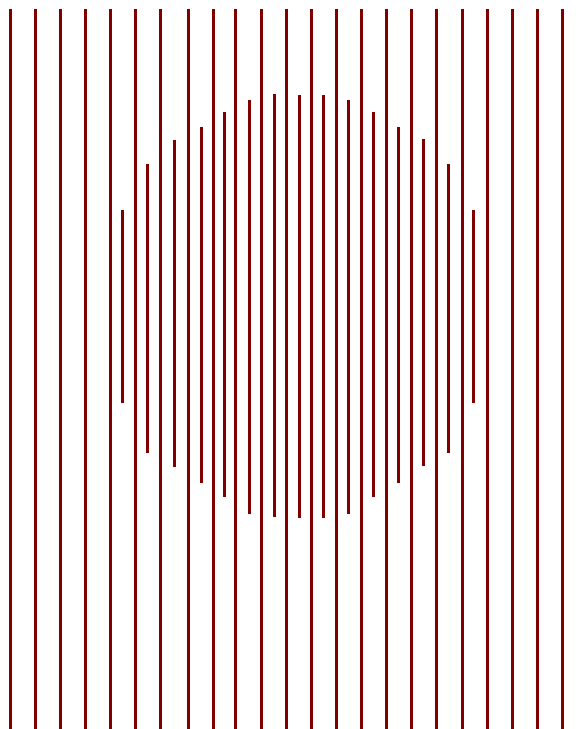


CBO PAPERS

**HEALTH CARE TRENDS
AND THE TAX TREATMENT
OF HEALTH CARE INSTITUTIONS**

August 1994



CONGRESSIONAL BUDGET OFFICE

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**CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515**

PREFACE

This Congressional Budget Office (CBO) paper looks at tax exemption for health care institutions--its benefits, costs, history, economic rationale, and status under current law. It points out the issues that recent trends in the medical marketplace and proposals for restructuring raise, and it summarizes some proposed legislative changes. The paper was prepared in response to a request from the House Committee on Ways and Means.

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INTRODUCTION AND SUMMARY

The tax treatment of health care institutions--particularly hospitals--has been an issue among policymakers, economists, and legal scholars for decades. More recently, the growth of health maintenance organizations (HMOs) and integrated delivery systems (IDSs)--which combine hospital and physician services--the potential expansion of the tax-exempt health care sector, and the prospect of health care restructuring have raised new questions about the basis for exempting health care institutions from taxation.

Some hospitals, HMOs, and IDSs are exempt from the federal income tax; others are fully taxable. Institutions that are exempt from paying federal income taxes usually are also exempt from state and local income, sales, and property taxes. In 1992, nearly 60 percent of all short-term, nonfederal hospitals, accounting for about 70 percent of all hospital beds, were tax-exempt. These include teaching hospitals and academic medical centers, which qualify for tax-exempt status as educational institutions. Approximately 14 percent of all short-term, nonfederal hospitals, representing about 10 percent of beds, were for-profit, investor-owned organizations. The remainder were public.¹ Most HMOs are organized as for-profit operations. Tax-exempt HMOs account for only one-third of the total number of organizations, but represent more than half of all HMO enrollees.²

Tax-exempt institutions fall into two broad classes, depending on whether they are exempt under Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code. Institutions that are tax-exempt under Section 501(c)(3) are eligible for benefits from tax preferences that are not available to other entities. The preferences are access to tax-deductible contributions and relatively unlimited access to tax-exempt financing for capital projects. (Federal law imposes strict limits on the use of tax-exempt financing by other tax-exempt and taxable entities.)

Public policy in this country has long exempted nonprofit health care institutions from income taxes.³ The broad justification for tax exemption is

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1. American Hospital Association, *AHA Hospital Statistics 93/94* (Chicago: American Hospital Association, 1994), p. 7.
 2. Group Hospital Association of America, *HMO Industry Profile 1993* (Washington, D.C.: Group Hospital Association of America, 1993), p. 310.
 3. Nonprofit status is a requirement for tax exemption. Thus, all tax-exempt organizations are nonprofit, but not all nonprofit organizations are tax-exempt. Depending on the issue, economists, lawyers, tax specialists, and health care analysts may distinguish between taxable and tax-exempt institutions or between nonprofit and for-profit institutions. For the purposes of this paper, the terms in both cases refer only to private-sector and not to public-sector institutions. Moreover, since virtually all nonprofit hospitals are exempt from taxation, as are most other nonprofit health care institutions, statements and data referring to nonprofit institutions also apply to tax-exempt institutions.

that an institution serves a public purpose. Over the years, new or modified federal programs and growing competitive pressures have brought about changes in the structure and behavior of tax-exempt health care institutions. At the same time, the requirements for tax exemption have changed, primarily through administrative regulation rather than legislative action. Until 1969, health care institutions had to satisfy a requirement to provide charity care in order to qualify for tax-exempt status under Section 501(c)(3); since then, they have had to satisfy a less rigorous requirement to provide a "community benefit." With the possibility of health care restructuring, the standards for assuring that tax exemption serves a public purpose may change again.

The health care bills that the House Committee on Ways and Means and the Senate Committee on Finance have reported out address the issue of public purpose by imposing new requirements for tax exemption on health care institutions and by codifying some of the provisions in existing rulings of the Internal Revenue Service (IRS). The proposals would also strengthen enforcement of the law by leveling new sanctions when an institution fails to comply with the conditions for tax exemption. In addition, the Senate Finance Committee's bill would expand the benefits that are available to Section 501(c)(3) institutions by lifting current limits on their access to tax-exempt financing.

Trends in the medical marketplace and the move toward health care restructuring raise several issues:

- o Are the current standards adequate for assuring that health care institutions provide a public benefit in exchange for the benefits they receive from being exempt from federal income taxes? What public purposes are tax-exempt health care providers serving today?
- o What role do the tax benefits associated with tax-exempt status under Section 501(c)(3), particularly the access to tax-exempt financing, play in the delivery of health care and how much do they cost the federal government?
- o With the move toward integration of health care delivery, new forms of organizations are emerging and the variety of institutions under the tax-exempt umbrella is growing. In the future, the public benefit that these new institutions serve and the standards for granting them tax-exempt status may warrant reevaluation.

BENEFITS AND COSTS OF THE CURRENT TAX TREATMENT

Tax-exempt status confers on institutions advantages not available to taxable entities and entails revenue losses to the federal government.

Exemption from Federal Income Taxes

Under Section 501(c)(3) of the Internal Revenue Code, entities are eligible for exemption from federal income taxes if they are organized as nonprofit corporations for charitable, religious, educational, scientific, or literary purposes; no part of their net earnings benefit members of the board, officers, managers, staff, employees, or other individuals associated with the enterprise; and they are organized for the benefit of public rather than private interests. Section 501(c)(3) does not specifically mention hospitals or other health care institutions, but it has always applied to them. (Private foundations are also charitable organizations but are subject to a 2 percent tax on investment income and to restrictions that do not apply to public charities.)

Nonprofit organizations that do not meet the criteria of Section 501(c)(3) are eligible for exemption from federal income taxes under the less stringent requirements of Section 501(c)(4), which apply to organizations that "promote social welfare." No specific statutory rule in Section 501(c)(4) prohibits the net earnings of a social welfare organization from benefiting a private shareholder or individual.

Exemption from paying income taxes is available to health care institutions under both sections of the code. But tax-exempt status under Section 501(c)(3) confers additional benefits on the institution, its donors, and the purchasers of the bonds that finance its facilities.

Tax-Deductible Contributions

Under Section 501(c)(3) of the Internal Revenue Code, charitable organizations have access to tax-deductible contributions; that is, donors to hospitals and other 501(c)(3) institutions may deduct their contributions when computing income for tax purposes. Donors to institutions that are exempt from federal income taxes under Section 501(c)(4) cannot claim tax deductions. Thus, in appealing for charitable donations, institutions with tax-exempt status under Section 501(c)(3) have an advantage over others.

Charitable contributions were once a significant source of financing for health care institutions, but in recent years they account for little more than 1 percent of the total revenue of nonprofit hospitals. For example, in 1948, charity made up nearly 17 percent of operating income in New York City hospitals; in 1956, it was 13 percent. In 1985, private contributions to all nonprofit hospitals constituted 1.6 percent of total revenues.⁴ In 1989 (the latest year for which these data from the IRS are available), private contributions accounted for only 1.2 percent of total nonprofit hospital revenues. Breakdowns of charitable contributions by type of institution, which are not available, might reveal that they are much more significant for some providers than others; however, their total contribution to hospital financing is small in relation to past levels.

The deduction for charitable contributions, which is available only to taxpayers who itemize deductions, provides an incentive for charitable giving by lowering the after-tax cost of contributions. For example, a taxpayer in the 28 percent tax bracket would need to give up only 72 cents of after-tax income to contribute an additional \$1 to a charitable organization. The federal government, in effect, provides the additional 28 cents of contribution. The amount that the government contributes, or the tax subsidy, therefore, depends upon the person's tax bracket. The higher the tax rate, the greater the tax subsidy for additional charitable contributions.

The deduction for charitable contributions is effective only if people are responsive to the after-tax cost of charitable giving. If people choose to give the same amount regardless of the tax subsidy, the deduction does not stimulate additional giving and is only a windfall to the taxpayer. If taxpayers are responsive to the after-tax cost of contributions, the deduction stimulates additional giving, and charitable organizations gain part or all of the benefits of the tax subsidy. A number of studies have found that taxpayers are very responsive to changes in the after-tax cost of giving, although recent evidence raises some questions about the size of the response.⁵

4. Cecelia Hilgert and Susan J. Mahler, "Nonprofit Charitable Organizations, 1985," *SOI Bulletin*, vol. 9, no. 2 (Fall 1989), pp. 57-58.

