Statement of John D. Colombo
Senate Finance Committee Minority Staff
Roundtable on Tax Exemption Standards for Nonprofit Hospitals
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I first want to congratulate the Minority Staff for their thorough and thoughtful Discussion Draft on issues relating to tax exemption for nonprofit hospitals. I have long criticized the lack of accountability in the current community benefit standard, and the Discussion Draft makes accountability a centerpiece of its proposals, which I strongly endorse.

I would like to comment briefly on the question raised at the end of the Draft regarding whether certain subsidized services should count for exemption purposes. I think that they should, and that a test that focuses almost exclusively on charity care is too narrow.[1]

Although there is no generally-accepted theory for defining what a "charity" is for 501(c)(3) purposes, almost everyone who has thought about this question agrees that tax exemption should depend on a nonprofit showing that they do something substantially different for society than what society gets from the private market or from government directly. The social scientists who study nonprofits often call this "pluralism" (nonprofits are valued because of their contributions to our pluralistic society), while the economists talk more directly about goods and services that nonprofits provide that are unavailable in the private market or from government. But however you say it, we really are talking about the same thing: saying nonprofits enhance "pluralism" is simply another way of saying that they do things for society that are not done by government or for-profit entities.

This observation – that we value nonprofits because they provide services different from what are otherwise available – provides the best baseline for measuring when nonprofits are entitled to tax exemption under 501(c)(3). In the hospital context, it means that 501(c)(3) status should be tied to a specific showing by a hospital that it does some important things that are unavailable from for-profit hospitals or from the government directly. One of those things might be providing free care to the uninsured poor who do not qualify for government health programs such as Medicaid. But a nonprofit hospital might do other things that are different, as well. Accordingly, I have argued that the test for exemption should not be limited to only charity care. Instead, we should "count" as an appropriate ground for exemption any substantial services that nonprofits provide to the general population that are unavailable from the for-profit sector. We should also count services provided to underserved groups, even if those services don't differ much from what for-profits provide to the general population. I call this test "enhancing access" – that is, nonprofit hospitals should get exemption when they can show that they either provide substantial services to the general population that are otherwise unavailable from for-profit competitors or that they provide services to populations underserved by for-profit competitors. So, for example, there is now a substantial body of empirical research that suggests that certain

[1] For a more complete discussion of this position, see John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST.L.U.L.J. 433 (2007).

nonprofit hospitals provide specific services that are not provided by the for-profit sector.[2] These services are those that tend to be unprofitable, such as a burn unit; emergency psychiatric services, and so forth. Similarly, a nonprofit hospital might sponsor an inner-city clinic where patients are expected to pay what they can, but nevertheless brings health services to populations who are otherwise underserved.

Notice that this test, while broader than that provided by the Discussion Draft in its current form, is still far narrower than the "community benefit" formulation. One of the problems with community benefit is that the phrase has no inherent content, and as a result, nonprofit hospitals have over the years claimed that virtually everything they do is a community benefit. For example, some nonprofit hospitals have claimed employee training expenses as community benefits.[3] That's frankly ridiculous; are we really to assume that the baseline standard is an untrained workforce, and that hospitals should get "credit" for providing professional training to their staff? Notice that if one focuses on how nonprofits differ from for-profits, these things don't make the cut – expenses for training employees are not different from what for-profits provide (they have to train their employees, too!). Neither would I count things like health fairs, or blood pressure screenings or the like, unless these services were aimed specifically at an underserved population – for profit hospitals provide these kinds of things to the general public as a form of advertising/goodwill, and hence these things also do not fall within the category of services that are different from what for-profits provide.

So what does this analysis mean for the issues raised by the Discussion Draft? Primarily, it means that we should be somewhat more flexible in determining what services should "count" for tax exemption purposes. In my view, the costs of access-enhancing services that a nonprofit provides should count toward whatever financial baseline (the 5% baseline in the Draft) we establish for exemption. If the only burn unit in town is run by a nonprofit, the nonprofit is providing a service otherwise unavailable from for-profit competitors; they are enhancing access to health services, and they should get credit for that. In a larger sense, this analysis means that more than just charity care should "count" for exemption purposes, but that hospitals should not get exemption based upon generalized claims that they do good things for society. In order to maintain some level of accountability, hospitals must be forced to identify specifically the services they provide that are different from the for-profit sector and specifically identify the financial commitment they make to those services. This kind of focus on both accountability and flexibility is what our tax exemption system desperately needs, and I congratulate the Minority Staff for taking the first steps down this road with the Discussion Draft.

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[2] *See, e.g.*, Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law and Ethics of Not-for-Profit Hospitals*, 50 U.C.L.A. L. REV. 1345, 1354-55 (2003); Mark Schlesinger and Bradford H. Gray, *How Nonprofits Matter in American Medicine and What to Do About It*, 25 HEALTH AFFAIRS w287, w293 (published on-line June 20, 2006 and available at http://content.healthaffairs.org/cgi/content/full/25/4/W287).

[3] *See, e.g.*, Southern New Hampshire Health System 2006 Community Benefit Report, available at http://www.snhmc.org/documents/pc/SNHMC_2006_CBR.pdf (listing "in-service training to professional staff" as part of the community benefit of "Medical Education"). But compare Catholic Health Association, A GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFIT 115-116 (2006) (in-service training for physicians, nurses and other staff should not count as community benefit expenses).