COLLOQUIUM REPORT ON
LEGAL ISSUES RELATED TO TAX EXEMPTION AND COMMUNITY BENEFIT

NATIONAL HEALTH LAWYERS ASSOCIATION
CONTRIBUTORS

NHLA is grateful to the many supporters of the Colloquium on Legal Issues Related to Tax Exemption and Community Benefit and the Colloquium Report. The commitment they have shown to NHLA’s public interest mission is deeply appreciated.

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NATIONAL HEALTH LAWYERS ASSOCIATION
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PREFACE

In the Public Interest

This Report is the result of the Colloquium on Legal Issues Related to Tax Exemption and Community Benefit held under the sponsorship of the National Health Lawyers Association (NHLA) in Washington, DC, on October 20 and 21, 1995.

An essential component of the NHLA mission is “to serve as a public resource on selected healthcare legal issues.” Assisted over the years by the support and input received from our membership concerning the Association’s public interest activities, NHLA has provided a non-partisan forum for representatives of major constituency groups to debate and examine a full range of specific legal issues on activities in the public interest. In 1995, NHLA designed the Colloquium to focus on tax exemption and community benefit and to clarify the intersection of social policy and tax policy through a rigorous legal analysis of accountability standards and community benefit. The Colloquium was structured to create opportunities for twenty-four representatives from institutional providers (tax-exempt and for-profit), HMOs and managed care systems, insurers, medical societies, federal and local governments, and academia to have practical impact on the substantive debate regarding the future of tax-exempt healthcare organizations.

The Colloquium was designed to meet the following objectives:

• To provide a neutral forum that promoted a frank exchange of views and analysis related to tax exemption and community benefit among various constituency groups with different and sometimes adverse points of view; to explore the basis for those differences; and to identify ways and means of accommodating the differences in the course of pursuing their respective missions to serve the public interest.

• To crystallize the intersection of legal, policy and social issues relating to tax exemption and to conduct a vigorous examination of accountability standards and measurements in an effort to maximize service in the public interest.

• To create opportunities for representatives of different groups to identify shared goals and interests and to develop potential collaborative working relationships.

• To publish a Report based on the findings of the Colloquium that would have practical impact on the substantive debate regarding the future of the tax-exempt healthcare sector. To disseminate the Report to NHLA members, participating constituency groups, policy makers,
and others in order to educate key players in the debate and those who are charged with advising clients on these matters and implementing and meeting standards of accountability.

• To provide an environment throughout the Colloquium that allowed for the free exchange of views and articulation of tensions, while preserving confidentiality and appropriate anonymity for Colloquium participants in the Report.

Over the past several years, much debate has ensued regarding the need for and values of tax exemption in the healthcare industry as dramatic structural changes have emerged. Exempt HMOs, hospitals, and other healthcare organizations are aggressively marketing their services, seeking to align their incentives with those of physicians, and probing for available funding to fuel this important change. With the actual corporate behavior of exempt and taxable health industry organizations becoming more and more similar, it is not surprising that healthcare leaders and policy makers argue whether the public interest is truly served through the advantages accorded exempt organizations.

The twenty-four individuals assembled for this Colloquium brought to the table many insightful, and at times colorful, perspectives that served to highlight the importance that this debate will play in future policy making that will affect all who are touched by the healthcare industry. To best utilize the enormous talents of those who volunteered their time to participate, they explored twenty-three core questions in the following four categories: policy issues; measurement, reporting, and enforcement issues; jurisdictional issues; and accountability issues. The resulting interaction was provocative and challenging and provided the seeds for identification of constructive means of accommodating differing opinions on this subject while providing pragmatic views of the health industry's future if tax exemption were removed.

The challenge in assembling this Report was to capture the intensity and spirit of the Colloquium debate. I hope the participants, as well as other constituencies that utilize the information contained in the Report agree that common ground on this issue can be reached in the public interest. Furthermore, to various healthcare constituency groups who bear responsibility for stewardship of resources in the public interest, this Report includes several innovative ideas to assist in this most difficult role. Applause and thanks to the participants and all involved in planning the Colloquium and in making this Report possible.

Michael F. Anthony, Esquire
1995–96 Chair
NHLA Public Interest Committee
It is with deep gratitude that the National Health Lawyers Association recognizes the commitment and support of those volunteers and Association members whose dedication to the public interest resulted in the Colloquium on Legal Issues Related to Tax Exemption and Community Benefit and the publication of this Colloquium Report. In addition, the National Health Lawyers Association is indebted to the generous contributors, listed on the inside back cover of this Report, without whose support the Colloquium and Report would not have been possible.

Members of the NHLA Board of Directors and, in particular, those who served on the 1995–96 Public Interest Committee devoted countless hours in bringing this public interest Colloquium to fruition. Special thanks go to James L. Hall, Jr., Esquire, President of the Association, and to Michael F. Anthony, Esquire, Chair of the Public Interest Committee, whose leadership was an essential component in bringing the Colloquium from concept to reality.

And finally, the National Health Lawyers Association extends profound thanks to the Colloquium participants themselves, listed on page xi of this Report. Their keen intelligence and dynamic interaction are testament to those in the health industry who struggle to reconcile market forces and the inexorable drive toward cost containment with humanism and the general welfare of the health of the American community. Surely without their dedication there would not have been the opportunity to inform the debate on these critical issues or to enhance the quality of the delivery of healthcare in the United States.
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COLLOQUIUM REPORT
ON
LEGAL ISSUES RELATED TO TAX EXEMPTION AND COMMUNITY BENEFIT
I. BACKGROUND OF THE COMMUNITY BENEFIT STANDARD

“The power to tax involves the power to destroy.”
— Chief Justice John Marshall, 
McCulloch v. Maryland (1819)

“[A] gift to a general public use, which extends to the poor as well as to the rich.”
— An 18th century Lord Chancellor of England’s definition of charity, 
Jones v. Williams, 2 Amb. 651.

INTRODUCTION

The inexorable forces reshaping the American healthcare system — the march of managed care and intensified competition driving hospitals and physicians to form new, integrated delivery systems; the pressure from payors to strive for the least costly and most efficient methods of curing or ameliorating illness; the demise of fee-for-service, cost-based reimbursement and the ascendancy of prospective payment, capitation and discounted care — have brought inescapable new demands upon nonprofit healthcare organizations to justify their tax exemptions and demonstrate to the satisfaction of regulators, rivals and the public alike what they contribute to improving the health of their communities.

Evidence of these demands abounds. Rival hospital chains and alliances produce dueling studies denigrating or defending the charitable contributions of exempt organizations. At every level of government, from the local property tax assessor’s office to the state department of taxation to the halls of Congress and the corridors of the Internal Revenue Service (IRS), policy makers want to know: What return does society receive for the tax revenues forgone from nonprofit hospitals, healthcare facilities and providers?

Investor-owned hospitals argue they provide many of the same services, from community health screenings to charity care in their emergency rooms and surgical-medical wards, to writing off the inevitable bad debts, that their tax-exempt competitors tout as part of their
community benefit. They also assert that the taxes they pay provide a further benefit to the community that exempt organizations fail to match.

**Hospitals’ Charitable Roots**

Privileged tax status for many hospitals and other healthcare institutions has a long and venerable history, with the notion of community benefit dating back to English common law. It became enshrined in a pivotal 1969 IRS ruling and remains the shield that exempt health organizations cling to in fending off the tax collectors’ challenges.

In an era when almost one in six Americans goes uninsured despite the expenditure of one-seventh of the gross domestic product on health, and where there is little or no prospect that the public or politicians will tolerate higher taxes to alleviate this imbalance, heightened scrutiny of nonprofit providers’ advantaged tax status was inevitable. Many of the nation’s largest and most prestigious 501(c)(3) medical institutions have heard the tax agents’ knock on their doors. In Utah, Texas, Pennsylvania, Indiana, Vermont, Massachusetts, California and elsewhere, nonprofit hospitals whose value to their communities once went unquestioned now face unremitting demands to document how they justify their exemptions.

Pressures from third-party payors — private and government alike — have compelled hospitals and other providers to stop hiding the cross subsidies in their charges and to keep rates in line with the actual cost of delivering each paying patient’s care. With 300,000 hospital beds empty each night, specialists hunting for work in parts of the country, and even patients with Cadillac-type coverage discharged days and weeks ahead of their counterparts of a generation ago, this rigorous examination of the tax-exempt status of healthcare organizations is only beginning.

Some believe it was long overdue. For too long, they argue, exemptions were handed out or left unquestioned for institutions with only the most tenuous of charitable ties. As legal scholar John Colombo noted:

> Our society has never really come to grips with what it wants in exchange for tax exemption. The concept of charity tends to be applied on an ‘I know it when I see it’ basis, which may be fine for lunchtime debates but is an unsatisfactory method for administering the tax laws. Nowhere are these problems more apparent than in the healthcare field, where hospitals began as poorhouses and now constitute multi-billion dollar business entities.¹

Care for the sick long has been regarded as an act of charity under U.S. law. The Utah Supreme Court, which grappled with the exemption question in a noted 1985 case, explained: “Nonprofit hospitals were traditionally treated as tax-exempt charitable institutions because, until late in the 19th century, they were true charities providing custodial care for those who were both sick and poor.” The sick and dying lived out their final days in these institutions with little prospect of remission. Those with the wherewithal to avoid hospitalization did so, for the risks of contagion or iatrogenic injury greatly exceeded the likelihood of cure. It was not until modern times that hospitals shed that image, as advances in medicine allowed the healing institutions to send the preponderance of patients home instead of to the graveyard.

Many nonprofit hospitals retained an air of penury well into the mid-20th century. They operated on the financial edge, counting on civic-minded trustees to bail them out of the inevitable bind. These were treasured community resources, admired all the more for their perennial struggle to make ends meet. Although not as lean as the typical big city public hospital with teeming charity wards, the nonprofits relied on charity to fuel their growth. They financed their expansion with building drives and appeals to benefactors to buy the high technology equipment and hire the specialists and skilled staffs who made the miracles of modern medicine possible, from catheterization and open-heart surgery to kidney dialysis and lithotripsy.

