story. Her mother-in-law had come from Poland to the United States on Friday to visit her son and new daughter-in-law. On Saturday morning she had a massive stroke and was taken to Yale-New Haven hospital for treatment. She died within a few days. The bill for her treatment was, as you can well imagine, far beyond anything that this young graduate student couple could face. Even worse, the mother-in-law had arranged some kind of travel insurance that she thought would cover this sort of problem, but didn't. So this young woman had not only to deal with this extraordinary experience of shock and dismay, but she believed she was threatened with financial disaster. I promised to do whatever I could to help. I called the head of the hospital and said, "You know, Mr. X, every once in a while a test of the central mission of an organization comes up, a test that distinguishes one place from another. I have one for you." After I described the situation, he promised to take care of it. He told me to assure the young couple that there would be no bill.

That story illustrates a theme about the work of a hospital with a tradition of hospital administration which gave this administrator the confidence that this board would understand why he made such a promise. If you had put the same story to the vice president of American Medical International, a chain of for-profit hospitals, he probably would have responded in somewhat the same words he actually used in an interview a few years back: "You don't expect Safeway and A&P to give away free food to people who can't afford it, do you?" I find this comment one of the most vulgar I have ever heard in the American medical world. He should have been fired as a result of that, because his message was bound to come back and hurt his organization at some later time.

These two stories capture the difference in, and the feelings attached to, the mission statements of nonprofit and for-profit hospitals. I use them to show how impossible it is, in my view, to get from the evidence about the central tendencies of nonprofit and for-profit institutions into the legal boxes that have been supplied for us. This is a particularly difficult problem when you have a dichotomous treatment that brings with it very substantial economic benefit, as in the case with the tax-exempt hospital. The incentives to try to get under the more profitable tent are very strong. The conclusion I have to come to is that there are features of the nonprofit hospital

world that seem to me very important, but separate from, the whole issue of tax exemption.

What strikes me as important about the nonprofit status of a hospital has everything to do with the question of who owns the hospital and where the hospital is located and how likely it is that the hospital is going to stay there for a substantial period of time. Let me explain a little more what I mean by this. Our discussion earlier in this symposium of private gain, concentrated almost exclusively on the possibilities of side payments to hospital physicians as a way of gaining their loyalty—a kind of bargain or deal—by which the hospital may have been used to transfer economic advantages to a set of subconstituents of the hospital. I have in mind something quite different.

In the dreamy world of the 1970s, it was not unusual to find people describing a future for American medicine in which a small number of large firms would own most American hospitals and HMOs. One of the points about the tax-exemption debate that seems important and undernourished in our consideration is the extent to which our fears about the future of American hospitals have to do not only with change but with corporate ownership of shares, and the implications of that form of ownership for the buying and selling of hospitals and the changing of where it is that hospitals do their work. One does not have to say, for example, that nonprofits are not commercial enterprises, because, as I have said before, they are. What one can say, however, is that the economic incentives facing commercial nonprofits are different from those facing for-profit organizations. Net revenues—translated into share prices and the value of those shares available to their owners—are what are crucial for the for-profit institution. Size alone is not the important matter. Prestige, size, and other things may be surrogates in the nonprofit world. But I urge you to think for a bit about whether, independent of tax exemption, we do not consider the nonprofit status—the barring of dividends and shareholders—a crucial element, giving us the feeling that claims of connection to the community have some durability over time.

IV. The Tax-Exemption Quandary

Now, how does the inconclusive evidence on the differences between nonprofit, for-profit, and governmental hospitals bear on the policy choices that we are actually facing in the nonprofit world? There is obviously some urgency about this question. The Internal Revenue Service as well as municipalities seem ready to act. Congress seems prepared to look into this issue. And looking for a sensible choice may not lead you to the optimal one, because the optimal one may not be available.

Let me describe for you five policy paths I see as possible. The first two—the all or nothing approaches—would be simple to follow but wrong, in my estimation. The other three are all on the right track but all will be difficult. You will see why I find myself in a quandary.

The Do Nothing Approach

The simplest thing to do would be to leave things exactly the way they are. This would be wrong, partly because both the perception of the American public and the law have moved beyond the point of being comfortable with the current behavior and legal status of the American hospital. Quite apart from the details that we may know, the view that all is okay is simply too complacent. The judicial reasoning in the Intermountain case is striking precisely because of the use of convergence, which they

claim has taken place despite the evidence that I was talking about, as a basis for arguing against such sharp distinctions between for-profits and nonprofits. This is another example of a fallacy: claiming that organizational forms have moved closer together is not the same as saying they are identical.