5. See Charles T. Clotfelter, *Federal Tax Policy and Charitable Giving* (Chicago: University of Chicago Press, 1985). More recent evidence is presented in Gerald A. Auten, James Cilke, and William C. Randolph, "The Effects of Tax Reform on Charitable Contributions," *National Tax Journal*, vol. 45 (September 1992), pp. 267-290; and William C. Randolph, "Dynamic Income, Progressive Taxes, and the Timing of Charitable Contributions," unpublished paper (Congressional Budget Office, July 1994).

Tax-Exempt Financing

Section 501(c)(3) institutions may finance facilities by issuing tax-exempt bonds. Because interest income from the bonds is exempt from federal taxation, investors will accept lower rates on them than on comparable taxable bonds, and 501(c)(3) institutions will benefit from borrowing at more favorable rates than generally prevail in the market.

At the same time, investors--typically those with high marginal tax rates--can shelter some of their income from taxation by purchasing and holding tax-exempt bonds. Currently, the interest rates on tax-exempt bonds are about 80 percent of the rates on comparable taxable bonds. Thus, an investor who faces a 20 percent marginal tax rate would find no difference between tax-exempt and taxable bonds. Investors in higher tax brackets, however, would realize a higher after-tax rate of return from tax-exempt than from taxable bonds.

For example, suppose the long-term interest rate on a high-grade taxable bond is 8 percent and the rate on a similar tax-exempt bond is 6.4 percent. For an investor in a marginal tax bracket of 36 percent, the after-tax return on the taxable bond would be 5.1 percent--more than a full percentage point less than the after-tax return on the tax-exempt bond. In order to attract sufficient investors, tax-exempt bonds must carry interest rates that offer appealing after-tax rates of return to more than just taxpayers in the highest tax bracket. High-income investors thus get a windfall, which reduces the efficiency of the subsidy--that is, the borrowers of funds do not reap the full benefits of tax-exempt financing; rather, they share them with some investors in the bonds.

The volume of tax-exempt financing and refunding for health care facilities has risen sharply in the past five years and is likely to continue to do so. It amounted to nearly \$31.7 billion in 1993, compared with an average of \$17.8 billion a year between 1989 and 1992.⁶ The bulk (84 percent in 1993) of tax-exempt financing for health care facilities is for nonprofit acute care hospitals.

At present, most tax-exempt hospitals have 501(c)(3) status and are eligible to use unlimited amounts of tax-exempt financing. All other 501(c)(3) institutions, such as HMOs and clinics, cannot have more than \$150 million in tax-exempt bonds outstanding at any time. Hospital facilities that are integrally

6. These amounts include refundings. New financing issues in 1993 amounted to \$11 billion; issues that combined new financing and refunding totaled \$7.3 billion, and refunding issues added up to \$13.2 billion. *The Bond Buyer, 1993 Yearbook* (New York: American Banker, 1993), p. 135, and *1994 Yearbook*, p. 134.

related to acute care provision--for example, same-day surgery centers--are not subject to the \$150 million limit. But other facilities that a hospital may construct, such as physicians' offices, are subject to the limit. Non-acute-care facilities that are under common ownership are subject to a total limit of \$150 million per institution. The limit was imposed in the Tax Reform Act of 1986, which classified tax-exempt bonds for 501(c)(3) institutions as private-purpose bonds, but imposed more lenient limits on them than on bonds for other private entities.

Tax-exempt financing is available to institutions that are exempt under Section 501(c)(4), but it is subject to the much stricter limits imposed on issues of tax-exempt bonds for private purposes. Apart from hospitals, most tax-exempt health care organizations, including HMOs, have 501(c)(4) status.

In brief, tax exemption under Section 501(c)(3) probably stimulates donations, lets nonprofit hospitals retain more of their earnings, and reduces the cost of capital assets purchased with borrowed funds.

Revenue Losses

By exempting some health care institutions from taxation, the federal government incurs costs in the form of forgone revenues, also known as tax expenditures. Official tax expenditure lists include revenues forgone by exempting from taxation the interest that investors earn on bonds for financing construction or acquisition of health care facilities and equipment. The tax expenditures also include revenues forgone as a result of permitting individual and corporate deductions for contributions to hospitals, nursing homes, hospices, and other health care institutions.

The Joint Committee on Taxation estimates that revenue losses from outstanding issues of tax-exempt bonds for health care facilities and equipment are projected to amount to \$1.5 billion in 1995 and about \$8 billion over the 1995-1999 period.⁷ The estimated revenue losses from deductions for contributions to health care institutions are projected to be about \$2 billion in 1995 and \$11 billion from 1995 to 1999.⁸

Currently, official estimates of tax expenditures do not include revenues forgone from exempting health care institutions from federal income taxes (see

7. Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 1995-1999* (forthcoming).

8. Ibid.

Box 1). A hypothetical calculation provides one estimate. The tax exemption for hospitals would have reduced federal corporate income taxes by roughly \$3 billion in 1992, assuming that these hospitals, if taxable, would have reported taxable income equal to the net income that they disclosed on their Medicare cost reports. This estimate is illustrative only. The Congressional Budget Office (CBO) does not intend it as a tax expenditure estimate, which would require more extensive analysis into the possible differences between taxable income and the available measure of net income.

HISTORY

The exemption of health care institutions from taxation has deep historical roots. The modern hospital is quite unlike its forebears. For centuries, hospitals were asylums for the poor. From the early Middle Ages through the mid-18th century, hospitals in western Europe, England, and, much later, in America were multipurpose charitable institutions that sheltered the sick, homeless, physically handicapped, and mentally deranged. People who were better off had private physicians, who treated them in their homes.

A growing recognition of the need for places to quarantine and care for people with infectious diseases, both rich and poor, led to the establishment of voluntary and municipal hospitals in the 19th century, but most were unsanitary and were not widely used. Not until the end of the century, when anesthesia and asepsis came into general use, did the modern hospital begin to take shape.⁹

During approximately the same period, beginning with the opening of Johns Hopkins Medical School and Hospital in 1893, the training of physicians in the United States became much more rigorous. Earlier reforms in medical education had taken place in the 1870s, when Harvard and the University of Pennsylvania expanded their medical schools' curriculums and lengthened the period of training from two to three years. Johns Hopkins instituted a four-year program and the unprecedented requirement that all entering students have college degrees. In the early 20th century, the American Medical Association made the improvement of medical education a top priority; the American College of Surgeons pushed for the accreditation of hospitals; and state licensing boards began raising their requirements. These moves, coupled with economic pressures, effectively eliminated many proprietary hospitals and most proprietary medical schools, which had increased rapidly in the latter half

9. Robert S. Bromberg, "The Charitable Hospital," *Catholic University Law Review*, vol. 20 (1970), pp. 237-238.

BOX 1.
**IS THE EXEMPTION OF HEALTH CARE INSTITUTIONS FROM
INCOME TAXES A TAX EXPENDITURE?**

The federal government's tax expenditure budgets, which both the Joint Committee on Taxation and the Treasury publish each year, do not include revenues forgone from exempting health care institutions from federal income taxes.

By definition, tax expenditures are revenue losses incurred as a result of provisions in the tax code that depart from a "normal" income tax by giving special preferences to individuals or corporations. By law, the revenues of institutions that are exempt from taxes under Section 501 of the tax code must be committed to the tax-exempt purpose of the organization. The law does not, however, prohibit tax-exempt institutions from generating surpluses of revenues over costs or earning income from investments. Many analysts have argued that the nonpayment of taxes on retained income represents a departure from a "normal" income tax and results in revenue losses that should appear on the federal government's lists of tax expenditures. That was the position of Stanley S. Surrey, who originated the concept of tax expenditures, and his coauthor Paul R. McDaniel.¹

Others have argued that the exemption represents not a tax subsidy, but the unique application of established principles of taxation to organizations that are not profit-oriented. This view holds that "tax exemption for charitable organizations . . . is independently and firmly grounded on the basic presuppositions of income taxation." The "net income" concept and the "ability to pay" rationale for income taxation rest on the premise that the essential purpose of an organization is to maximize profits. Since the premise does not apply to nonprofit institutions, neither do the concepts that stem from it. From this standpoint, the exemption of nonprofit organizations from income tax is not a preference or a special favor, requiring affirmative justification, but an organic acknowledgement of the appropriate boundaries of the income tax itself."²

1. Stanley S. Surrey and Paul R. McDaniel, *Tax Expenditures* (Cambridge, Mass.: Harvard University Press, 1985), p. 219.

2. Boris I. Bittker and George K. Rahdert, "The Exemption of Nonprofit Organizations from Federal Income Taxation," *Yale Law Journal*, vol. 85, no. 3 (January 1976), pp.307-316 and 333.

of the 19th century.¹⁰ As a consequence, medical education became closely intertwined with nonprofit hospitals.

By the early 20th century, the cores of most metropolitan hospital systems were made up of municipal hospitals and private, nonsectarian charitable hospitals, run by voluntary boards of trustees. Ethnic and religious hospitals were somewhat smaller and less central. For-profit (or proprietary) hospitals, although numerous, were generally small and operated on the fringes of the system. Of all of these, the nonsectarian charitable hospitals were the most prestigious and the most likely to be affiliated with medical schools. They concentrated on acute care, filling the wards with low-income patients (for teaching purposes) and private rooms with those who were better off (for revenue). Municipal and county hospitals provided care for the full range of acute and chronic illness. They generally treated the poor and relied on government appropriations rather than fees. Some also were affiliated with teaching institutions. The religious and ethnic hospitals rarely had large endowments and relied on fees from patients. Their medical staffs were more open than those of municipal or nonsectarian hospitals and their ties with medical schools were not as close. Proprietary hospitals relied entirely on fees, operated mainly as small surgical centers, and had no ties to medical schools.¹¹

As hospitals evolved, the financing of health care also changed. Increases in income, the growth of private insurance coverage, the enactment of health insurance programs--particularly Medicare and Medicaid in the 1960s--all caused a relative decline in the amount of charity care that nonprofit hospitals provided. And as federal and state subsidies increased, the relative role of charitable contributions in financing health care declined.