For decades, these institutions operated not according to strict business principles, but with a faith in the future and the presumption that what served the community also worked best for the welfare of the hospital — and vice versa.

With the explosive growth of employment-based private health insurance after World War II and the advent of Medicare and Medicaid in the 1960s, the American healthcare system reinvented itself and became a very big business, no less so for the nonprofit sector than for the investor-owned facilities with which the tax-exempt hospitals increasingly vied for market share.

Hospitals no longer had to write off care for legions of the elderly and poor. Hill-Burton funding and Medicare’s capital payments financed an explosion of new construction (and set the stage for today’s surfeit of beds). This burgeoning industry by necessity paid more attention to the bottom line. Hospitals, investor-owned and nonprofit alike, began operating as what they were: no longer purely eleemosynary institutions

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for the poor, but vast, complex, labor- and capital-intensive enterprises with operating budgets that quickly ran into the tens and hundreds of millions of dollars.

**THE IRS AND COMMUNITY BENEFIT**

From the inception of the federal income tax, a large majority of hospitals have enjoyed exemption from federal taxation. While healthcare is not singled out in Section 501(c)(3) of the Internal Revenue Code, hospitals always fit squarely under the category of “charitable” organizations that qualified for exemption, along with universities, churches and other nonprofit pillars of society.

For four decades the IRS has employed special rules for judging whether a hospital merited 501(c)(3) charitable exemption. The first rules were published in 1956 in Revenue Ruling 56-185, or the “financial ability” or free care standard as it came to be known. It laid out a four-part test for hospital exemption:

- It must be organized on a nonprofit basis to care for the sick.
- The hospital to the extent of its financial ability had to serve those unable to pay for services, not just paying customers.
- It had to maintain an open staff and not restrict use of the hospital facilities to a particular group of physicians.
- Like other 501(c)(3) organizations, its earnings could not inure, directly or indirectly, to any private shareholder or individual.

Three years later, the Agency acknowledged for the first time that charity was not confined to relief for the poor. In 1959 regulations defining “charitable” purposes, the Agency decreed that the term “charitable” was used in its generally accepted legal sense. There was no direct mention of health in the 1959 rules. But they laid the groundwork for the issuance of Revenue Ruling 69-545, discussed below.

The “financial ability” standard proved difficult to enforce. It was far from a model of clarity. Hospital executives complained loudly to their representatives in Congress that IRS examiners, uncomfortable with the ambiguities of how to gauge the financial ability of these multi-million dollar institutions, had begun telling hospitals flatly that if they wanted to retain their tax exemptions, they had to earmark five percent of patient days to charity care.

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3 Rev. Rul. 56-185, 1956-1 C.B. 202  
As expressed earlier, the passage of the Social Security Amendments of 1965, which created both Medicare and Medicaid, transformed millions of the elderly and poor into paying customers for hospitals, physicians and other providers. In that Great Society era, many believed that charity care was a thing of the past and that the country would proceed apace to universal coverage.

This proved to be wildly off the mark, but the optimistic belief left its imprint on a major policy change the IRS set forth in 1969 for tax-exempt healthcare organizations: the community benefit standard.

Revenue Ruling 69-545 moved beyond the ambiguous financial ability standard that required hospitals to provide as much free care as they could afford. Community benefit, not charity care, became the touchstone for providers’ exemptions.

The new IRS rules stated that the “promotion of health ... is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as [the] indigent.” A hospital could qualify for exemption under these new criteria by:

- Operating a full-time emergency room open to all, regardless of ability to pay.
- Providing hospital care for everyone able to pay either themselves, through private insurance or with the help of public programs such as Medicare.
- Demonstrating that it is operated to serve public rather than private interests, by having a board of directors drawn from the community, an open medical staff, and applying any surplus to improving facilities, equipment, patient care and medical education and research.

This was a wide swing of the pendulum. The ruling implied that a hospital could remain exempt even if it routinely shipped off poor or uninsured non-emergency patients to a public facility. This raised eyebrows on Capitol Hill, where before 12 months elapsed the Democratic staff of the Senate Finance Committee was agitating for the revocation of Ruling 69-545. A phalanx of health and welfare rights organizations sued the Nixon Administration Treasury Secretary William Simon, contending the regulation was tantamount to slamming hospital doors in the face of the poor.

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But the United States Court of Appeals for the District of Columbia rebuffed their class action lawsuit and upheld the Agency's broader interpretation of the charitable exemption. Noting that private philanthropy had given way to Medicare, Medicaid and other government sources of care for the poor, the appellate court said it “appears that the rationale upon which the limited definition of ‘charitable’ was predicated has largely disappeared. To continue to base the ‘charitable’ status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of healthcare.”6

In 1983, in Revenue Ruling 83-157,7 the IRS allowed that under certain circumstances, even hospitals without emergency rooms could qualify for exemption under the community benefit standard, such as when a state health planning agency determined that opening yet another emergency department in a community would be a waste of resources. This ruling also recognized that specialized facilities such as eye and cancer hospitals seldom treated patients needing emergency care. (Subsequently, the IRS has taken pains to emphasize that these specialized hospitals without emergency rooms are the exception, not the rule, and that most acute care hospitals must run a 24-hour emergency room if they want to remain exempt.)

Although the United States has been unwilling or unable to ensure health coverage for everyone within its borders, Americans also have been loathe to leave anyone in dire medical straits without access to hospital care. Congress enacted an anti-patient dumping statute in the Consolidated Omnibus Budget Reconciliation Act of 19858 that requires all hospitals in the Medicare program to treat patients in emergencies, regardless of ability to pay; tougher compliance requirements were added in 1989. A visible reminder of that law can be found posted in every emergency department, where signs conspicuously remind patients of their right to be treated regardless of ability to pay in a medical emergency. Hospitals also must keep records for five years on emergency patients they transfer.

The IRS rarely attempts to revoke a healthcare organization’s tax exemption. The isolated instances in which the Agency has acted usually involve private inurement, in which insiders have sought to enrich themselves at the expense of the exempt enterprise.

The explosion of joint ventures, spinoffs and subsidiaries created by nonprofit and investor-owned healthcare facilities alike has compli-

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cated the question of tax exemption. A 1980 Tax Court decision\(^9\) allowing a theater group to retain its exemption despite its partnership with private individuals and a for-profit company opened the door for the growth of joint ventures between exempt hospitals, physicians and other providers organized for profit.

The very size and success of many nonprofit hospitals, and their growing involvement in enterprises far afield from in-patient care, have intensified this scrutiny of their tax-exempt status. A 1990 General Accounting Office study concluded 15 percent of the nation's nonprofit hospitals provided less charity care than the value of their tax exemptions.\(^10\)

Bills were introduced in Congress in 1991 to require nonprofit hospitals to deliver certain levels of charity care. They produced hearings, but no action.

The IRS, while never attempting to reimpose the more stringent free care standard on exempt hospitals, did not shrink from demanding evidence of concrete commitment to the poor and uninsured from new types of entities seeking 501(c)(3) exemptions, including joint ventures by exempt organizations with physicians and other for-profit organizations.

In the landmark Friendly Hills Healthcare Network deal in 1993, in which a California foundation paid physicians $120 million for a hospital, clinics and other assets, the IRS granted the foundation a tax exemption only after satisfying itself that the new organization would treat Medicaid patients, provide charity care and engage in medical research. Its January 29, 1993 letter ruling also noted that the foundation would keep doing the bedrock obligations of tax-exempt healthcare providers: running a hospital with an open medical staff and a 24-hour emergency room and treating both Medicare and Medi-Cal patients, as well as conducting medical research and education.\(^11\)

The Agency also has demanded evidence of free care in other cases involving integrated delivery systems, most notably in its legal fight with the Geisinger Health Plan. There the Agency clearly signaled that the promotion of health and the absence of private inurement were not by themselves sufficient for Geisinger's new health plan to qualify for the exempt status its parent enjoyed. The HMO-style plan was an integral part of the Geisinger System, a comprehensive Pennsylvania healthcare

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organization that included two hospitals and a clinic with 501(c)(3) exemptions. The Agency told Geisinger its health plan failed the community benefit test because it provided benefits solely to subscribers and not the community at large. The Agency faulted the plan for serving Medicaid patients inadequately and cherry picking risks. The Tax Court initially overturned the Agency's denial of the exemption, but the Third Circuit Court of Appeals reversed that ruling. Subsequently, the Third Circuit ruled that the Geisinger Health Plan also failed to qualify for exemption as an “integral part” of a healthcare system.

Like parents unable to restore a disciplinary edict once they relaxed it, the Agency's executives felt powerless — absent orders from Congress — to reimpose the free care standard of the 1950s on hospitals once they had become accustomed to the more lenient community benefit standard.

PRESSURE FROM STATE AND LOCAL AUTHORITIES

If the federal tax collectors shied away from a straight calculus of free care versus the costs of tax exemption, state and local authorities have shown no such disinclination.

Federal 501(c)(3) status never provided a blanket exemption from state and local taxation. Aggressive local tax collectors in Pennsylvania, Vermont, Utah, Indiana and elsewhere have succeeded in forcing non-profit hospitals to pay millions in lieu of property taxes. The state of Texas in 1993 enacted a law requiring exempt hospitals to spend 4 percent of revenues on charity care and an additional 1 percent providing community benefit. It also imposed extensive reporting requirements on the hospitals.

A state official explained the rationale to a congressional subcommittee: “In Texas, we believe that hospitals should be held accountable to their communities for their tax-exempt benefits. As charitable, tax-exempt institutions, they are stewards for millions of public dollars .... It is the provision of community benefits, including charity care, that largely differentiates the services of tax-exempt hospitals from those of tax-paying hospitals.” Texas enacted its law after jousting with 820-bed Methodist Hospital in Houston over how much charity care it provided. Methodist defended itself in court and prevailed; the hospital calculated

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12 Geisinger Health Plan v. Commissioner, 985 F.2nd 1210 (3d Cir. 1993).
13 Geisinger Health Plan v. Commissioner, 30 F.3d 494 (3d Cir. 1994).
it spent $21 million on community benefits, or 5 percent of its 1995 revenues — more than the state requirement.