I disagree with the frequently made claim that this public perception can be turned around pretty easily. One of the casualties of the last two decades of entrepreneurial enthusiasm in American medicine has been a real blurring of a sense of distinctive mission for the nonprofit world. That blurring has to be attended to, rather than ignored as though it never happened.

Abolish the Exemption Completely

The second option, conceptually simple and wrongheaded, is to abolish the exemption immediately, completely, and thereby, allegedly, level the playing field. What makes this option so utterly wrong is that it ignores all the evidence that there are, on average, systematic differences between for-profits and nonprofits. Then, without any special effort, the playing field will be one on which many hospitals do not want to play, or one on which the players will all resemble the for-profit form and produce the market failure that Walter Fackler talked about earlier—the systematic and predictable market failures suggested by the locational and service-mix decisions of the most aggressive of the for-profits.

Maintain Tax Exemption for "Worthy" Nonprofits

This third option, although more on the right track, would be terribly hard to implement. This path can be eloquently described as long as one concentrates on the future. This is because the tendency to confuse what is with what should be or will be is very great. Many in the industry will tell you that we have strayed from the true path, that it is a time for rededication. And it may well be. But it is hard to get the case for rededication out of the flurry of behavior that we have seen in the last decade. This option, and this rededication, would involve two very tough jobs—one internal to the hospital world and a second, maybe more difficult, communicating that well to the outside world.

I do not mean to take an evangelistic tone here—that would be against my principles. Although I never knew Michael M. Davis, I sense from his books a carefully controlled passion that is part of what I want to convey to you today about the nonprofit mission. If the claim of a special mission is to be taken seriously, then it is important to identify institutions that, following that mission, do something special, warranting either tax exemption or some other form of special treatment that may be more appropriately targeted than tax exemption. If this is the goal, then, I assure you, one will not be able to reach it through either the language of horizontal and vertical integration, or the rhetoric of health marketing and medical holding companies. These symbols—however appealing in some sectors—are inappropriate to health care because they deny the noncommercial elements that have been so important to those who chose to work in, or to support, nonprofit health institutions. Business rhetoric played for a time, particularly during the period of confusion in the 1970s over how to deal with rampant medical inflation amid economic stagnation. We are probably ten years and hundreds of billions of dollars in outlays too late for engaging in that kind of simple talk. Medical care's organization is no longer simply a scholarly dispute. It has turned to fury, fury worsened by the increasing pool of the uninsured in the 1980s. The new payment mechanisms

have made it much harder for hospitals to engage in the easy cross-subsidization that used to be the case and that used to mask some of the less profitable forms of care.

Although I want to say something nice about this option, I find the concept of community benefit—both what the benefit is and what constitutes the community—very troubling. What virtue means in the medical world in this context is a very uncertain matter but one worth worrying about. What would it take to inspire people to behave well in this industry? How can we get audiences to actually appreciate that good behavior? How do we take into account the disturbing behavior they have already seen? How do you talk about this with a mix of modesty and hopefulness rather than a mix of arrogance and cleverness? Those seem to be the tough choices that deciding to reward the worthy nonprofits would entail.

Tax Exemption for Nonprofits in Proportion to their Social Contribution

This too has conceptual merit but would be very difficult to do. Nonprofits would be able to write off particular socially relevant items. The trouble with this is that setting payment rules that drive a lot of behavior this way requires increased monitoring costs. The monitoring of every aspect of hospital behavior would entail surveillance that defeats part of the original nonprofit conception itself. So the remedy undermines its own rationale and it is likely to result in simple-minded accounting and clever manipulation.

The Unspoken Solution—National Health Insurance

No one today has mentioned the fifth and equally difficult alternative by name, although some have referred to "universal access." This must be a new code world for national financing of hospital and medical care. It is interesting that the lingo we choose to use reflects our fears rather than our hopes.