The expansion of federal and other health insurance programs helped give rise to the growth of for-profit enterprise in health care. For-profit hospitals were not new. In the early 1900s, more than half of the hospitals in the United States were proprietary, but the enterprises were small and therefore never accounted for a significant proportion of hospital capacity. By the mid-1940s, they had either disappeared or been converted to nonprofit institutions by the physicians who owned them.¹² In 1975, investor-owned

10. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), pp. 112-123.

11. *Ibid.*, pp. 170-172. See also Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), pp. 20-39.

12. Starr, *The Social Transformation of American Medicine*, p. 219.

hospitals accounted for only 6.3 percent of the nonfederal short-term hospitals and only 5.3 percent of the beds.

The number of investor-owned hospitals grew rapidly in the late 1970s and early 1980s. Since 1984, for-profit hospitals have accounted for between 13 percent and 14 percent of all short-term nonfederal hospitals and for about 10 percent of hospital beds. The character of investor-owned hospitals also changed between 1975 and 1984. The number of independent (stand-alone) hospitals declined from 682 in 1975 to 303 in 1984. The reduction resulted both from closures and from the purchase of independent hospitals by investor-owned systems.¹³

ECONOMIC RATIONALE

Apart from their historical roots, nonprofit institutions have an economic rationale. The standard for comparison among models of economic production and distribution is the private, for-profit firm in a market economy. The simple competitive model is based on the presence in an industry of many firms acting to maximize their profits and many consumers acting to maximize their welfare. If firms can enter and leave an industry readily and if consumers have enough information to make informed decisions, prices will serve as signals for how much firms should produce. In a state of equilibrium, firms will produce the quantity and mix of goods and services that consumers will want to buy. When competitive markets work well, the price system leads to an efficient allocation of resources.

The private sector may fail to produce the goods and services that society desires or it may produce them in insufficient quantities. Private markets may fail because certain conditions, such as sufficient information for consumers to make informed decisions, are lacking or because production and consumption of some goods and services have benefits or costs that extend to other parties beyond those involved in the transaction. Even if all conditions for an efficient private market exist, some goods and services may be too expensive for the poor to afford. Society may decide that all people, regardless of income, should have access to "merit" goods such as health care and education. When the outcome from the private market is believed to be inadequate, governments sometime intervene by producing the good or service itself or subsidizing its private production.

13. Bradford Gray, ed., *For-Profit Enterprise in Health Care* (Washington, D.C.: National Academy Press, 1986), pp. 28-29.

The Rationale for a Nonprofit Health Care Sector

The medical care market differs from the hypothetical competitive market in important ways. Consumers are often poorly equipped to judge the quality of medical services. Patients must rely on the judgment of their doctors regarding appropriate diagnostic measures and medical treatments.¹⁴ In addition, many aspects of health care and related activity--such as medical and pharmaceutical research, immunization, and treatment for contagious diseases--benefit society at large. Most of society today believes that access to health care should not be limited on the basis of income.

If the private market provides insufficient health care services and public provision of care does not adequately compensate for the shortfall, the nonprofit sector may help fill the gap. Many Americans are uninsured and unable to afford medical care. Nonprofit institutions can provide public benefits by supplying charity care, running immunization programs, operating clinics in neighborhoods that have a shortage of medical personnel, providing public health education, or operating emergency rooms that are open to all.

Second, nonprofit organizations may correct for the "contract failure" that can occur when consumers are inadequately informed about the products or services they are buying and high transaction costs inhibit their ability to switch from one supplier to another. When buyers are at such a disadvantage, producers can have an incentive to take advantage of them by selling inferior goods or services at excessive prices or in excessive quantities. Consumers may feel that a nonprofit organization, which has goals other than maximizing profits, may be more likely to act in their interests than would a for-profit organization.¹⁵

In the case of health care institutions, nonprofit hospitals for centuries provided services, such as charity care, that neither the private market nor the government provided. Many still do, but to a lesser extent, largely because the federal government has assumed greater responsibility through the Medicaid program. Conversely, in view of the growing trend toward consolidation of health care institutions and integration of health care services, the role of nonprofit institutions in compensating for contract failure may become more important than it has been.

14. See Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review*, vol. 53, no. 5 (December 1963), pp. 941-973.

15. See Henry B. Hansmann, "The Role of Nonprofit Enterprise," *The Yale Law Journal*, vol. 8, no. 5 (April 1980); Dennis Zimmerman, "Nonprofit Organizations, Social Benefits, and Tax Policy," *National Tax Journal*, vol. XLIV, no. 3 (Fall 1991); and Burton A. Weisbrod, *The Nonprofit Economy* (Cambridge, Mass.: Harvard University Press, 1988).

To date, the role of the nonprofit hospital in compensating for contract failure has probably been small, since physicians typically have served as intermediaries between hospitals and patients. In the forms of medical practice most common during much of this century--and still dominant today--physicians usually have the primary responsibility for admitting and discharging patients from hospitals, ordering tests and medications, and supervising treatments. Typically, the physician is in a private or group practice and bills the patient or the patient's insurer for his or her services, not the hospital. Supervision of treatment by a physician on the staff of a hospital is common only in emergency situations or in academic medical centers, which have multiple missions and in which medical faculty may also hold staff positions.

In short, the role of the physician is much the same in traditional medical practice, whether the hospital is for-profit or not. Hospitals depend on doctors for patient referrals and, in urban areas particularly, physicians commonly have practice privileges at several hospitals.¹⁶ If a physician acts as a patient's agent in assessing and supervising a hospital's services, he or she can advance the patient's interest when the institution's interests differ. Therefore, what matters most from the patient's standpoint is not whether the hospital or clinical facility is for-profit or nonprofit, but whether the physician's economic interests are linked to or independent of the institution.

Medical practices are changing, however. In response to market pressures, physicians, HMOs, and hospitals have been forming joint ventures, mostly on a for-profit basis. In many joint ventures, the economic interests of physician and HMO, HMO and hospital, or physician and hospital may coincide. In some cases, physicians are hospital employees. In others, physicians have special relationships with one hospital and refer patients to it exclusively. And in still others, hospitals and HMOs try to control costs by offering bonus incentives to physicians for keeping costs down or by making profit-sharing arrangements with them. These practices may put physicians in positions of conflict of interest.¹⁷ In such situations, the "nondistribution constraint" (the constraint against distribution of net earnings or assets) on nonprofit institutions may result in higher-quality service and more consumer confidence in nonprofit than in for-profit providers. Although nonprofit institutions must be sensitive to costs like for-profit institutions, they need not provide returns to shareholders and thus might strive harder than for-profit

16. Gray, ed., *For-Profit Enterprise in Health Care*, p. 174.

17. *Ibid.*, pp. 164-165.

institutions to maintain the quality of patient care.¹⁸ In theory, then, the current trend toward joint ventures may make compensation for contract failure a more significant rationale for a nonprofit health care sector than it may have been in the past.

The Rationale for Tax Exemption

If health care is a merit good and private markets fall short of meeting the needs of all members of society, the case for public assistance becomes compelling. Tax subsidies are one way to provide that assistance.

Tax exemptions, tax-deductible contributions and tax-exempt financing serve the public purpose by subsidizing the availability of health care. Although these subsidies may increase access for those who otherwise could not afford health care, they are not specifically targeted to the low-income population. The federal government directly subsidizes health care for a portion of this population through Medicaid and other programs, although coverage is far from complete. If the main purpose of the special tax treatment of nonprofit institutions is to provide the low-income population with access to health care, direct subsidies may serve this purpose more efficiently.

A significant portion of the tax subsidy is for capital acquisition and construction. Currently, tax-exempt financing for health care facilities is broadly available to 501(c)(3) institutions and is not targeted toward any particular purposes or areas. Thus, the subsidy could stimulate investment where facilities are in short supply but it could lead to overinvestment in other areas. A more direct approach such as providing federal loans at below-market interest rates or federal grants to subsidize interest costs could be used to target investment where needed. Direct subsidies avoid the problem that arises when some of the benefits of tax-exempt financing go to the purchasers of tax-exempt bonds.

The argument for any subsidies as compensation for contract failure is less clear. The nonprofit sector might exist to solve the contract failure problem even without tax exemption and other tax benefits. As economist Kenneth Arrow noted, "medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it." So the relationship has an element of trust. "The physician's behavior is supposed to

18. For example, see Robert A. Boisture, "Maintaining a Strong Nonprofit Health Care System Will Be More--Not Less--Important After Health Care Reform," *The Exempt Organization Tax Review*, vol. 9, no. 4 (April 1994), pp. 785-787.

be governed by a concern for the customer's welfare," said Arrow, and a physician's advice "as to further treatment by himself or others is supposed to be completely divorced from self-interest." Although the reality is surely not as ethically pristine in fact as it is in theory, it probably has some influence over resource allocation. "Departure from the profit motive," said Arrow, "is strikingly manifested by the overwhelming predominance of nonprofit over proprietary hospitals." However nonprofit health care institutions can be explained, their existence implies a preference for them by some group--patients, physicians, or donors.¹⁹

REQUIREMENTS FOR TAX EXEMPTION UNDER CURRENT LAW

The basis for exempting health care institutions from taxes has evolved over the better part of this century in response to changes in the practice of medicine, the financing of medical care, and the nature of health care institutions. The criteria for exemption of hospitals from taxes have largely been in place since 1969, but their history at the federal level goes back to the Civil War. In 1863, the federal government imposed a corporate income tax to finance the war and exempted charitable organizations from its provisions.²⁰ The Revenue Act of 1894 and, later, the Revenue Act of 1913 also provided that organizations operated for charitable purposes would be exempt from tax.²¹ Donations to charitable organizations have been tax deductible since 1917. Until 1968, the availability of tax-exempt bonds to finance the projects of health care institutions depended entirely on state law. The Revenue Act of 1968 placed limits for the first time on the use of tax-exempt bonds to finance projects within the private sector. Section 501(c)(3) institutions were exempted from those limits. The Tax Reform Act of 1986 set the current limits on bonds for 501(c)(3) organizations.