In Massachusetts, the Office of the Attorney General issued community benefit guidelines for nonprofit acute care hospitals in June 1994 that require the 75 hospitals and four health systems to prepare a “Community Benefits Mission Statement,” delineate the specific community or communities they serve, and submit annual reports to the Attorney General. “Across the nation, nonprofit acute care hospitals — the linchpin of our current healthcare system — are renewing their historic charitable mission,” the Guidelines stated. Among the compelling reasons it cited for the regulatory thrust were taxpayers’ concern “in an era of fiscal austerity, that there be accountability for privileges and benefits bestowed.”16

Massachusetts Attorney General Scott Harshbarger amplified the state’s motivation in a speech to healthcare leaders:

There is a community benefits revolution going on in cities and towns across New England and all across the country. It started in response to a prevailing community view that nonprofit hospitals were acting just like any other big businesses in town. And they were losing sight of the historical connection between community and hospital. Hospitals are being forced to re-examine their charitable mission because local, state and federal authorities are taking a close look at a nonprofit’s right to financial subsidies, such as exemption from taxation. Tax breaks are based upon the carrying out of a charitable mission. And that charitable mission can no longer be limited to acute in-patient care largely aimed at insured citizens.17

The initial draft of the Massachusetts Guidelines stipulated that hospitals would have to spend on community benefits 2 to 6 percent of total patient operating revenues, depending on their size. But the final June 1994 Guidelines deferred this standard for two years to give the hospitals an opportunity to demonstrate how they were fulfilling their obligations without such a rigid yardstick. Another reason for the deferral was that the state discovered the nonprofit hospitals already were spending an average of 1.5 percent of total patient costs on unreimbursed free care. Massachusetts now is weighing the hospitals’ first accountability reports, even while the Attorney General’s office prepares final guidelines for nonprofit health maintenance organizations.

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17 Harshbarger, Scott, Attorney General, Commonwealth of Massachusetts, address to the New England Health Care Assembly, April 13, 1995.
The longest legal struggle over exemption was played out in Utah, where the State Legislature in 1973 adopted the federal community benefit standards for determining whether nonprofit hospitals qualified for exemption from property taxes. In 1980, the Utah County Board of Equalization challenged the tax exemptions of two Intermountain Healthcare hospitals. On appeal, the Utah State Tax Commission upheld the exempt status of the hospitals. In 1985, the Utah Supreme Court set aside the 1973 legislative standards and proposed a six-legged test for property tax exemption. Those guidelines proved ambiguous; in 1990, the State Tax Commission replaced them with a half dozen new standards, including a requirement that nonprofit hospitals and nursing homes confer annually with county boards of equalization and that the institution “establish that its total gift to the community exceeds on an annual basis its property tax liability for that year.” Indigent care, community education and service, discounts for Medicare and Medicaid care, volunteer hours and donations of money to the nonprofit hospital or nursing home all counted toward this annual “gift to the community.” These standards were upheld by the Utah Supreme Court.

New York began requiring its hospitals to develop community service plans in 1990 as part of a prospective reimbursement methodology for all hospitals, regardless of taxable status. California lawmakers in 1993 voted to require nonprofit hospitals to complete an annual community needs assessment starting January 1, 1996, and to adopt a community benefit plan by April 1, 1996.

Legislatures in nearly a dozen other states have debated similar measures, some with more teeth. A bill before the Florida Senate in 1994 would have forced nonprofit hospitals to pay a 6 percent state sales tax unless they devoted more than 3.7 percent of their revenues to charity care. The 3.7 percent figure was supposed to match the amount of uncompensated care that investor-owned hospitals in Florida claimed they were providing without the benefits of tax exemption. The bill did not pass.

19 Howell, Cache County Assessor v. County Board of Cache County ex rel. IHC Hospitals, Inc., Logan Regional Hospital, 881 P.2d 880 (1994).
21 1994 Fl. S.B. 2710.
Voluntary Efforts

Leaders of the nonprofit health industry have applied their shoulders to the community benefit wheel. The Voluntary Hospitals of America — an alliance formed in the late 1970s by nonprofit facilities apprehensive over the growth of investor-owned competitors — produced its own community benefit standards in 1992 that speak to the need for hospitals “to expand their circle of concern beyond individual clinical care to the entire health of the community.” The VHA guide elaborated:

While public attention to hospital community benefits has arisen from government's challenges to not-for-profit hospitals' tax-exempt status, these institutions have recognized that a re-examination of hospital community benefits is more than a means for satisfying such government challenges. These challenges, reflective of a general decline in the public's trust of our voluntary healthcare institutions, are also an opportunity to honestly examine how well we have demonstrated stewardship for the health of our communities, how well we have maximized our ability to improve health status and how we can improve.22

VHA and the SunHealth Alliance presented a forceful case for the tax-exempt sector in a joint document, “Realizing the Broader Vision: The Continuing Role of America's Not-for-Profit Healthcare Organizations.”23 It summarized the arguments that the investor-owned sector was raising against tax exemption and sought to parry those thrusts:

[Some] for-profit companies maintain that not-for-profit healthcare organizations are no longer delivering a value to society that equals or exceeds the support they receive through tax exemption. They argue that investor-owned providers are more efficient, more accountable to their owners and offer comparable levels of community service — plus the added contribution of taxes paid to local, state and federal governments. They conclude that since all healthcare organizations are in business to sell similar services, governments should eliminate the ‘unfair’ advantage afforded to not-for-profit institutions through their tax-exempt status. But there are significant differences ... despite surface similarities in structure and strategy. Not-for-profit institutions embrace a vision of healthcare that looks beyond profits to broader service to patients and communities.24

24 (ibid.)
On a separate track, the Hospital Community Benefit Standard Program was launched with help from the Kellogg Foundation in 1989 under the leadership of Robert Sigmond, Anthony R. Kovner, Paul A. Hattis and others at New York University to encourage nonprofit hospitals to undergo scrutiny of their community benefit efforts, much as they would seek accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). It was a noble attempt to move hospitals, in Sigmond’s blunt phrase, “beyond the body shop mentality” and into the business of bolstering the health of entire communities. Despite support from the Hospital Research and Education Trust connected with the American Hospital Association and encomiums from a broad spectrum of healthcare leaders, this voluntary program failed to advance beyond the demonstration stage.

Other organizations including the Catholic Health Association took their own crack at trying to focus attention on the importance of community benefits by requiring member hospitals to prepare “social accountability budgets” that quantified their contributions.

Exempt providers are keenly aware that even without challenges or changes in their tax status, the dramatic changes in the marketplace could have a profound impact on their ability to carry out the missions to which they historically have been committed. The community benefit standard, to some minds, remains clouded by uncertainties and ambiguities. It is an area in which fear of the dead hand of bureaucracy inhibits even the most community-minded nonprofit healthcare providers from demanding clear answers to the question: Exactly what does society expect in return for exemption?

It was the persistence of this tension, indeed the tug-of-war over tax exemption in the healthcare field that prompted the Public Interest Committee of the National Health Lawyers Association to convene the Colloquium on Legal Issues Related to Tax Exemption and Community Benefit on Oct. 20–21, 1995.
II. MAJOR LEGAL AND POLICY QUESTIONS

The organizers of the Colloquium identified in advance nearly two dozen core legal and policy issues on the topic of tax exemption and community benefit. These issues were divided into four core question areas: (1) policy issues; (2) measurement, reporting and enforcement issues; (3) jurisdictional issues; and (4) accountability issues. They served as the springboard for the two-day discussion and are listed below in their entirety. For the convenience of the reader, the core questions are repeated in Section III as they relate to the four individual summary discussions.

#1: POLICY ISSUES

- What is the current basis for according tax-exempt status to a hospital or other healthcare organization? How has this basis shifted over the years?
- Are the issues underlying the question of whether healthcare organizations should be entitled to tax exemption in certain circumstances primarily legal questions or primarily political questions?
- Are the legal issues that should be considered in deciding whether healthcare organizations should be accorded tax-exempt status different in any substantial way than the legal issues relevant to deciding whether any type of organization should be accorded tax-exempt status? Is the promotion of health itself a qualifying exempt purpose?
- Is the original charitable purpose of care for the indigent still relevant in today’s managed healthcare marketplace?
- What are the benefits to a healthcare provider or insurer from being tax exempt?
- Should a tax-exempt organization lose its exemption if it earns too large a net income on earnings or fails to use such earnings in identifiable public interest projects within a set time frame?
• Should a tax-exempt organization lose its exemption if its net income is too large? If it pays salaries similar to those in fair price marketplace? If it is conducted ‘as a business’?
• Do the benefits of tax-exempt status put those health industry entities that are not tax exempt at a significant competitive disadvantage?

#2: MEASUREMENT, REPORTING AND ENFORCEMENT ISSUES

• If some entities should continue to be entitled to tax-exempt status, what is the best mechanism for enforcing continued adherence to any applicable requirements?
• What are the various factors that influence enforcement activities by the Internal Revenue Service?
• How should private inurement be measured? Are intermediate sanctions advisable?
• If tax exemption is a privilege (which it is), how does the exempt healthcare entity measure its consideration for the exemption and distinguish its community service from that of proprietary health industry entities?
• Should the basis for granting tax exemption to a healthcare organization relate to some numerical formula that balances community contributions against the cost of forgone taxes?
• Should community benefit be defined in solely, or even largely, numerical terms related to uncompensated care? Are taxes paid considered community benefit?