If we believed charity care to be the defining characteristic of the hospital, governmental health insurance, one would think, would in fact destroy the nonprofit hospital. In practice this does not appear to be the case. Engage in a thought experiment about this by moving yourself north to Canada, where they have had universal hospital and medical insurance since 1971. Ask yourself why the nonprofit hospital, the dominant form of ownership of hospitals in the period before national health insurance, has in no significant way been replaced by government-owned and managed hospitals. Or transplant yourself to Britain where voluntarism in government-owned hospitals has not diminished, because the hospitals have a geographic focus that makes them feel, to their clientele, like "their" hospital. So even government ownership of hospitals need not drive out the desirable elements one associates with the nonprofit form.

Now engage in another thought experiment, about what you would like to see nonprofit hospitals do, especially if the financial question about how to pay for the care they provided were firmly settled by some kind of financing device. That experiment would seem to me very useful as one tries to sort out the question of tax exemption for hospitals.

In closing, I want to return to Michael Davis. Toward the end of his professional career, this wise person said that the important thing was to understand your past but not be imprisoned by it, and not to think that the faults of the present make the future's difficulties any easier. This is not a counsel of easy caution and casual optimism. But it strikes me that through the debate over treatment of the nonprofit hospital under the

tax code, it is possible to reach almost all of the important moral, social, and medical issues facing American hospitals. The tax-exemption issue is a window through which to look not only at the present and the immediate past, but the troubled future of both the American hospital and the larger world of American medical care.

ENDNOTES

[1]For more elaborate discussion of the developments discussed in this section in a variety of contexts, see T. R. Marmor, "Commentary," *Case Western Reserve Law Review*, Vol. 36, No. 4, 1985-1986, 686-92; "Health Policy in Historical Perspective, A Review Essay," *Journal of Policy History*, Vol. 1, No. 1, 1989, 108-28.

[2]Kennedy, E. M. *In Critical Condition: The Crisis in America's Health Care* (New York: Simon & Schuster, 1972).

[3]See, for instance, *Health Affairs*, Summer 1986, pp. 5-31.

[4]Evans, Robert G. *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworth & Co., 1984), part 2, chapter 7.

[5]The relevance of comparative hospital studies to the tax exemption debate is complicated by methodological disputes. But all the studies reveal overlapping distributions. Some for-profits act in ways that are, if not identical, quite similar to their nonprofit counterparts. Equally, some nonprofits seem to resemble the most entrepreneurial characters in the medical world.

[6]Theodore R. Marmor, Mark Schlesinger, and Richard W. Smithey, "Nonprofit Organizations and Health Care," in W. W. Powell (Ed.), *The Nonprofit Sector: A Research Handbook* (Yale University Press: New Haven, CT, 1987), pp. 221-239. More detailed data are available from that chapter.

QUESTIONS FOR MR. MARMOR

QUESTION. You've given us five alternatives toward a direction for answering the tax exemption debate. I'm not quite sure where to get out of this dilemma. Can you give us some guidelines, perhaps indicate which answer you lean towards?

THEODORE MARMOR. What needs to be done, it seems to me, is to make plain what distinctive social contributions are made by hospitals who claim the status of nonprofit. To measure it insofar as you can measure it and describe it insofar as you can honestly and accurately describe it. I think what's important is to get away from the view that because you have the legal status of a nonprofit that gives any special warrant for describing you as a socially valuable institution. It no longer does in the modern world. And so I share the view of those who believe that you might have two categories at least of nonprofits. Those that are given relatively better treatment and those that are not, even though you might want to retain the nonprofit status because of the ownership point I was making. What I would like to suggest is that people think of either the tax exemption or other forms of social subsidy to reward behavior consistent with the nonprofit mission, and not assume that the legal form insures it.

QUESTION. You made a passing reference to pilot programs, payment in lieu of taxes, and said you were going to come back to that.

THEODORE MARMOR. I didn't because I was mindful of the time. I think it's very important, frankly, to distinguish the case for tax exemption or other forms of social subsidy to continue missions that are given special rationales. They wouldn't have been created in the way they were, public goods and the like, if they didn't make some return to local communities. But I thought, for example, it was a great mistake to treat the local Vermont community as if it had no claim on some form of compensation for the public services that were provided to the hospitals. Because the original justification had nothing to do with hospitals being decent places. It had everything to do with hospitals functioning with resources that were donations. You can't make that case now. It seems to me particularly in cities like Pittsburgh, and other places where the nonprofit world has grown so large, that either you want to get away from property taxes as a form of financing or you've got to contribute. But what you should contribute is something in the form of user taxes. Not something connected with your revenues. What's important is not to make others pay disproportionately for the ingredients to the production process. And, frankly, this argument applies just as much to universities as it does to hospitals. It's a matter of catching our tax treatment and our legal rules with the modern hospital without throwing the baby out with the bathwater.