The Concept of "Charitable" Activity

In 1923, an Internal Revenue Service ruling narrowly defined "charitable" as the relief of poverty. The definition remained in force until 1959, when the Treasury's final regulations putting into effect the Internal Revenue Code of

19. Arrow, "Uncertainty and the Welfare Economics of Medical Care," pp. 949-950.

20. David A. Hyman, "The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals," *American Journal of Law and Medicine*, vol. 16, no. 3 (1990), p. 334.

21. The Revenue Act of 1894 was declared unconstitutional in *Pollack v. Farmers' Loan and Trust Company*, 158 U.S. 601 (1895).

1954 changed it to conform to a much broader "generally accepted legal definition."²² The broader definition had its roots in British common law, which recognizes as charitable activities several that go beyond providing relief for the poor, such as advancement of education, religion, or community benefit. The Congress had never provided a statutory definition of the term "charitable." Thus, in writing the new regulations, the Treasury relied on judicial decisions, which echo the British Statute of Charitable Uses of 1601. A British legal decision of 1891, for example, defined "charity" as consisting of "four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community."²³

The "Financial Ability" Standard: The Revenue Ruling of 1956. The 1959 regulations had no immediate effect on an IRS ruling of 1956, which had held that a hospital was charitable only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."²⁴ With respect to the "financial ability" standard, the IRS noted that a hospital could not refuse to accept patients who needed care and were unable to pay for services, but it did not necessarily have to engage in a high level of charitable activity to qualify for tax exemption. It could, for example, provide charity by furnishing services at rates below cost and by setting aside funds for improvement of hospital facilities.²⁵

In several instances following the Revenue Ruling of 1956, the IRS ruled that private hospitals that provided free treatment for less than 5 percent of their patients were not qualified for tax exemption. The "financial ability" standard nonetheless was typically interpreted broadly enough so that in the absence of local demand a hospital might provide no charity care and still meet the operational test for tax exemption, as long as it did not refuse to admit anyone who was unable to pay.²⁶

22. Treasury Regulations, Section 1.501(c)(3)-1(d)(2).

23. *Commissioners for Special Purpose of Income Tax v. Pense* (1891), as cited in Boris I. Bittker and George K. Rahdert, "The Exemption of Nonprofit Organizations from Federal Income Taxation," *Yale Law Journal*, vol. 85, no. 3 (January 1976), p. 331.

24. Revenue Ruling 56-185, 1956-1 C.B. 202,203.

25. Revenue Ruling 56-185, 1956-1 C.B. 202.

26. Note, "Federal Income Tax Exemption for Private Hospitals," *Fordham Law Review*, vol. 36, no. 4 (May 1968), p. 758.

The Switch to a Community Benefit Standard: The Revenue Ruling of 1969. The 1956 ruling remained in place until 1969, when the Internal Revenue Service modified it "to remove . . . the requirements relating to caring for patients without charge or at rates below cost."²⁷ The new ruling, 69-545, defined the charity of nonprofit hospitals as providing benefits to a community as a whole.²⁸

The concept of community benefit also harks back to British common law, and in advancing it the IRS brought the criteria for exempting hospitals from taxation into closer conformity with the regulations issued in 1959. But the 1969 ruling also reflected the (in retrospect, overoptimistic) belief that the earlier standard was archaic because the Medicaid and Medicare programs had sharply reduced the need for charity care.

The new ruling was issued a few months before passage of the Tax Reform Act of 1969. The House version of the act (H.R. 13270) included a measure conferring tax-exempt status on hospitals without regard to care for the indigent. The Senate version had no such provision, and ultimately the change was not enacted. According to the report of the Committee on Ways and Means, the reason for the proposed change was to alleviate the "significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."²⁹

The new ruling was controversial. Less than a year after publication of the ruling, the staff of the Senate Finance Committee issued a report recommending that it be revoked and that the previous ruling be restored until such time as the Congress could "devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital."³⁰ The recommendation was not acted on.

In 1973, the Eastern Kentucky Welfare Rights Organization, representing a group of plaintiffs who had been refused treatment in tax-exempt hospitals because of an inability to pay, challenged the community benefit standard in a class action suit on the grounds that it failed to identify

27. 1956 Internal Revenue Bulletin, no. 44, p. 10, as cited in Bromberg, "The Charitable Hospital," p. 237.

28. Revenue Ruling 69-545, 1969-2 C.B. 117.

29. House Report No. 413, 91st Congress, 1st Session, p. 43, as cited in *Eastern Kentucky Welfare Rights Organization v. Shultz*, 370 F. Supp. 325 at 332.

30. Senate Finance Committee, *Medicare and Medicaid: Problems, Issues, and Alternatives*, Report of the Staff, 91st Congress, 1st Session (1970), as cited in *Eastern Kentucky Welfare Rights Organization v. Shultz*, 370 F. Supp. 325, note 14 at 332.

a charitable class. In *Eastern Kentucky Welfare Rights Organization v. Shultz*, a federal district court upheld the challenge and concluded that the Congress had intended to restrict the term "charitable" to the narrow definition of relief of the poor.³¹ The United States Court of Appeals reversed the district court's decision, however, in *Eastern Kentucky Welfare Rights Organization v. Simon*.³²

The Court of Appeals based its decision on whether the term "charitable" as used in Section 501(c)(3) could be broadly interpreted, as it was in Revenue Ruling 69-545, or whether it was to be restricted to the narrower concept of relief for the poor. Noting that the law of charitable trusts supported the broader concept, the court stated:

We cannot conclude. . . that the Congress intended the . . . [narrower] construction. While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of "charitable" status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society. . . . In summary we conclude that Revenue Ruling 69-545 is founded on a permissible definition of the term 'charitable' and is not contrary to any express Congressional intent.³³

The court also expressed the view that the Medicare and Medicaid programs, "combined with the rapid growth of medical and hospital insurance [had] . . . greatly reduced the number of poor people requiring free or below cost hospital services. . . . Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay. Thus, it appears that the rationale upon which the limited definition of 'charitable' was predicated has largely disappeared."³⁴

On appeal of the Court of Appeal's decision, the Supreme Court ruled that the federal courts lacked power under the Constitution to hear the suit because the plaintiffs lacked standing--that is, a sufficient interest in the legal

31. 370 F. Supp. 325 (U.S. District Court for the District of Columbia, 1973).

32. 506 F. 2d 1278 (D.C. Circuit, 1974); vacated on other grounds, *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976).

33. 506 F. 2d 1278, at 1287-88 and 1290.

34. 506 F. 2d 1278 at 1288.

issue they had raised.³⁵ This nullified the judgments of both the District Court and the Court of Appeals. The 1969 ruling stands.

The Criteria for Tax Exemption

Hospitals, HMOs, and integrated delivery systems may be organized as tax-exempt or taxable entities; with a few exceptions, health insurance companies are fully taxable. All nonprofit health care institutions must satisfy the same basic standards for tax exemption, but the criteria for doing so vary with the type of institution. In particular, although all institutions must satisfy a community benefit standard in order to qualify for tax exemption, the requirements under the standard vary with the institution and with the type of tax exemption it is seeking. For each type of institution, the requirements will be more exacting for Section 501(c)(3) than for 501(c)(4) status. For hospitals, most of which are tax-exempt under Section 501(c)(3), the requirements are relatively fixed and longstanding. For HMOs, the requirements for 501(c)(3) status have evolved more recently. Most HMOs are tax-exempt under Section 501(c)(4). In some cases, however, the requirements for 501(c)(4) status are not entirely clear. For IDSs, the standards are still evolving.

Hospitals

Under current law, a hospital qualifies for charitable exemption if it is organized as a nonprofit corporation and complies with the community benefit standard, the prohibitions on private inurement and private benefit (see below), and nontax federal health statutes, such as the Medicare fraud and abuse rules and the laws prohibiting patient-dumping.

Community Benefit Criteria. In applying the standard of community benefit, the IRS has considered whether the hospital operates an emergency room that is open to all regardless of ability to pay, accepts Medicaid and Medicare patients on a nondiscriminatory basis, has a governing board that represents the community at large, is open to all medical staff who wish to use it, or conducts medical research and education programs. Apart from emergency room care, a nonprofit hospital need admit only those patients who have private insurance or are covered under Medicare or Medicaid and may refer indigent patients to public hospitals.

35. *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976).

In the years following the 1969 IRS ruling, instances of refusals by tax-exempt hospitals to accept nonpaying patients in their emergency rooms were reported, but those hospitals did not lose their tax exemptions.³⁶ In 1985, the Congress wrote into the Consolidated Omnibus Budget Reconciliation Act (COBRA) a requirement that all hospitals participating in Medicare accept nonpaying patients in their emergency rooms and that hospitals with Medicaid agreements admit Medicaid patients without discrimination. And, in 1990, an IRS official testified before the House Select Committee on Aging that the agency would consider the COBRA requirements to be the two most important factors in determining a hospital's tax-exempt status.³⁷ The IRS has ruled that in some circumstances, however, a nonprofit hospital may be able to demonstrate sufficient community benefit to qualify for exemption without operating an emergency room. The circumstances include instances when a state agency has determined that an emergency room would be unnecessary and duplicative and when specialty hospitals do not generally treat emergency medical conditions.³⁸

Prohibitions Against Private Inurement and Private Benefit. The rules regarding private inurement stipulate that no part of an institution's net earnings may benefit members of the board, officers, managers, staff, employees, or other individuals associated with the enterprise. The function of the rules is to assure that income and assets serve a public purpose and to prevent their distribution to physicians or other insiders within the institution. The purpose of the prohibition against private benefit is to assure that a hospital or other exempt organization is organized to serve the community as a whole and not private individuals or groups.