#3: JURISDICTIONAL ISSUES

• Should exemption from federal taxes automatically entitle an entity to exemption from state and local taxes?
• Is it legal for local and state governments to offer entities that meet the legal requirements for continued recognition as tax-exempt organizations an opportunity to participate in programs through which such entities make payment in lieu of taxes or provide services?
• What are the ancillary (other than Internal Revenue Code) statutory and regulatory changes that should be made if the tax exemption for healthcare industry entities were eliminated?
• Are there areas that are important to the community that would be negatively affected by a decision not to accord tax-exempt status to qualified healthcare entities?

#4: ACCOUNTABILITY ISSUES

• Should tax-exempt organizations be required to submit on some periodic basis reports that justify their continued tax-exempt status? To whom? For what distribution?
• What factors can the tax-exempt healthcare entity use to provide that the involvement in a specific managed care initiative or arrangement meets the community benefit standard?
• Is government specification of private board composition an appropriate method of enforcing accountability among tax-exempt healthcare systems, HMOs, and hospitals?
• How can a more inclusive yet stricter definition of “community benefit” be expressed in legal terms?
• To what extent should issues such as personnel policies and compensation, competitive activity, and corporate structure be factors in deciding whether an entity should be accorded tax-exemption status?
III. SUMMARY OF DISCUSSIONS: CONSENSUS AND POINTS OF TENSION

The Colloquium participants — leading members of the healthcare bar, experts from academe, prominent regulators and leaders from both the nonprofit and investor-owned healthcare industry — spent two days discussing the fundamental driving questions at the heart of community benefit and tax exemption. While grappling with the core questions, the participants attempted to discern both the major areas of agreement and disagreement. The format allowed for separate discussion of the four major issue categories (policy issues; measurement, reporting and enforcement issues; jurisdictional issues; and accountability issues) led by facilitators, followed by small group workshops that sought to synthesize the discussion in each of these four key areas.

The following is a synopsis of their discussions. Each of the four major areas lists the relevant core questions, followed by a box summarizing the major areas of consensus and points of tension or disagreement, as well as issues that the group felt needed further exploration beyond the scope of the Colloquium.
ISSUES

Core Questions
• What is the current basis for according tax-exempt status to a hospital or other healthcare organization? How has this basis shifted over the years?

• Are the issues underlying the question of whether healthcare organizations should be entitled to tax exemption in certain circumstances primarily legal questions or primarily political questions?

• Are the legal issues that should be considered in deciding whether healthcare organizations should be accorded tax-exempt status different in any substantial way than the legal issues relevant to deciding whether any type of organization should be accorded tax-exempt status? Is the promotion of health itself a qualifying exempt purpose?

• Is the original charitable purpose of care for the indigent still relevant in today’s managed healthcare marketplace?

• What are the benefits to a healthcare provider or insurer from being tax exempt?

• Should a tax-exempt organization lose its exemption if it earns too large a net income on earnings or fails to use such earnings in identifiable public interest projects within a set time frame?

• Should a tax-exempt organization lose its exemption if its net income is too large? If it pays salaries similar to those in fair price marketplace? If it is conducted ‘as a business’?

• Do the benefits of tax-exempt status put those health industry entities that are not tax exempt at a significant competitive disadvantage?
Major Areas of Consensus, Points of Tension and Unresolved Issues

**CONSENSUS**
- Community benefit, not just free care, is the appropriate focus for public policy.
- Community benefit should equal at least the substantial tax and other benefits conveyed to the institution by virtue of its exemption from income and property taxes.
- Exempt providers’ financial statements should juxtapose the value of community benefit against the forgone tax revenues.

**POINTS OF TENSION**
- Can a numerical standard for community benefit be imposed or developed?
- Do investor-owned hospitals ultimately provide the same level and types of community benefit as tax-exempt hospitals but without the advantage of tax relief?
- Should tax-exempt health maintenance organizations be held to the same requirements as hospitals for meeting their community benefit obligations?

**UNRESOLVED**
- The community benefit standard was created in an era when inpatient hospital care was still the heart of the healthcare enterprise. The policy has not caught up with the reality that most care today is given outside the hospital and delivered through HMOs and other forms of integrated delivery systems.
The Colloquium participants grappled from the outset with fundamental questions about the basis for according tax-exempt status to healthcare organizations, how such organizations can meet their community benefit obligations and what distinguishes tax-exempt providers from their taxable, for-profit competitors.

A participant from the nonprofit world described the problem that confronts exempt healthcare providers. They are faced daily with confusing, inconsistent and nonuniform regulation and interpretations by federal, state and local taxing authorities, and by growing demands from regulators and rivals to justify their exempt status. They resist attempts to pin down what community benefits they must provide, but chafe at the frustrations of living under the current ambiguous standard while the real value of exemption erodes rapidly around them. They realize the need for legislative clarity in this arena, but are reluctant to push the issue for fear of opening Pandora’s Box and losing the tax privileges they now enjoy. In a phrase, the nonprofit providers are “very schizophrenic about this issue.”

This lack of clarity becomes all the more frustrating as the nonprofits scramble to create new undertakings and launch joint ventures in a market in which the risks are shifting rapidly from insurers to providers. Their lawyers are hard-pressed to convince the Agency that these new entities fit under the nonprofit tent. But the exempt providers, by their actions or inactions, have elected to live with this confusion over the rigmarole and expense of meeting rigid rules on how much to expend on community benefit.

Regulators in Washington are well aware of the confusion of the status quo, but feel powerless to return to the free care standard of the 1950s absent clear instructions from Congress. The 1969 IRS Revenue Ruling 69-545 that enshrined community benefit as the touchstone of exemption for healthcare providers was constructed on a glaringly faulty premise: that charity care would soon become a thing of the past for American hospitals.

The investor-owned hospitals, for their part, resent the “holier-than-thou” attitude evinced by some of their 501(c)(3) competitors and do not shrink from demanding that the nonprofit hospitals produce hard numbers to back up their claims of greater contributions to the community. Their deep-seated suspicion is that many of these tax-exempt entities talk a better community benefits game than they deliver. Some in the investor-owned sector are eager to stack up what they pay in property and income taxes plus charity care against the contributions that exempt providers make.
With some obvious exceptions — such as Columbia/HCA Healthcare Corporation's skirmishes with nonprofit hospitals over exemption in Florida and Tennessee, and demands by states that the nonprofits quantify their charitable exemptions — this battle is played out behind the scenes. The for-profit providers, with their own complex tax battles with the IRS, have refrained from mounting a major challenge to the community benefit standard, however much it chafes them that the tax code may give their rivals an edge. The Agency seems locked in place, awaiting new orders from Congress that never come. Even the Clinton administration, which showed no reluctance to tilt at windmills in framing its short-lived universal health insurance proposal, left the ground rules for exemption largely intact in the massive 1,243-page Health Security Act it proposed in November 1993 while adding just one new requirement: the provider must assess the health needs of its community at least annually and develop a plan to meet those needs. This would have applied to any tax-exempt charitable healthcare organization, including hospitals, HMOs, nursing homes, clinics and home health agencies. A Senate committee later grafted mandatory outreach and charity care provisions to that short-lived bill.

When you strip away the onion of the current law, one Colloquium participant said, all that may really be required for exemption is that an organization promote health and operate on a nonprofit basis.

Indeed, for hospitals, it was suggested, the Agency uses a very straightforward test for 501(c)(3) status: Does the hospital have an emergency room staffed around the clock? Does it participate in Medicare and Medicaid? Does it have an open medical staff? Is the governing board not controlled by physicians or other insiders? Is there no private inurement?

The investor-owned industry argues that except for their governance and distribution of profits, their hospitals could meet virtually all these other tests for exemption. Even some at the Colloquium from the nonprofit world conceded that if charity care were the sole criteria, it might be hard to distinguish the for-profits and nonprofit providers. It was acknowledged that some nonprofit healthcare organizations do little to justify their exemptions. A proponent of stricter community benefit requirements claimed that as many as 90 percent of exempt providers may be out of compliance with today's lax community benefit standards without even knowing it.

26 Foley, Maurice B., Deputy Tax Legislative Counsel, Department of the Treasury, testimony before the House Committee on Ways and Means Subcommittee on Select Revenue Measures, Dec. 14, 1993.
So what distinguishes these two worlds?

The nonprofit participants argued that it was a matter of mission and a question of character, not merely governance. Their charter, the nonprofits said, puts the health of the community first, whereas investor-owned providers must tend to the interests of stockholders. The nonprofits aver with pride that they have stood in the front ranks pushing for universal coverage and community rating. Their facilities house the burn units, the 24-hour-a-day trauma centers, and the high cost oncology services, programs for hemophiliacs and other low demand services vital to community health, but injurious to the bottom line, they argue. For the investor-owned hospitals, community benefit activities are merely a marketing tool, at least in the eyes of the nonprofit providers.

But the nonprofit medical world came in for its own criticism at the Colloquium.

Some tax-exempt hospitals use community benefit activities as a marketing tool, too, orchestrated by “the case hustler crowd,” one critic said. Furthermore, no one driving up East Monument Street in Baltimore would mistake Johns Hopkins Hospital and University for a fragile, nonprofit institution. Its chief executive makes more than $1 million a year, and hundreds of Hopkins doctors earn half as much. Institutions like this exist, in large measure, not to improve community health, but “to enhance the economic status of the people who work in them,” this speaker said. “The reason we look to these institutions for the crumbs that they throw into community outreach is because all the other energy is over treating, over medicating, over attending well-insured people.”

No one disputed that there is much profit in many tax-exempt institutions. Few hospitals follow the Salvation Army for their operating model.

But other voices at the Colloquium defended the robustness of some tax-exempt healthcare providers and warned of the fragility of others. New York City’s largest academic health centers finished 1993 with barely enough cash on hand to meet the next week’s payroll and other expenses. Massive, tax-exempt hospitals may stand fortress-like in the midst of blighted cities, but they remain a major local employer and are often one of the few industries not to abandon the inner city.

What purpose would be served by a tax policy that sought to keep hospitals economically fragile?