COMMENT. Being a hospital administrator or a physician or a nurse these days is a sort of a thankless, confusing job. I have to congratulate you on at least pointing the compass back in the direction of what a lot of us I think got into this area of public service for in the first place, and that was to try to find a rational way to provide something that had some business rationale, incorporated public policy and some social contribution with it at the same time. And that's sort of where the discussion today has headed. To put the equity of our activity back toward taking care of our patients and our community, and directing just a little bit less attention and energy toward diversification and all of these other business-related, rather than people-related issues.

THEODORE MARMOR. There's one point I wanted to make in connection with that. I hope you took away a message of something other than speaking nobly about the hospital world. What I was trying to say at the very least that's responsive to your point, is that you're in a world of the not-only-for-profit institution. That's Bob Evans' phrase

and it's very clever. Any effort to describe you or me as a world of selfless altruists with vows of poverty and selflessness is bound to seem fraudulent. But it's not fraudulent to say that the objectives of an institution that you want to be in or I want to be in are not going to be measured by our stock price or on an income level. Institutions differ in their capacity to draw people. Now I think the difficulty is that justice took place in the insurance industry in the 1940s and 1950s. You have to worry about the terms of competition when the players are coming from different legal circumstances. It was very hard on Blue Cross to deal with insurance companies that didn't believe in community rating because experience rating gave them ways of creaming the population which have analogies in locational decision-making. There are tough areas of what form of competition to allow between forms. And I think there's a something to be said for not worrying whether the nonprofit hospital deserves its exemption; but to be concerned about hospitals that don't behave according to certain rules governing where they go, or what they have available. We should be concerned that an indirect form of skimming does not occur. So I leave with you that: the not-only-for-profit way is a serious effort to speak to critics who will be very quick to discover self-congratulation or foolishness in the more simpleminded formulation.

QUESTION. In your third path you talked about distinguishing between those nonprofits that perhaps deserve exemption and those that didn't. And I actually agree with that sort of world. The question I have is, knowing the constraints of government, would you rather see government making those determinations or would you rather see those determinations delegated to voluntary determinations such as what Bob described? Do you have an opinion as to whether ultimately, or in this case, government should delegate to a private agency the ability to make the distinction between those nonprofits who are entitled to the tax exemption and those who are not?

THEODORE MARMOR. My guess is that we've become too cynical to permit an absolutely easy delegation. We have had more decades than not of skepticism concerning self-regulation. But that doesn't lead me to the view that the most important contributors to what would count as superior behavior won't come from within the industry. It seems, above all, if I were to give advice, I would urge communication between the IRS and the organized world of hospitals. Bringing a clear understanding that you can't get away from describing any behavior that sounds good as an example of it. And really wrestle with what are decent indicators of minimum qualifications. The trouble with reward in a very subtle way is that ipso facto review or prior review is unlikely to be a very fine grain instrument to base reward on. What I would urge you to do is to treat the effort to designate the conception of the minimal acceptable hospital mission and activities as something which is a matter of negotiation and bargaining between the government and the industry. And not a matter of submission or domination one way or the other.

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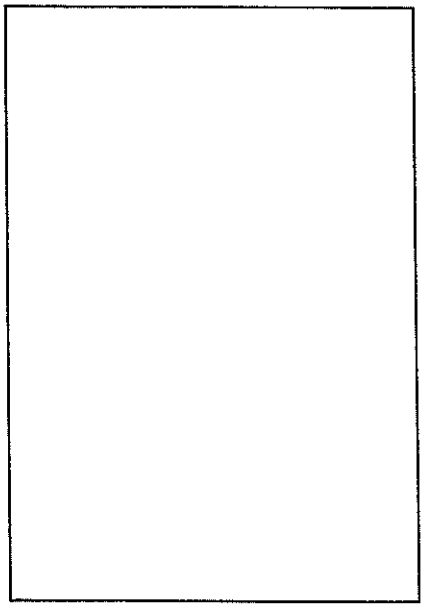

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