In applying the private inurement and private benefit rules, the IRS has concentrated on joint ventures between hospitals and physicians and on hospitals' policies for recruiting physicians to assure that the policies do not result in payment of unreasonable compensation or the transfer to physicians of an interest in the net income of a hospital.³⁹ The IRS makes determinations on private inurement and private benefit based on the facts and circumstances in each case.

36. Daniel C. Schaffer and Daniel M. Fox, "Tax Administration as Health Policy: the Tax Exemption of Hospitals, 1969-1990," *Tax Notes* (October 21, 1991), p. 228.

37. *Ibid.*

38. Revenue Ruling 83-157, 1983-2 C.B. 94.

39. IRS General Counsel Memorandum 39862 (1991).

HMOs

Health maintenance organizations provide health benefits at a fixed, prepaid price through physicians and other providers who are affiliated with the organization. In the past 10 years, enrollment in HMOs has more than tripled, and the current emphasis on controlling health care costs makes continued growth likely. At the beginning of 1994, some 45.2 million people were enrolled in 545 HMOs--up from 38.7 million people in 541 HMOs two years earlier.⁴⁰

The four basic types of HMOs are the staff model, which employs physicians and staff at its own facilities; the group model, which contracts with an independently organized medical group to provide services at the HMO's or the group's facilities; the network model, which provides services through two or more independent medical groups; and the individual practice association (IPA) model, which provides services through independent physicians who belong to the association.

Physicians in group and staff model HMOs provide services exclusively to the HMO's enrollees, while physicians in network and IPA models may contract with several HMOs and usually maintain a fee-for-service practice as well.

As of the end of 1991, staff-model HMOs accounted for 12 percent of HMO enrollment; group-model HMOs for 27 percent; network HMOs for 16 percent; and IPAs for 46 percent. This breakdown is based on the predominant model type for each HMO. Many HMOs are mixed-model plans. About half of staff-model HMOs, for example, incorporate components of other model types. So do 13 percent of group models, 28 percent of network models, and 8 percent of IPA models.⁴¹

Criteria for Tax-Exemption. HMOs are eligible for tax exemption under Section 501(c)(3), based on the same community benefit standard that applies to hospitals. In applying the community benefit standard to HMOs, the IRS requires as a minimum condition for tax exemption that the HMO provide health care services directly. Thus, staff and dedicated group models are eligible for 501(c)(3) status; HMOs that fit the network or IPA models are not.

40. Group Health Association of America, *HMO Industry Profile 1993*, p. 310; also Bruce Japsen, "Creation of New HMOs Picks Up Steam, Fueled by Reform, Market Forces," *Modern Healthcare* (June 13, 1994), p. 46.

41. Group Health Association of America, *HMO Industry Profile 1993*, p. vii.

Among the other characteristics that the IRS looks for in determining an HMO's tax status are whether it offers open membership, particularly to individuals and small groups; uses a community rating system and charges individuals and groups similar rates; treats patients, regardless of their ability to pay; has an open emergency room; conducts health education programs; and is open to nonmembers on a fee-for-service basis. An HMO need not have all of these characteristics, however, in order to qualify for 501(c)(3) status. Acceptance of applicants with preexisting conditions is not among the criteria for tax-exemption.⁴²

The exemption of HMOs under 501(c)(4) is based on a community benefit standard "that is less exacting than that under 501(c)(3)."⁴³ In assessing an HMO's eligibility for 501(c)(4) status, the IRS looks at whether premiums are set on a community-rated basis, whether membership is open to individuals and small groups, and whether the HMO serves low-income, high-risk, elderly, or medically underserved people. The IRS has indicated that IPAs may not qualify for tax exemption if they are controlled by member physicians, and it has not granted tax exemption to any IPAs under Section 501(c)(4) since 1986.⁴⁴

Taxable HMOs. The tax treatment of a nonexempt HMO depends on whether it qualifies as an insurance company. If it does, it can deduct additions that it makes to reserves to cover accrued liabilities before the taxpayer's obligation has been determined, and it need not postpone deductions until payment.

Commercial Insurers

Health insurance companies are fully taxable. Under Section 501(m), enacted in 1986, an organization may be exempt from taxes only insofar as no substantial part of its activities consists of providing commercial-type insurance. Until 1986, Blue Cross and Blue Shield organizations (BC/BS) were exempt

42. The IRS initially held that while HMOs could qualify for tax-exempt status under Section 501(c)(4), they could not qualify as charitable organizations under Section 501(c)(3) because the preferential treatment they provided members did not constitute a public benefit. The United States Tax Court rejected this position in *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978), on the grounds that the association's membership class was so broad that it constituted a community benefit. In 1993, in *Geisinger Health Plan v. Commissioner*, 985 F. 2d 1210 (3rd Circuit 1993), the Court of Appeals applied the criteria set forth in *Sound Health* and ruled that a network-model HMO, which provided no services directly and excluded applicants with poor health histories, did not benefit the community.

43. Internal Revenue Service, *Exempt Organizations, Technical Instruction Program for FY 1994*.

44. See Revenue Ruling 86-98, 1986-2 C.B. 74; also, General Counsel Memorandums 38898 (1982) and 39829 (1990).

from taxes under Section 501(c)(4). When they were established, BC/BS offered insurance based on community ratings. As more insurance companies entered the market, BC/BS responded by becoming more like them and, to keep costs down, many eventually moved to experience ratings. (Community rating is a method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. Experience rating is a method of determining health plan premiums based on the historical use and distinguishing characteristics of a specific subscriber group.)

Recognizing that BC/BS plans essentially were offering commercial-type insurance, the Congress withdrew their tax exemption in the Tax Reform Act of 1986. At the same time, the Congress enacted Section 833, which provided special relief for BC/BS and similar insurers that were in existence on August 16, 1986, and that meet specified community service requirements. These include community rating for at least 35 percent of the health insurance they provide, coverage of preexisting conditions at no extra charge, and maintenance of continuous, full-year, open enrollment for individuals and small groups, who must account for at least 10 percent of the insurance the companies provide. Section 833 exempts eligible organizations from the rule that requires a 20 percent reduction in the amount an insurance company can deduct for any increase in unearned premium reserves. It also permits eligible organizations to claim a special deduction for their health business for 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

Integrated Delivery Systems

Integrated delivery systems are proliferating. Many hospitals and physicians have established networks for providing comprehensive health care benefits and more seek to do so. Integration ranges from fully integrated delivery systems (IDS) to management services organizations (MSOs) and physician-hospital organizations (PHOs). In the most fully integrated system, a tax-exempt hospital may simply purchase a physicians' group practice and employ the physicians directly. In some states, however, laws prohibiting the corporate practice of medicine make such arrangements impossible. These laws prohibit hospitals and other corporations from employing physicians or directly providing physician services.

The Foundation-Model IDS. The foundation-model IDS has evolved in states such as California and Texas that prohibit the corporate practice of medicine. Under the foundation model, a hospital establishes a new nonprofit organization, which acquires the assets of one or more medical groups.

Typically, the foundation then contracts with the medical group to provide physician services for the IDS. The acquired assets of the foundation can include hospitals, clinics, equipment, and possibly intangibles. Once the IDS has 501(c)(3) status, it is eligible to obtain financing through tax-exempt bonds. Thus, some acquisitions may be financed with tax-exempt bonds. Other acquisitions may be structured as a bargain sale. If the value of the assets is greater than the purchase price, the owners of the medical group may claim a charitable deduction under Section 170 to the extent that the actual sales price (plus any ascertainable value of the benefit of the transaction to the physicians) is less than the fair market value (determined by an independent appraisal) of the practice.

The IRS has granted several foundation-model IDSs tax-exempt status under Section 501(c)(3). As with hospitals, the IRS's recognition of an IDS's Section 501(c)(3) tax-exempt status is based on the community benefit principle. The IRS has required that the board of the IDS be representative of the community and that the number of medical group physicians on the foundation board be limited. In its favorable tax-exemption determinations to date, the IRS has used a 20 percent limit on the medical group physicians' participation on the foundation board as a safe harbor.

More generally, the IRS has indicated that it would expect IDSs to provide benefits to the community beyond operating an open emergency room and treating Medicaid and Medicare patients without discrimination, but the standards for determining whether an IDS is providing a community benefit are still evolving.⁴⁵ Thus, the IRS has indicated that conducting public health education programs may constitute a community benefit. It has also indicated that it believes that integrating hospital and physician services and patient records can benefit a community by eliminating duplication of procedures, thus lowering prices.⁴⁶

In reviewing foundation-model IDSs, the IRS seeks to assure that the hospital did not pay more than fair market value for the medical group's assets and that the intangible assets will contribute to the organization's exempt purposes. The Internal Revenue Service is more likely to grant tax exemption if the foundation has purchased rather than leased the assets of a medical group. The IRS's view is that leasing arrangements can change over time and thus have greater potential for private inurement. The IRS also scrutinizes agreements between medical groups and foundations to assure that physicians do not derive more than incidental private benefit from the relationship and

45. Internal Revenue Service, *Exempt Organizations: Technical Instruction Program for FY 1994*, p. 225.

46. *Ibid.*, pp. 226 and 243.

that physician compensation is based on arm's-length negotiations between medical groups and foundations or their parent hospitals.