If success is to be penalized or avoided, it was asked, how does one avoid the evils of the welfare state? There is nothing antithetical between operating like a business and meeting obligations to the community, the defenders of the nonprofit world said. A nonprofit hospital not run on a sound business footing will not long provide either community or medical benefits.
What benefits do hospitals and other providers derive from their tax exemptions?

The Colloquium heard a litany of benefits that providers gain from being tax-exempt. They go well beyond not having to pay taxes on earnings and, in most jurisdictions, not paying property taxes. Tax-exempt status makes an organization eligible for government grants, and allows donors to claim a tax deduction for gifts to the facility. It helps them attract board members who view their service as an in-kind donation to a charitable enterprise and who otherwise might be unwilling to lend their time and expertise. Exemption undergirds and supports their educational and research missions (although it was noted that academic medical centers might qualify for exemption separately as educational institutions if there were no exemption for them as healthcare providers). For 501(c)(3) organizations — but not 501(c)(4)s — exempt status also affords access to the tax-exempt financing markets.

But the need to raise new capital is spurring some nonprofits, including a growing number of Blue Cross and Blue Shield plans, to abandon tax-exempt status and convert to mutual and other forms of proprietary ownership. In the current changing market, the IRS will not be getting many new applications for 501(c)(3) exemptions from hospitals, one speaker said.

If a hospital or health plan is losing money, exemption from income taxes may not actually save it a cent. But relief from ad valorem property taxes is a valuable bonus for any enterprise. One unidentified nonprofit organization estimated that its exemption and access to lower cost capital was worth $40 million a year, its entire operating margin.

For some, the nonprofit side argued, exemption provides not just a fiscal cushion but a moral mandate to keep providing services that may subtract from the bottom line but add benefit to the community. An investor-owned health plan that went into an underserved community and recruited members who could not afford to pay might be considered to be breaching its fiduciary duty by certain of its shareholders. But a tax-exempt plan has both the flexibility and, to some minds, the obligation to look for such customers. Exemption may make it possible for a health plan to keep offering a community rated product, or for a hospital to keep its burn unit open.

However faulty the IRS’s premise for its shift from a free care to the community benefit standard in 1969, it was suggested at the Colloquium that the Agency’s emphasis on community benefit was prescient and anticipated the current emphasis in healthcare on finding ways to improve the outcomes for entire groups, not just treating individuals when they fall ill.
Community benefit should not be confused with the “warm and fuzzy” community service activities in which hospitals always have engaged. These activities seldom were organized in any way that could produce demonstrable results, much less be used to hold hospital executives accountable for improvements. Most community service activity produces little or no benefit beyond making people feel good, it was said. (At least one prominent exception was noted: the chief executive officer of Cambridge Community Hospital in Massachusetts, who helped turn around that institution’s fortunes by emphasizing community benefit and tied his own compensation in part to the results.27)

The goal of those within the tax-exempt healthcare sector who have led the community benefit movement has been to encourage their colleagues to refocus on and discover what was for many their founding purpose: meeting the health needs of their communities. They admit that much of the momentum behind the movement has been defensive, growing out of the widely perceived need to blunt efforts by regulators to force the nonprofits to make concrete their platitudes about providing community benefit. Only when the potential loss of exempt status was viewed as a serious threat did the movement gain much momentum, one participant said.

At the Colloquium, as in any forum where this debate has been joined, representatives of investor-owned providers argued vigorously that nonprofit organizations have no monopoly on community benefit. Columbia/HCA Corporation, the largest investor-owned chain with 325 hospitals and over 100 surgery centers, calculates that it paid over $1 billion in taxes in 1994 — and provided $800 million in charity care to boot. The investor-owned hospitals contend that if they failed to provide significant community benefits, they would soon be out of business. They want the qualifications for exemption narrowly drawn, and insist that exempt providers spell out exactly what benefits they are providing for the community. They stand on common ground here with regulators and local tax collectors, who make the same demands.

In Washington, it was noted, the IRS never has so much as attempted to dictate precisely what community a nonprofit healthcare provider must serve. It leaves that definition to the healthcare organizations themselves.

The other major current that ran through the Colloquium’s discussion of the policy issues was how to apply the notion of community benefit

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27 Jill Sherer, Linking incomes & outcomes: hospital CEO salaries may eventually be connected to medical outcomes, 68 Hosp. & Health Networks 38 (Feb. 20, 1994).
to exempt providers other than hospitals, such as health maintenance organizations and other new types of integrated delivery systems.

If hospitals are wary of attempts to count or mandate how much they must contribute to charity or community benefit, HMOs are even more disturbed at the prospect of being measured by the same yardstick. HMOs pride themselves on years of commitment to prevention and improved outcomes; that is their contribution to community benefit, they say. Because a premise of managed care is that these plans can reduce in-hospital stays and expenditures while achieving better health outcomes, it makes no sense to require HMOs to provide a fixed amount of acute care services, the Colloquium was told. The contribution of HMOs and other managed care plans is keeping people out of the hospital, not providing free care to those who fall sick. No one hospital or health plan can claim to hold the key to the health of Los Angeles. But an HMO or plan that finds ways to improve the delivery of care can have an affect far broader than its own caseload of patients or membership roster, it was argued. Nonetheless, one speaker’s assertion that “free care does not necessarily apply in an HMO setting” sparked immediate dissent and debate.

It was suggested that the public expects all exempt providers to deliver free or reduced price care for the needy, and any organization — hospital or HMO — that fails to do so simply is not worthy of exemption.

But a note of caution again was raised about the temptation to couch the exemption solely in terms of free care. Should that come to pass, the distinction between for-profit and nonprofit providers would be further blurred. And what need would there be for a tax-exempt hospital in Beverly Hills, CA, or some other wealthy enclave?

The nonprofits’ answer was that there is much suffering, even in Beverly Hills. A hospital there might justify its tax exemption with a program to reduce the incidence of alcohol abuse among males from 12 percent to 8 percent, it was suggested. A skeptic replied that the reality is health plans and hospitals that scour Beverly Hills to sign up well-insured alcoholics for treatment in their facilities will conduct no such search in the barrios of Los Angeles.

The Colloquium reviewed what happens when an exempt organization is acquired by a for-profit organization. Most of the action here has been on the state level, where state attorneys general have played the lead regulatory role in dealing with such conversions. The IRS insists on nondistribution constraints. In some instances, such as with Blue Cross of California and its for-profit Wellpoint Health Systems, new charitable foundations are created as a way of paying back the benefits that accrued to an organization from years of exemption. Some attorneys
general have regarded these foundations more as a bonus than an actual cashing out of the exempt organization's obligations, the Colloquium was told. The regulators assume that the new, for-profit entity is not going to take on many of its parent's charitable activities, so the foundation is there to do what the parent was doing, or should have been doing.

The inherent difficulties of trying to define exactly how much community benefit an exempt organization is obliged to deliver led one participant to suggest in frustration that perhaps it was time to look outside this box and tax everybody. Organizations that incurred expenses providing community benefits could earn the money back, whereas those that took a pass would get nothing. A concern was voiced that nonprofit providers would be left in the worst of both worlds if stripped of their exemption and forced to compete without help from the tax code or the financial backing of investors. Whatever their mission or character, the formerly exempt organizations might lack the wherewithal to perform good works.
#2: Measurement, Reporting and Enforcement Issues

Core Questions

• If some entities should continue to be entitled to tax-exempt status, what is the best mechanism for enforcing continued adherence to any applicable requirements?

• What are the various factors that influence enforcement activities by the Internal Revenue Service?

• How should private inurement be measured? Are intermediate sanctions advisable?

• If tax exemption is a privilege (which it is), how does the exempt healthcare entity measure its consideration for the exemption and distinguish its community service from that of proprietary health industry entities?

• Should the basis for granting tax exemption to a healthcare organization relate to some numerical formula that balances community contributions against the cost of forgone taxes?

• Should community benefit be defined in solely, or even largely, numerical terms related to uncompensated care? Are taxes paid considered community benefit?
Major Areas of Consensus, Points of Tension and Unresolved Issues

**Consensus**

- Objective measures of community benefit are needed. The “trust me” approach is inadequate.
- Process measures are the antecedent to quality measures.
- Some quid pro quo should exist between community benefit and forgone tax revenues.
- Charity care is not the sole measure of community benefit.
- Intermediate sanctions are needed for breaches of the ban on private inurement for 501(c)(3) organizations.

**Points of Tension**

- Should physician participation in governance and management of exempt organizations be limited to the extent it is today so long as appropriate community benefit is delivered?
- What can be quantified toward meeting a provider’s community benefit obligations?
- Do taxable healthcare organizations provide charity care and other community benefit equivalent to exempt providers?
- Who should measure an exempt provider’s community benefits — the federal government, state and local regulators, or the exempt providers themselves?
- Are formal reporting tools effective and useful to regulators and the public?

**Unresolved**

- Whether the tax code is the proper vehicle for influencing how exempt healthcare entities behave.
The Colloquium wrestled with the question of how the government should enforce the difference between taxable and tax-exempt healthcare organizations, assuming that tax exemption stays in some form. It began by reviewing the tools used by the IRS and others for measuring and enforcing community benefit requirements.

The current system relies on audits; reporting requirements; the Agency's own educational efforts to let the tax-exempt sector know what is expected; peer pressure and public disclosure, from bringing to light the compensation of top executives of 501(c)(3) organizations to the signs posted in emergency rooms about hospitals' obligations to provide emergency care; the taxes and applications process; civil actions and criminal prosecutions; and the Agency's board composition rules, namely its insistence that physicians control no more than 20 percent of the seats on new, exempt organizations. One participant suggested that bond counsel also play a key enforcement role of tax-exempt status, because without their signatures nonprofit hospitals and other entities cannot access the bond markets for capital.

Another tool was suggested: the government could lend recognition to an accreditation program for community benefits, just as Medicare now has a deemed status accreditation program with the JCAHO. But others warned that if the IRS tried to make such accreditation mandatory as a condition for tax exemption, it would ignite a political firefight. Putting peer and regulatory pressure on hospitals is one thing, but threatening to revoke their exemption for non-compliance is something else altogether. If one part of a healthcare system failed to meet the community benefit threshold and lost exempt status, the entire system's bonds could fall into default. As one speaker observed wryly, shifting $1.5 billion in debt from a tax-exempt rate to a taxable rate “would be a career-limiting opportunity for a number of individuals.”