Management Services Organizations. MSOs are not as fully integrated as IDSs. MSOs do not provide medical services; rather they purchase the tangible assets of medical groups and then provide support staff, equipment, and facilities necessary for the group to conduct its private practices. Typically, a hospital capitalizes MSOs, which may be organized in several ways: for example, as a subsidiary of a hospital, an operating division of a hospital, or a separately incorporated entity. Under a contractual arrangement, the physician group provides medical services to the hospital, and the hospital provides physical assets, support staff, and administrative and management services necessary to conduct a medical practice. The MSO may be a first step toward fuller integration and offers a hospital stronger ties with a medical group. It offers a medical group the opportunity to realize the cash value of its tangible assets and freedom from administrative responsibilities. And it eases physician recruitment by eliminating "buy-in" requirements.⁴⁷

So far, MSOs have not applied to the IRS for recognition of tax-exempt status, nor has the IRS issued any rulings or guidelines about them. MSOs are unlikely to have a charitable purpose that would support recognition of tax-exempt status. In general, the IRS considers joint ventures between hospitals and physicians to be consistent with 501(c)(3) status only if they advance the hospital's charitable purposes and do not result in private inurement or more than incidental private benefit to the physicians involved. Thus, tax-exempt hospitals involved in creating MSOs must ensure that their payments to a medical group do not jeopardize their tax-exempt status. An MSO could jeopardize a hospital's tax-exempt status if the MSO were capitalized by a hospital and the MSO paid more than fair market value for a medical group's tangible assets or charged less than fair market prices for the services it provides to a physician's group.

Physician-Hospital Organizations. PHOs are collective negotiating entities that enable physicians and hospitals to contract with HMOs and employers. Typically, physicians and hospitals jointly govern in such arrangements, physicians retain substantial autonomy over clinical decisions, and hospitals provide the financial and administrative expertise necessary to manage capitated payments. PHOs serve as delivery systems for HMOs, while HMOs fulfill managerial, administrative, sales, and marketing functions. In some cases, HMOs pay the PHO on a discounted fee-for-service basis; in others, the

47. Robert A. Boisture, "Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs," *The Exempt Organization Tax Review*, vol. 9, no. 2 (February 1994), p. 281.

PHO is paid a per capita fee to provide services to HMO members, and individual physicians' fees are limited by the PHO.⁴⁸ Physician-hospital organizations are generally analogous to independent practice associations with a hospital participant. The IRS has not ruled on the tax-exempt status of PHOs to date, although it has received some applications. The same standards that the IRS has applied to the newly approved IDSs will probably apply to PHOs seeking tax exemption.

As of 1993, about 14 percent of all hospitals had formed PHOs, 7 percent had formed MSOs, and 4 percent had formed joint ventures with physician groups. Joint ventures of all types are more common in urban than in rural areas and among teaching rather than nonteaching hospitals.⁴⁹

PROPOSALS FOR CHANGE

The House Committee on Ways and Means and the Senate Committee on Finance have reported out bills that in some respects would change the current tax treatment of health care providers and codify some of the IRS's practices.⁵⁰ The key provisions of these measures include new requirements for tax exemption and new sanctions when an institution fails to comply with the conditions for tax exemption. Several measures in the two bills are similar; the main difference is that the Ways and Means bill imposes more requirements for tax exemption. In addition, the Senate Finance bill would lift current limits on the use of tax-exempt financing by 501(c)(3) institutions.

New Requirements for Tax Exemption

Both the Ways and Means and Finance Committee bills would impose new requirements for tax exemption to Section 501(c)(3) and 501(c)(4) organizations that provide health care, including hospitals, HMOs, clinics, nursing homes, and old age homes. The new provisions delineate the public benefits that health care providers must furnish in exchange for tax exemption. Some states have enacted similar measures (see below). The Finance Committee's bill exempts from the new requirements institutions that have as

48. *Medical and Health Perspectives* (February 28, 1994), p. 4.

49. Prospective Payment Assessment Commission, *Report and Recommendations to the Congress* (March 1, 1994), p. 24.

50. House Committee on Ways and Means, *Health Security Act*, Report 103-601, Part 1 (July 14, 1994); Senate Committee on Finance, *Health Security Act* (August 2, 1994).

a principal purpose academic training or medical research. Under the Ways and Means bill, an educational or other organization would be exempt from the new provisions only if its predominant activities did not involve delivering health care services to patients. Under the proposals, tax-exempt health care institutions--in addition to satisfying a community benefit standard--would have to:

- o Provide significant "qualified outreach services." The Ways and Means bill defines these as health care services and related education and social service programs that are provided in a medically underserved area or are offered below cost to individuals otherwise unable to afford them. The Finance Committee's bill adds to that definition the option of providing specialty emergency care facilities that normally operate at a loss, such as emergency trauma, emergency psychiatry, or burn centers. Under both bills, an institution would demonstrate that it provides qualified outreach services on a facts-and-circumstances basis. Both bills would permit an institution to provide outreach directly or by making a contribution to another institution that offers it.
- o Annually assess their community's need for health care and for qualified outreach services and prepare a written plan for meeting those needs, with the participation of community representatives.
- o Refrain from discriminating against individuals participating in government-sponsored health plans, such as Medicare or Medicaid, and from discriminating in providing emergency services on the basis of a patient's ability to pay.⁵¹ These two provisions would essentially codify existing IRS rulings pertaining to hospitals.

Additionally:

- o Under the Ways and Means bill, tax-exempt institutions--to the extent of their financial ability--would have to provide nonemergency health care services without regard to the patient's ability to pay.⁵² This provision is similar to the IRS's

51. The latter provision applies only to institutions that operate emergency rooms.

52. This provision would not apply to HMOs that do not directly provide medical services.

1956 ruling with regard to charity care. It would not apply to HMOs that do not directly provide medical services.

- o The Ways and Means bill would require tax-exempt health care providers to maintain an independent board of directors; that is, at least 80 percent of the governing board of a tax-exempt health care organization would have to be composed of individuals who receive no compensation directly or indirectly (a) for medical services performed in connection with the organization or (b) as an officer of the organization. This proposal would codify and apply to health care institutions generally the 20 percent limit on insider or physician board representation that the IRS has applied in recent exemption determinations involving IDSs.
- o Both the Ways and Means and the Finance Committee bills would deny tax-exempt status under Section 501(c)(4) to health care organizations that permit any part of their net earnings to inure to the benefit of any private shareholder or individual.

Provisions Relating to HMOs. Both the Ways and Means and the Finance Committee bills would codify current IRS rulings regarding tax-exemption requirements for HMOs. In order to qualify for 501(c)(3) status, the bills require HMOs to furnish primary health care services at their own facilities by professionals who essentially do not provide such services elsewhere. Thus, as under current regulations, only staff- and dedicated-group-model HMOs would qualify.

In order to qualify for 501(c)(4) status, HMOs would not have to provide services at their own facilities, but would have to furnish primary care through fixed-fee contracts and supply other care only on referral from an HMO. Providers would qualify for 501(c)(4) status by assuming the risk in relation to the rate at which an HMO's members use health care services. Under current law, if the provision of insurance is only "incidental" to an HMO's regular operations, the activity is tax-exempt. But if a tax-exempt HMO expands its operations by arranging to provide medical care through a network of physicians on a fee-for-service basis, present law considers it to be providing commercial-type insurance. As under present law, depending on its extent, the insurance activity might be taxed as an unrelated business, or the HMO might lose its tax-exempt status.⁵³

53. For more detail, see House Committee on Ways and Means, *Health Security Act*, pp. 590-592; and Senate Committee on Finance, *Health Security Act*, pp. 203-204.

Intermediate Sanctions

Currently, when an institution fails to comply with the conditions for tax exemption, the IRS's only option is to revoke the status. The severity of the penalty is a disincentive for vigorous enforcement of the law, especially in cases where the violation may be minor or caused by oversight rather than willful neglect. To remedy the problem, both the Ways and Means and the Senate Finance bills include intermediate sanctions on private inurement. The sanctions would impose taxes on insiders and organization managers who knowingly participate in a transaction involving improper personal gain. The Ways and Means bill also includes intermediate sanctions for failure to comply with the new exemption requirements for health care organizations. The tax would amount to \$25,000 or 5 percent of the organization's net investment income, whichever is greater. The tax would be effective January 1, 1995, for all of the new requirements, except the one for an independent board, which would be effective January 1, 1997.

Health Insurance Purchasing Cooperatives

Under both bills, health insurance purchasing cooperatives that may be established at the state or local level would be eligible for tax-exempt status, provided they adhered to the restrictions on private inurement, lobbying, and political involvement in present law. Purchasing cooperatives would not be eligible to use financing from the proceeds of tax-exempt bonds.

Taxable HMOs and Commercial Insurers

Both bills would expand the scope of organizations that are treated as taxable insurance companies in similar ways. In both cases, organizations would be taxed as insurance companies if more than half of their business (measured, for example, by gross revenues) consists of issuing accident and health insurance contracts or reinsuring accident and health risks; if they operate as an HMO; or if they enter into arrangements under which they receive fixed payments for providing health care services and assume the risks associated with their rates of use.

In the case of taxable staff- or dedicated- group-model HMOs, no deduction would be allowed for incurred but unreported losses, because the use of an HMO's services for professional care is or can be known by the end of the HMO's taxable year. If, however, the period during which members are covered extends beyond the end of the taxable year (for example, if premiums are paid not monthly, but quarterly or annually over a period other than the

taxable year), a deduction reflecting the increase in unearned premiums for the year would be appropriate.

Special Rules for Insurance Companies. Both bills would retain the special rules that apply to Blue Cross and Blue Shield under Section 833. Both bills would also extend the rules to certain other organizations that meet the requirements of Section 833(c)(2), effective for taxable years beginning December 31, 1986. The special rules would extend to organizations that are not HMOs and are governed by state laws that apply specifically and exclusively to not-for-profit health insurance or health service organizations.

Tax-Exempt Financing

The Finance Committee's bill would repeal the \$150 million tax-exempt bond limit that now applies to facilities of all 501(c)(3) institutions except hospitals. The committee intended the measure to accommodate restructuring and expansion of nonhospital health care facilities. The bill would also remove the classification of 501(c)(3) bonds as private-purpose and raise the limit on the share of proceeds that can be used for other than the exempt purposes of the 501(c)(3) institution from 5 percent to 10 percent--which is the limit that now applies to public-purpose bonds. In addition, the bill would remove the restrictions on bond-financed costs of issuance. (Currently, no more than 2 percent of the proceeds of a bond issue may be used to finance issuance costs, and these funds are not counted in determining whether the bonds satisfy the requirement that at least 95 percent of the net proceeds be used for the exempt activities of the organization.) The Ways and Means bill contains no such provisions.

The Joint Committee on Taxation estimates that revenue lost as a result of lifting the limit on all 501(c)(3) institutions would amount to about \$200 million between 1995 and 1999 and to about \$1 billion between 1995 and 2004. If the limit were lifted for health care institutions only (and continued to apply to nursing homes), revenue losses would amount to about \$100 million over five years and about \$400 million over 10 years.

CURRENT TRENDS AND EMERGING ISSUES

Recent changes in the medical marketplace and the possibility of health care restructuring reopen the issue of the basis for exempting health care institutions from income taxes. The Ways and Means and Senate Finance Committee's bills would stiffen the requirements for tax exemption and strengthen their

enforcement. The Finance Committee's bill would also expand the benefits associated with 501(c)(3) status.

The federal government subsidizes health care institutions through the tax system. The justification for these tax subsidies is that these institutions provide a public benefit. The questions, then, are what benefits do tax-exempt institutions now provide that taxable institutions do not also provide, and what benefits are they likely to provide under some of the proposed changes in the health care system?

Distinctions Between Taxable and Tax-Exempt Institutions

In 1992, nearly 60 percent of all short-term nonfederal hospitals, accounting for more than 70 percent of hospital beds, were nonprofit tax-exempt institutions.⁵⁴ These include teaching hospitals and academic medical centers, which qualify for 501(c)(3) status as educational institutions. Approximately one-third of all hospital beds and nearly one-half of the beds in nonprofit hospitals are in teaching hospitals. Nonpublic teaching hospitals represent slightly less than one-fifth of all hospitals and close to one-third of all nonprofit hospitals.⁵⁵ Less than 14 percent of all short-term, nonfederal hospitals, representing about 10 percent of beds, are for-profit, investor-owned organizations. The remainder are government-owned.⁵⁶ Most HMOs are organized as for-profit operations, but some of the largest are nonprofit and tax-exempt. Tax-exempt HMOs account for only one-third of the total number of organizations, but represent more than half of all HMO enrollees.⁵⁷

The differences in the way for-profit and nonprofit health care institutions behave are difficult to measure. The most comprehensive attempt to study the issues involved in for-profit health care was undertaken in 1981 by the Institute of Medicine, which set up a Committee on Implications of For-Profit Enterprise in Health Care. The committee published its report in 1986. Most of the data that it gathered related to hospitals. And much of the data about costs, quality, and access to care in for-profit and nonprofit hospitals was gathered in the early 1980s, a period dominated by cost-based reimbursement from Medicare and other third-party payers, which provided little incentive for

54. American Hospital Association, *AHA Hospital Statistics 93/94*, p. 7.

55. Congressional Budget Office, based on analysis of data from the Health Care Financing Administration.

56. American Hospital Association, *Hospital Statistics 93/94*, p. 7.

57. Group Health Association of America, *HMO Industry Profile 1993*, p. 310.

price competition among providers. The committee was aware that Medicare's prospective payment system and other emerging developments could affect its conclusions and therefore regarded its findings as tentative.

The committee found that investor-owned hospitals did not produce the same services at lower cost than their nonprofit counterparts; prices and expenses were higher in investor-owned hospitals.⁵⁸ Another study that appeared about the same time found that differences in costs were insignificant, but charges by for-profit hospitals were about 10 percent higher after netting out taxes paid by for-profit hospitals and contributions received by nonprofit hospitals.⁵⁹ The committee reported that overall quality of care --based on such limited indicators as accreditation, board certification of staff physicians, and amount of nursing personnel--did not seem to vary between for-profit and nonprofit hospitals. Occupancy rates were higher in nonprofit hospitals, and commitment to research and education was greater. The amount of uncompensated care also was greater at nonprofit hospitals, particularly where for-profit hospitals were most heavily concentrated.

The committee also found that regardless of the form of ownership, debt and retained earnings were the source of almost all capital financing for hospitals. Thus, nonprofit institutions shared with for-profit institutions the need to generate surpluses in order to build reserves for use as working capital and for future renovation or expansion. The surpluses affect credit ratings and, thus, access to capital. On a national basis, the margins of surplus of nonprofit and for-profit hospitals were similar. The comparison was based on the inclusion of gifts and investment income in hospital revenues and involved subtracting from revenues the accrued taxes of investor-owned hospitals.⁶⁰

More recent information is available. Data for 1992 indicate that, as a percentage of total costs, nonprofit hospitals provided somewhat more uncompensated care (charity care and bad debts) net of subsidies from state and local governments than for-profit hospitals (see Table 1). The data also indicate that, on average, for-profit hospitals charge private payers higher fees in relation to their costs than do nonprofits. Nonpatient revenues (which include interest on investments, nonoperating revenues from such facilities as cafeterias and parking garages, federal grants, gifts, and donations) make up

58. Gray, ed., *For-Profit Enterprise in Health Care*, pp. 185-186.

59. J.M. Watt, Robert A. Derzon, and others, "The Comparative Economic Performance of Investor-Owned Chain and Not-for-Profit Hospitals," *New England Journal of Medicine* (January 9, 1986), pp. 89-96.

60. Gray, ed., *For-Profit Enterprise in Health Care*, pp. 182-201.

TABLE 1. GAINS OR LOSSES BY PAYER, BY HOSPITAL GROUP, 1992

Hospital Group	Total Gain ^a (Percent)	Gains or Losses as a Percentage of Total Costs ^b					Private Payers	
		Medicare ^c	Medicaid ^c	Uncompensated Care ^d	Private	Nonpatient ^e	Share of Total Costs (Percent)	Payment-to- Cost Ratio
All Hospitals ^f	4.8	-4.4	-1.2	-4.9	11.8	3.3	37.6	1.31
Nonprofit	4.7	-4.4	-1.5	-4.6	11.6	3.5	39.4	1.29
For-Profit	6.3	-6.2	-2.1	-3.9	17.4	1.0	40.6	1.43
Public								
Urban areas	4.3	-2.8	0.9	-6.9	8.8	4.0	26.5	1.33
Rural areas	6.1	-4.4	-0.2	-5.0	11.5	3.2	31.8	1.36
Major Teaching ^g								
Public	2.8	-1.2	1.5	-7.3	5.6	4.3	22.1	1.25
Nonpublic	3.6	-2.9	-1.3	-4.8	8.6	4.0	38.8	1.22

SOURCE: Congressional Budget Office based on data from Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1994), p. 44.

NOTE: Because of reporting inconsistencies, there are significant margins of error for the numbers related to all payers in 1992.

- a. Total gain equals total revenues minus total costs for the hospital group, divided by costs for the hospital group.
- b. The gain or loss is equal to the difference between revenues and cost for each source, expressed as a percentage of hospitals' total costs.
- c. Medicare and Medicaid costs equal all costs, both inpatient and outpatient, attributed to these programs' patients regardless of whether the costs are allowable (and therefore reimbursable) by the programs.
- d. Uncompensated care includes charity care and bad debts. Operating subsidies from state and local governments were considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs.
- e. Nonpatient revenues include charitable donations, federal grants, earnings on investments, and nonoperating revenues from such facilities as cafeterias and parking garages.
- f. The table is based on all hospitals covered by Medicare's prospective payment system.
- g. Major teaching hospitals are hospitals with a graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater.

a greater share of total costs for nonprofits than for for-profit institutions (see Table 1).⁶¹

As a percentage of total costs, nonpublic major teaching hospitals in 1992 had greater losses from uncompensated care, lower "profit" margins, and smaller losses from treating Medicare and Medicaid patients than either nonprofit hospitals or for-profit hospitals. (Major teaching hospitals are those with a graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater.) In general, for-profit hospitals incur greater losses on Medicare and Medicaid patients as a proportion of total costs than nonprofit hospitals do.⁶² The payments of privately insured patients and uninsured patients who pay for their care were lower in relation to total costs in major teaching hospitals than in other nonprofit hospitals.

Measured as a percentage of total inpatient days in 1991, nonprofit hospitals had a slightly heavier Medicaid patient load than for-profit hospitals in urban areas; in rural areas, for-profit hospitals had a significantly heavier Medicaid patient load than nonprofits (see Table 2). Nonpublic teaching hospitals generally carried a heavier Medicaid patient load than nonprofit hospitals in urban areas, and particularly in large urban areas. (Large urban areas are metropolitan statistical areas with a population of 1 million or more or New England County Metropolitan Areas with a population of 970,000 or more.) Among nonpublic hospitals, the Medicaid patient load was greatest in major teaching hospitals in large urban areas; it is about 66 percent heavier than in nonprofit hospitals generally (see Table 3).

The overall Medicare patient load in 1991 was much the same for nonprofit and for-profit hospitals, about 47 percent of inpatient days. Nonprofit hospitals had a slightly heavier Medicare patient load in large urban areas; for-profit hospitals had a slightly heavier Medicare patient load in other urban and rural areas (see Table 2). Nonpublic teaching hospitals generally had a lower Medicare patient load than nonprofits (see Table 3).