The Hospital Community Benefit Standards Program at New York University (NYU) took the approach that community benefit had to be measured in a multitude of ways, much as quality in healthcare is assessed. No single number or score on a hospital's accreditation report is the sole determinant of quality. The Hospital Community Benefit Standards Program looked to specific initiatives that hospitals undertook to benefit their communities, and at the concrete goals set for those initiatives. That made it possible to measure what results they achieved, and also facilitated a judgment on whether the goals were meaningful.
The American Hospital Association, the VHA and several other organizations have developed tools to assist hospitals in developing an inventory of community services. The Catholic Health Association of the United States (CHA) has moved aggressively in this direction with its “social accountability budget,” which sets forth a formal mechanism for identifying community needs and performing an inventory of services that a not-for-profit organization is providing. The CHA’s six-step process stops short of imposing a numerical requirement for how much a provider must expend on community benefit. The CHA members are still at the early stage of dialogue with their various communities to identify needs and ways to meet them.

Despite the inherent difficulties in moving from a subjective judgment to an objective standard, it was argued that anything important enough to be talked about can be counted. Something so intangible that it cannot be measured should not be accepted as community benefit, one participant said. A hospital that sets a goal of reducing the number of pregnant teenagers who receive no care until the last trimester can chart the results of its pre-natal care initiative. Measuring success on other fronts may pose greater difficulty, such as deciding how to value the research conducted by a nonprofit provider. But if healthcare executives are given the right incentives — such as tying their own compensation packages to the results — they will find ways to demonstrate and deliver on their commitment to improving the health of their communities, several participants said. Never underestimate the capacity and creativity of CEOs to design truly innovative, aggressive plans to address and measure community benefit once it becomes an imperative and important to them, Colloquium participants noted.

The pitfall is avoiding a measurement and enforcement model that gives more weight to process than results. Any attempt to draw a sharp line is fraught with difficulties. Hospitals may devote time and resources to fulfilling procedural requirements when that energy could have gone into better serving the community, participants from the nonprofit side warned.

Some felt the JCAHO accreditation procedures were exactly the wrong model for weighing community benefit. The Joint Commission grades a hospital on a scale of 1 to 5 on how it is complying with a host of quality improvement procedures. But the visiting JCAHO team asks not how many people died at a hospital during a given procedure, but what the hospital measures to know that patients are not dying unnecessarily. A hospital can score points for the medical journals in its library, the fire extinguishers on its walls and the plaque in the front hall attesting that it is already accredited — none of which speak directly to the current quality of care, one speaker complained.
Exempt providers should not be judged by how many shots they gave at a health fair nor by the National Committee for Quality Assurance’s Health Employer Data Information Set (HEDIS), but by Medicare mortality and like data, one speaker said.

The greatest demand for objective measures comes from the state regulators, who know from experience that what cannot be defined cannot be enforced. The regulators in Texas and elsewhere who have resorted to stringent, quantifiable standards for charity care or community benefit acknowledge their measures are far from perfect — but they are enforceable and provide some assurance that a provider at least meets a floor requirement for serving its community. Without measurable, tangible standards, the enforcers lack credibility and face all the classic prosecutorial nonenforcement problems, including lack of uniformity and an inability to educate providers about what is expected, the Colloquium was told.

Texas opted not to measure exempt hospitals against each other, but against their own economic base in requiring them to spend at least 4 percent of revenues on charity care. Initially the draft Texas statute did not specify a percentage of revenue, but it was added to the bill at the behest of the Texas Hospital Association, whose members preferred knowing exactly what they were facing.

Massachusetts, for its part, considered imposing a minimum requirement for community benefit expenditures, but heeded the arguments of the apostles of the community benefit movement and opted instead to give hospitals wider latitude for the first two years. Massachusetts decided that improving health outcomes was more important than meeting a fixed spending target. It did so in part from concern that hospitals with little community involvement would disdain a real dialogue and instead simply direct their accountants and public relations staffs to churn out glossy reports demonstrating they were in compliance.

Utah’s standards for exempt healthcare providers spelled out more than a dozen targets, some expressed in terms of dollars-and-cents and others dealing with such procedural issues as the composition of community boards.

The investor-owned providers believe firmly that exempt providers’ community benefit should be quantified and matched against the tax revenues that government forgoes from their exempt status. It was suggested that if an organization spends less on community benefit than the value of its forgone taxes, they should turn the difference over to public charities willing to do the job. The refrain from the for-profit providers is that the privilege of tax exemption must be very narrow. But
deciding what belongs in the numerator and denominator of the community benefits equation will always be “an absolute dog fight,” as one participant put it.

A suggestion that accounting rules be changed to require providers to list tax exemption as a source of income on their books evoked broad support at the Colloquium. Making that figure visible, and holding it up against actual expenditures for community benefit, would help safeguard against waste. One objection was tendered: it would create new bookkeeping headaches for nonprofit providers.

Public disclosure was cited as a key enforcement tool by state regulators, who count on the news media to publicize the information they gather about nonprofit executives’ salaries as well as their charitable expenditures.

A larger, philosophical problem with any money or percentage-of-revenues target is that it makes no attempt to hold providers accountable for results; it looks only at whether they spent enough toward their goal. What if Hospital A spends $10 million on an infant mortality project that yields meager results, whereas Hospital B spends $1 million but succeeds in dramatically lowering infant mortality in its community? Which has contributed more to community benefit?

Another scenario was offered of an inner city hospital that sets out to reduce the toll of shootings of teenage males who wind up in its emergency department. Currently 30 of every 1,000 teens ages 15–19 in its community are shot; three of them die. The hospital spends $35,000 sponsoring a midnight basketball league to keep teens off the streets and out of harm’s way. The shootings drop to 20 per 1,000 with just one death. Is the value of that community benefit program $35,000 or a much greater sum representing the value of two lives saved?

This example drew sharp rejoinders. A hospital might spend the $35,000 and the shootings could still jump to 40 per 1,000 for other reasons. An institution’s tax exemption should not ride on factors beyond its control, one speaker said. Even if the shooting rate dropped, how can it be shown that the midnight basketball league deserves the credit? Another said that if a hospital’s tax exemption was worth $7 million, perhaps it should fund 200 midnight basketball leagues at $35,000 apiece — and even then taxpayers would want to judge whether that expenditure was worthwhile. Another said flatly that midnight basketball leagues had no place in any calculation of hospitals’ community benefits.
The Colloquium also heard the other side of this debate over what and how to measure community benefit.

Although the public and government officials may be more comfortable with things they can count, it was argued, the greatest benefits that some tax-exempt organizations produce may not be readily visible or quantifiable. For instance, the concept of managed care was pioneered by the Blue Cross and Blue Shield plans in the 1930s, then all tax-exempt. To the extent that an exempt healthcare provider leads the way to innovations that produce better health for large segments of the population, it may be generating community benefits on a scale far larger than just filling hospital beds with charity patients. No one hospital or health plan holds the key to the health of a city as large as Los Angeles, but a plan that finds a better way to treat certain conditions or to keep large groups in better health can affect the delivery of care far beyond its own patient rolls or membership roster.

The Colloquium also heard concerns voiced about the practical versus the ideal. Creating a bureaucracy to produce some perfect measurement of community benefit could be a colossal waste of time and energy for the providers and their watchdogs alike.

So what can be measured?
One healthcare executive offered this list:
- Charity care, at cost.
- Medical and allied health education.
- Community education programs and support groups.
- Health screenings and fairs.
- The net cost of research.
- Reports to the public.
- Efforts to measure a community’s unmet health needs.

The latter prompted a complaint that taxpayers should not get stuck with the costs that nonprofits incur trying to justify their exemptions.

Despite the broad support for putting greater emphasis on nonprofit providers’ obligation to provide community benefit, a large majority of the Colloquium participants felt that community benefit should not be defined solely or largely in numerical terms related to uncompensated care.

The IRS, it was noted, has never attempted to dictate precisely what community a nonprofit healthcare provider must serve. It leaves that definition to the healthcare organizations themselves.
Historically, many healthcare providers have taken the paternalistic attitude that they know what is best for the community. For such aloof organizations, giving the community a real role in designing and developing the community benefit plan becomes all the more vital.

The state of Texas, in its statute, defined each nonprofit hospital’s community as the entire county in which it was located, because the county was the tax base forgoing the taxes. The NYU Hospital Community Benefit Standards Program’s definition of community was less easy to chart on a map. It defined community as all the people and all the organizations in a reasonably circumscribed geographic area in which there was a sense of interdependence and belonging.

One argument for government’s setting the parameters for community is that tax-exempt healthcare providers, left to their own devices, might define community in terms that protect their parochial or proprietary interests. A world-class teaching hospital in Boston might decide its community includes wealthy patients from Saudi Arabia, but not the poor of neighboring East Boston. But an ironclad definition drawn largely from a map could overlook the benefits from novel delivery arrangements, such as telemedicine, that fall into no neat geographic boundaries, one speaker cautioned.

A bare majority of Colloquium participants supported the idea that a numerical formula that balances community contributions against the cost of forgone taxes should be a factor in the Agency’s decision to grant tax exemption to a healthcare organization.

The Colloquium found unanimity on this key point: the IRS needs the power to impose intermediate sanctions on exempt providers who enrich themselves illegally. In many cases, stiff fines against the individuals would be a more fitting form of justice than punishing the entire health system by revoking its exempt status, one speaker said.

Although sympathetic to the IRS’s need for new tools to combat private inurement, several participants criticized the Agency’s insistence that physicians occupy no more than 20 percent of the board seats on new, exempt organizations.

Inurement questions usually arise when an exempt hospital or other organization is buying the practices of private physicians, cashing them out by acquiring existing assets. If physicians control more than 20 percent of the board, the Agency automatically examines the transaction to determine the existence of private inurement from the arrangement.
Physicians view this 20/80 rule as a roadblock to their playing the lead role in new exempt ventures and initiatives. Because such venerable, physician-run institutions as the Mayo Clinic and Cleveland Clinic face no threat of losing their 501(c)(3) exemptions, it would be impossible to create a new Mayo today under the IRS board representation rule, one participant claimed.

But the Mayos were created in a different era with donated assets and clearly demonstrable charitable missions and sometimes under state laws that allowed no other charter — circumstances far different from those surrounding most of today’s buy-out deals and commingled commercial ventures. The Mayo Clinic’s community at its inception consisted largely of the farmers of Olmstead County and other residents of Minnesota. Today, Mayo draws a far broader clientele to Rochester, and has built satellite clinics in wealthy enclaves in Arizona and Florida that cater to Sun Belt retirees.

Nonetheless, it was argued that the IRS restriction on board control may drive away from the exempt sector physicians interested in research and education and willing to be subject to a community benefit standard, but unwilling to accept 20 percent control of the board. Physicians attracted to nonprofit, research- and education-intensive settings are not out to maximize income, it was argued; often they easily could make more money elsewhere. The IRS board stricture makes them feel they have no control of the medical destiny of these new organizations and ventures.

In a capitated environment where the pressures to boost market share and find the most efficient methods of delivering care are driving physicians and hospitals into partnerships, perhaps the safe harbor line should be drawn closer to 50/50, one speaker suggested. If exempt organizations behave properly, others asked, what is the difference who controls the board? Why does not the Agency just scrutinize their actual behavior instead of harping on proxies such as board composition? From another participant came a quick answer: Because there is no agreement on precisely what that behavior should be.

The Agency insists its 20/80 safe harbor does not inhibit physicians from controlling decisions about clinical care. The regulators’ suspicion is that what really vexes the physicians is not the question of control, but the nondistribution constraints that prevent them from realizing the returns from for-profit hospitals, laboratories or clinics.
Core Questions

• Should exemption from federal taxes automatically entitle an entity to exemption from state and local taxes?

• Is it legal for local and state governments to offer entities that meet the legal requirements for continued recognition as tax-exempt organizations an opportunity to participate in programs through which such entities make payment in lieu of taxes or provide services?

• What are the ancillary (other than Internal Revenue Code) statutory and regulatory changes that should be made if the tax exemption for healthcare industry entities were eliminated?

• Are there areas that are important to the community that would be negatively affected by a decision not to accord tax-exempt status to qualified healthcare entities?
Major Areas of Consensus, Points of Tension and Unresolved Issues

**Consensus**

- Exemption should not carry over automatically from the federal to the state and local levels.
- Payments in lieu of taxes are not the answer to how to provide community benefits.
- Communication with the community on benefits provided is an important element in diffusing extreme positions taken on local taxes by enforcement agencies.
- This is an ideal time for local experimentation with community benefit expectations of exempt organizations.

**Points of Tension**

- Should investor-owned healthcare providers receive tax credits for the charity care they provide?
- Should some numerical formula be applied to determine whether an organization qualifies for tax exemption?

**Unresolved**

- The complexities of dealing with the question of exemption for pluralistic integrated delivery systems that cut across for-profit and tax-exempt lines but are linked by common contracts and capitation payments have yet to be unraveled.
The Colloquium quickly disposed of the question that started this discussion: Should exemption from federal taxes automatically entitle an entity to exemption from state and local taxes?

By a lopsided margin, the sentiment was no.

The consensus was against tampering with the Eleventh Amendment. A blanket exemption would defer too much to federal authority and impose too many constraints on levels of local government that lack Washington’s ability to print money, several participants said.

Although uniformity might make life easier for exempt providers, it would deprive state and local taxpayers of any say over which organizations were off their tax rolls. If a state decided that a broad tax to provide medical care for its citizens was in the community interest, it should be able to tax exempt providers along with everybody else, it was argued. Also, a rigid uniformity could work the other way, preventing a state from granting exemption to an organization that lacked federal 501(c)(3) status.

With the notion of community benefit still in an early stage of development, this is the ideal time for states to serve as laboratories of change and to encourage experimentation, participants said. Let states tax hospitals that fail to provide their fair share of charity care, or let counties impose levies to pay for mental health or child health initiatives.

There was also a general recognition that the property tax is different from the income tax. Property taxes are an issue best left to local discretion. The local property tax pays for essential services, including police and fire protection, that benefit tax-exempt organizations along with everyone else, so there is a rationale for asking nonprofits to shoulder their share of the costs. In practice, this is already happening. Some 550 nonprofit hospitals, in their Medicare cost reports for 1993, informed the Health Care Financing Administration (HCFA) that they had made some payments in lieu of taxes to local jurisdictions. Some are reluctant donors. One Colloquium participant flatly called it extortion.

But resentment over exemption has triggered a backlash against nonprofits’ expansion in cities worried about losing any more property from their tax rolls. The Colloquium heard that half the property in Boston and two-thirds of Albany, NY, is in the hands of tax-exempt institutions — primarily universities, hospitals and churches — or government itself.

Some tax collectors may have taken it upon themselves to decide that nonprofit healthcare providers are not providing sufficient community benefit and thus should pay local taxes. One participant said that seems to be the mind set of local tax collectors, even when faced with clear interpretations of the law to the contrary.
But it also may indicate local governmental authorities are not aware of what community benefits exempt providers are delivering, or they have decided they prefer a different kind of benefit — or they want both, one speaker said.

A touch of schizophrenia was evident, too, in the Colloquium’s discussion of these growing demands for payments in lieu of taxes. Philosophically, most exempt healthcare organizations agree that state and local authorities should be free to make their own taxing decisions, especially about property taxes. If a community wants its nonprofits to contribute toward municipal services, so be it. But practically speaking, they resent having the gun held to their head. “You’re either exempt or you’re not exempt,” as one put it.

(On the other hand, another participant thought the real problem was the tax collectors’ tendency to “settle for peanuts — about 15 percent of what they ought to have gotten out of the hospital.” The tax collectors may ask for large sums, but the hospital lawyers “always knock them down.”)

The nonprofits most vulnerable to such demands may have distanced themselves from their community and its needs. When a community hospital suddenly announces plans to close its doors or curtail an important clinical service without advance warning, citizens are taken aback. In an area where the community viewed those services as vital, the supposedly charitable healthcare organization may suddenly be revealed to the public as just another business putting its own interests first. To some, the lesson was that the public cannot rely solely on the good will of tax-exempt institutions to serve community needs.

Other hospitals have aroused taxpayer resentment and media scrutiny by undertaking activities far afield from their mission of improving health. In Pennsylvania, a state where the property tax battle has been fought the hardest, one of the first targeted hospitals owned a marina.

Conversely, a hospital that has engaged in a genuine dialogue with its community may be less vulnerable to unexpected demands from local tax collectors, and better positioned for survival. An analogy was made to medical malpractice, where studies have found that physicians are more likely to be sued if they fail to communicate with patients, regardless of the quality of their care. Those who keep the lines of communication open, responding to patients’ phone calls and answering questions, are less likely to wind up in court, even if their medical skills are wanting.
But quality and caring are no guarantee of immunity from importunate demands. The Colloquium heard that when one large exempt health system tried to demonstrate that it already provided services far in excess of any forgone taxes, the only response from the tax office was: “Make your payment by X-date or we’re challenging your tax-exempt status.”

Advocates of ambitious community benefit programs believe that delivering results in this arena can help nonprofit hospitals survive and prosper in the current market upheavals. In a world with fully integrated delivery systems and capitated payments, institutions that are truly accountable to their communities and operating outside their own walls will have an advantage. They will be completely open about what they do, what they charge and what outcomes they deliver. It was suggested that such openness is not the hallmark of many nonprofit providers today, particularly those searching for new ways to conduct business. One participant said reporters sometimes complain that mergers between nonprofits are shrouded in more secrecy and inner-sanctum discussions than deals in which a for-profit entity is involved.

Another participant predicted that five years from now, no CEOs of tax-exempt healthcare institutions will be riding to work in chauffeured cars. The market transformation will force a much closer alignment of incentives and compensation. The nonprofits either will have become so responsive and open — by downsizing, by regulating doctors’ income, by demonstrating they are operating on the community’s behalf — that they will dominate the market and have earned renewed exemption from taxation; or they will have embraced “cowboy capitalism,” one participant said.

That could mean hard times ahead for the for-profit chains and insurers now busily blending healthcare organizations together. Deflation will make huge profits in healthcare less achievable, and increased certainty about the causes and treatment of diseases could leave the health insurance industry without a future. With no need for huge reserves as a hedge against uncertainty, it will become much easier for providers to become their own insurance company.

What happens to the uninsured and the underinsured during this sea change?

States increasingly may flex their regulatory muscles, and the courts may let them. The New York State Conference of Blue Cross and Blue Shield Plans v. Travelers case may signal that the risk of pre-emption of

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Excess capacity will be wrung from the healthcare system. Many hospitals will close, including nonprofit facilities. How are the survivors to keep providing community benefit? As subsidies and inefficiencies are squeezed from the system, funds may dry up for community benefit activities, too, from the burn units and trauma centers to programs aimed at the poor and uninsured. The “fat” in what hospitals have been charging has been subsidizing those activities. One speaker said that in San Diego, CA, a city in the vanguard of managed care and capitation, the only unprofitable portion of the large, integrated delivery systems are the six nonprofit hospitals that serve as the safety valve for uncompensated care.

But this rate squeeze poses serious challenges for taxable providers as well. One speaker suggested that as payments across the board are brought close to the efficient cost of producing the services, the big investor-owned organizations may look elsewhere for profits and desert the hospital or HMO business entirely. The pitfall here for organizations weighing conversion to for-profit status is whether they will be left under those circumstances with any hospital at all.

Inevitably, society will be forced to find new sources of payment for vital hospital services that have no payor, possibly by forcing other portions of the healthcare system to share the costs of that burden.

The challenge that regulators foresee in a period of retrenchment in the hospital industry is ensuring that the hospitals that survive are the ones that look to the health of their communities, and not those that resort to kickbacks and other shady dealings to bolster their bottom line.
#4: Accountability Issues

Core Questions

- Should tax-exempt organizations be required to submit on some periodic basis reports that justify their continued tax-exempt status? To whom? For what distribution?

- What factors can the tax-exempt healthcare entity use to provide that the involvement in a specific managed care initiative or arrangement meets the community benefit standard?

- Is government specification of private board composition an appropriate method of enforcing accountability among tax-exempt healthcare systems, HMOs and hospitals?

- How can a more inclusive yet stricter definition of “community benefit” be expressed in legal terms?

- To what extent should issues such as personnel policies and compensation, competitive activity, and corporate structure be factors in deciding whether an entity should be accorded tax-exemption status?
## Major Areas of Consensus, Points of Tension and Unresolved Issues

### Consensus
- Tax-exempt organizations have an obligation to report regularly both to the community and to the government to justify their exempt status.
- The government should not prescribe board composition or executive salary limits.
- Identification of community need should be a collaborative process involving exempt and taxable healthcare organizations as well as physicians.

### Points of Tension
- What should the community benefit obligations be for HMOs and managed care plans?
- Do community rating and open enrollment present imbalance for certain plans and employers favored by experience rating?
- Are education and research part of community benefit or distinct from it?

### Unresolved
- Sorting out the community benefit obligations of integrated networks that encompass both taxable and tax-exempt providers.
- Creating a model community benefit plan and finding ways to engage the community in that process.
The issue is not whether tax-exempt healthcare providers are to be held accountable — they must answer to a wide range of overseers and constituents, from the IRS to the attorneys general and the legislatures of their states to their own board of trustees to third parties through lawsuits to their members and even to the community itself. But how can they handle and respond to these pressures?

First, it is critical for the precise activities of the tax-exempt entity to be known. Step one in the accountability process is often to inventory the community benefit activities and programs an exempt organization currently provides. Although many organizations have a vague sense that they are engaged in such activities, there is nothing like an inventory to find out what really goes on inside the organization.

The inventory is at the heart of both the CHA’s “Social Accountability Budget” and California law SB-697, which requires exempt providers to prepare social accountability plans.

In addition to the inventory, the CHA requires its hospitals to:
• Make a community needs assessment.
• Develop a community benefit plan with measurable standards of service.
• Prepare a community benefit report to the public.
• Make an annual budgetary commitment to those services (although the level is not specified).

The California law tracks most of those requirements, but does not require any budgetary commitment. Other states follow different approaches. Texas enacted a law in 1993, as discussed earlier, requiring explicit budgetary commitments, but no inventory. In Utah, nonprofit healthcare providers must file an affidavit and go before the county commissioners each year if they wish to remain exempt.

Increasingly, hospitals, HMOs and healthcare systems are producing report cards for public inspection, although most are grading themselves. Some report their performance as monitored by the JCAHO or the National Committee for Quality Assurance. Some publish special reports to their community as advertising inserts in local newspapers. Others build upon the information that nonprofits already must make available in the Form 990 they prepare for the IRS each year. That information, including the salaries of the five top executives, is already in the public domain, although the trustees of some nonprofits do not know what the CEO is making.

If the community benefit movement is still in an embryonic stage, so is the preparation of these reports to the community and public at large. The Colloquium heard that these initial report cards are, for the
most part, marketing tools. One executive complained that a rival facility was making boasts without the statistics to back up its claims.

The Colloquium voiced support for the idea that all nonprofit providers’ report cards should disclose how much the organization saved by being exempt from taxation.

Exempt providers, in attempting to meet their obligations to the community, face special challenges in trying to engage the community in a dialogue over the community’s needs and what the institution’s response should be. The institution must first ask who or what are the communities it is trying to serve.

Most hospitals already have advisory boards and dealings with a variety of citizen groups, but usually they must cast a far wider net to engage in a genuine dialogue with the community. If the process is dominated by the acute care hospital with the repair-shop mentality, one speaker said, it is unlikely to lead to improved community health. Casting the net widely may rattle board members who consider themselves the proper representatives of the community. It may also unsettle hospital administrators who worry about fanning expectations in the community that will be hard to meet.

The questions of accountability for HMOs proved particularly vexing for the Colloquium participants.

HMO leaders believe their plans deserve credit for community rating, Medicare and Medicaid enrollment and, to some extent, premium subsidies for those who otherwise could not afford insurance. But skepticism was voiced about the capacity of HMOs or any other non-profit health plans to stand alone for community rating. Blue Cross plans already have retreated from their status as the sole community rated health plan and insurer of last resort in some states; some Blues plans have relinquished their 501(c)(4) status and converted to for-profit mutual plans to gain entry to capital markets.

A health plan with a minority share in a market that offers community rating, guaranteed issue and open enrollment while its competitors practice underwriting and experience rating is embarked on a suicide mission, the Colloquium was told. No single class or type of institution can pretend by itself that the insurance playing field is level. Kaiser Permanente, the largest nonprofit HMO, for decades observed an absolute commitment to community rating, but as its products were priced out of some markets, it switched to adjusted community rating, with individual policies still sold at below market rates. Kaiser and some of the nation’s largest group practices also consider their outcomes research a major part of their contribution to community benefit.
But the public should not count on HMOs or academic medicine producing any breakthroughs for improving community health, one speaker argued. Outcomes research was forced upon the industry by regulators, not because academic hospitals or HMOs voluntarily stepped forward with information. Diagnostic related groups grew out of the work of hospital regulators in New Jersey and Maryland. Private sector companies are more likely to produce meaningful outcomes research than academic hospitals, HMOs or anything else.

One speaker argued that no special community benefits should be asked of nonprofit HMOs beyond their meeting the same tests that hospitals face. In a world of managed care in which the risk has shifted to providers and the danger now is undertreatment, not overtreatment, public policy should reward HMOs that operate on a nonprofit basis. Exemption could serve as implicit compensation for the handicap these HMOs face in the capital markets.

But others argued that even with HMOs, society deserves an explicit offset for the tax revenues it forgoes. It need not be open enrollment or pure community rating, but exempt HMOs should charge lower premiums or offer wider, easier enrollment.

Although no one at the Colloquium disputed the need for regulators to hold tax-exempt providers accountable, there was only a smattering of support for the notion that government should specify the composition of private boards or impose limits on executive salaries. For the latter, disclosure alone has often been the regulators’ tonic — and the source of headlines for the news media.
Several major themes emerged from the Colloquium:

- The discomfort of many in the healthcare world with the vagueness of the community benefit standard for exemption.
- The unwillingness of tax-exempt providers to press for legislative clarity for fear that the tax advantages they now enjoy may be stripped away.
- Broad support for the notion that community benefit, not just charity care, is the right focus for public policy.
- Disagreement over whether exempt providers should have to meet a specific numerical standard for community benefit, but support for the idea that community benefit at least should equal the tax benefits conveyed to the entity.
- Dispute over whether tax exemption for healthcare organizations is an anachronism, or whether exemption is well worth the price paid to empower and encourage care-givers to behave in the right way.
- Divisions over whether the community benefit obligations for health maintenance organizations and other integrated delivery systems should be the same as for hospitals.

The Colloquium illuminated areas where tax-exempt and taxable healthcare providers found common ground on the community benefit standard, but the Colloquium also provided a forum to vent deep-seated differences. Twenty-seven years after the IRS made community benefit the touchstone for exemption for healthcare organizations, the Colloquium underscored how many unanswered questions remain about this topic.

Inevitably, two days of discussion were too short to delve fully into all these questions. Indeed, one of the themes that emerged from the final workshops was that the growth of integrated networks, which bridge the tax-exempt and taxable worlds, poses new dilemmas for how providers can fulfill their community benefit obligations. Although many at the Colloquium seemed willing to make hospitals jump through new regulatory hoops to obtain or retain exemptions — including more reports, full disclosure in financial statements of how much they save in taxes, and intermediate sanctions for breach of the rules against private inurement — there was far less certainty over what demands should be laid at the doorstep of HMOs and pluralistic integrated delivery systems. The participants agreed that the trust-me approach is inadequate for
hospitals, but they were divided over how much HMOs were to be trusted on the community benefit front.

The Colloquium did not attempt to prescribe what an ideal community benefit program should entail. Indeed, the message to exempt providers was not to take prepackaged ideas off the shelf, but to engage in a genuine dialogue with its community or communities to discern their needs and find the best ways to address them.

There was also agreement that payments in lieu of taxes were not the optimum way to address community benefit. In some instances, communities settle for too little. But the main problem is that these payments absolve exempt providers from taking on the deeper and more difficult challenges they owe under the community benefit standard.

The Colloquium noted that the charitable trust doctrine remains a key basis for state enforcement in this arena, and that the states in general and the attorneys general in particular play an important role in assuring the continued use in the public interest of assets from tax-exempt providers that convert to for-profit status.

In sum, the Colloquium achieved the frank exchange of views on a major issue in which legal, policy and social issues intersect. This Report, containing the areas of consensus and points of tension voiced at the Colloquium, sheds new light on the challenges ahead for tax-exempt providers and those who watch over them. Now it stands as testament to the Colloquium's broader mission: to help the NHLA membership, participating constituency groups, policy makers and others better understand the questions facing society in a debate about the future of tax-exempt healthcare organizations that is just beginning.
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The National Health Lawyers Association (NHLA) is the nation’s largest educational organization devoted to legal issues in the healthcare field. NHLA is a nonpartisan §501 (c)(3) educational association whose 7,800 members practice in law firms, government, in-house settings, and academia. They represent the entire spectrum of the health industry: physicians, hospitals, health maintenance organizations, health insurers, managed care companies, nursing facilities, home care providers, and consumers.

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