Occupancy rates were higher for nonprofit than for for-profit hospitals in 1991, as they have been for the past 20 years (see Table 2).⁶³ Among nonpublic hospitals--and among all hospitals, public and private--the highest

61. Prospective Payment Assessment Commission, based on analysis of American Hospital Association data, as reported in *Medicare and the American Health Care System: Report to the Congress* (June 1994), pp. 43-44.

62. Prospective Payment Assessment Commission analysis of data from the American Hospital Association Annual Survey of Hospitals, in *Medicare and the American Health Care System*, p. 44.

63. American Hospital Association, *Hospital Statistics 93/94*, p. 7.

**TABLE 2. PATIENT DAYS FOR MEDICARE AND MEDICAID
AND OCCUPANCY RATES, BY HOSPITAL GROUP, 1991**

Hospital Group	Percentage of Patient Days		Occupancy Rate (Percent)
	Medicare	Medicaid	
All Hospitals	45.3	14.1	57.7
For-Profit			
All	46.9	11.5	46.6
Large urban areas ^a	43.5	11.2	45.6
Other urban areas ^b	49.2	9.9	50.0
Rural areas ^c	53.5	16.7	42.5
Nonprofit			
All	46.7	12.9	60.8
Large urban areas ^a	44.3	13.6	65.7
Other urban areas ^b	48.6	11.7	61.2
Rural areas ^c	52.8	13.2	44.8
Public			
All	37.1	21.9	52.8
Large urban areas ^a	26.6	26.9	66.8
Other urban areas ^b	35.6	22.3	60.8
Rural areas ^c	51.4	15.4	37.5

SOURCE: Congressional Budget Office based on analysis of data from the Health Care Financing Administration.

NOTE: Data correspond to hospitals' cost-reporting periods beginning in fiscal year 1991.

- a. Large urban areas are metropolitan statistical areas (MSAs) with a population of 1 million or more or New England County Metropolitan Areas with a population of 970,000 or more.
- b. Other urban areas are MSAs with a population of less than 1 million or New England County Metropolitan Areas with fewer than 970,000.
- c. Rural areas are outside MSAs.

**TABLE 3. PATIENT DAYS FOR MEDICARE AND MEDICAID
AND OCCUPANCY RATES IN TEACHING HOSPITALS, 1991**

Hospital Group	Percentage of Patient Days		Occupancy Rate (Percent)
	Medicare	Medicaid	
All Teaching Hospitals	40.6	16.9	69.2
Nonpublic			
All	43.3	14.7	68.6
Large urban areas ^a	41.9	15.7	70.7
Other urban areas ^b	45.8	12.8	65.5
Rural areas ^c	50.0	12.8	59.3
Major Teaching, Nonpublic^d			
All	36.6	21.3	76.6
Large urban areas ^a	37.0	21.4	76.7
Other urban areas ^b	32.7	22.1	75.7
Rural areas ^c	40.3	12.2	75.2
Public			
All	23.8	30.5	72.6
Large urban areas ^a	18.7	33.9	74.8
Other urban areas ^b	28.8	27.0	70.9
Rural areas ^c	44.1	20.1	55.2
Major Teaching, Public^d			
All	20.1	32.3	75.0
Large urban areas ^a	17.5	34.2	75.3
Other urban areas ^b	24.9	28.8	74.4

SOURCE: Congressional Budget Office based on analysis of data from the Health Care Financing Administration.

NOTE: Data correspond to hospitals' cost-reporting periods beginning in fiscal year 1991.

- a. Large urban areas are metropolitan statistical areas (MSAs) with a population of 1 million or more or New England County Metropolitan Areas with a population of 970,000 or more.
- b. Other urban areas are MSAs with a population of less than 1 million or New England County Metropolitan Areas with fewer than 970,000.
- c. Rural areas are outside MSAs.
- d. Major teaching hospitals are hospitals with a graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater. Data for nonpublic hospitals include a few for-profit institutions.

occupancy rates were in major teaching hospitals in large urban areas (see Table 3).

Charity Care

The primary burden of caring for the medically indigent has fallen on public hospitals. Nonprofit hospitals fill a much smaller share of the need, although some evidence suggests that nonprofit, and particularly teaching, hospitals in large urban areas provide significant amounts of indigent care, especially in their emergency rooms.⁶⁴

The amount of charity care that hospitals provide is difficult to measure. Uncompensated care includes both charity care and bad debts. It does not include any unreimbursed costs of caring for Medicaid or Medicare patients. Charity care and bad debts traditionally have been difficult to separate, although current accounting guidelines make distinctions between them.

In the past few years, the American Institute of Certified Public Accountants and the Hospital Financial Management Association have established criteria for distinguishing between charity care and bad debt. The criteria state that bad debts result from the unwillingness of a patient to pay, while charity service is provided to a patient with demonstrated inability to pay. Nevertheless, the requisites for charity care can vary from state to state, and most analysts caution against attempts to distinguish such care from bad debt. The American Hospital Association, which is the primary source of data on uncompensated care, avoids making distinctions between charity care and bad debt. The General Accounting Office in 1990 also noted inconsistencies in the way hospitals distinguish between the two.⁶⁵ A survey by *Modern Healthcare* of more than 150 health care systems suggests that in 1992 and 1993 charity care expenses were substantially higher in relation to net patient revenues for nonprofit than for-profit systems.⁶⁶

A few states have recently enacted legislation requiring hospitals that are exempt from state taxes to provide charity care or meet specific community benefit criteria. For example, in the fall of 1993, the Texas legislature passed a law specifying charity care criteria for exemption from state property taxes.

64. General Accounting Office, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption*, GAO/HRD-90-84 (May 1990), pp. 2-3.

65. *Ibid.*, p. 18.

66. Jay Greene and Sandy Lutz, "Systems Post Fourth Straight Year of Income Growth," *Modern Healthcare*, vol. 24, no. 21 (May 23, 1994), p. 42.

Under the Texas statute, a hospital must meet either a charity care or a community benefit requirement to qualify for the tax exemption. The charity care requirement is 4 percent of net patient revenues. The community benefit requirement is charity care equal to 3 percent of net patient revenues, plus a community benefit requirement equal to 2 percent of net patient revenues. The unreimbursed costs of caring for financially or medically indigent patients count toward meeting the charity and community benefit requirements. Losses from unreimbursed costs of caring for Medicaid patients count toward the charity care requirement. Losses from Medicare patients count toward the community benefit requirement.

In Massachusetts, the attorney general's office took a different approach, deferring for two years a set of specific targets for nonprofit hospitals to meet in determining the value of the charitable benefits they provide. Current guidelines encourage hospitals to assess community health care needs and to develop plans and budgets for meeting local needs consistent with the hospitals' financial resources and in consultation with local representatives. The guidelines require hospitals to submit annual reports on community benefits to the state attorney general and to make the reports available to the public, but leave it up to the hospitals to delineate which communities to focus on.⁶⁷

If health care restructuring is enacted, the need for charity care may decline but it would not disappear, at least during a period of transition. As health care coverage broadens, the number of people who are insured would increase, thereby removing some of the burden on both public and private hospitals. But the shortfall from reimbursements by government-sponsored and private insurance programs that do not fully cover costs would persist until cost increases are held in check, as would the burden of providing health care for illegal aliens, who (based on proposals to date) would have no required insurance coverage and would probably be free riders on the system. In short, hospitals and other health care providers would continue to care for people who are uninsured and unable to pay for their medical care, although generally to a lesser extent than they do now.

Mergers, Acquisitions, and the Tax-Exempt Sector

Although the number of hospitals and hospital beds in relation to population has been steadily declining over the past 20 years, the tax-exempt sector of the

67. John Morrissey, "Massachusetts Community Benefit Guidelines Omit Targets," *Modern Healthcare* (June 27, 1994), p. 14.

health care system is expanding in other ways and is likely to continue to do so with or without the advent of health care restructuring. Much of the expansion has resulted from, and is likely to continue to be caused by, the horizontal merger of hospitals and the vertical integration of health care services. As a by-product of these developments, the variety of institutions under the tax-exempt umbrella is growing.

Horizontal mergers of hospitals generally consolidate existing resources, but in the process hospitals may also add equipment or expand facilities to broaden their range of services. Mergers and the formation of hospital systems have been taking place in both the tax-exempt and taxable sectors. Between 1983 and 1992, the number of hospital systems increased from 249 (representing 2,050 hospitals with 378,000 beds) to 300 (representing 2,826 hospitals with 540,000 beds). At the same time, the total number of nonfederal acute care hospitals declined from 5,788 to 5,292.⁶⁸

Vertical integration of health care institutions has included a variety of joint ventures between physicians and hospitals. In a recent survey of nearly 1,200 top hospital executives by the accounting firm of Deloitte and Touche, 81 percent of the respondents indicated that they did not believe that in five years their institutions would be operating on a stand-alone basis. Hospitals are linking up with physicians' groups and HMOs to provide a wide variety of services, including routine office visits, diagnostic procedures, inpatient treatment, and even home or nursing home care. The traditional hospital--which provides inpatient services ordered by independent physicians--seems to be losing ground to new forms of health care delivery.⁶⁹

Horizontal mergers and integrated delivery systems could, in theory, constrain the growth in costs by consolidating resources. Survey information, however, indicates that mergers have often entailed acquisition of more equipment, renovation of buildings, and construction of new facilities, which--at least over the short run--have caused operating costs and prices to rise at a faster rate than before the mergers took place. For example, a study by Health Care Investment Analysts of 14 mergers involving 28 hospitals reported that the aftermath included higher occupancy rates, improved profit margins, and price increases at higher annual rates. The rate of price increases began to level off four years after the mergers took place.⁷⁰

68. American Hospital Association, *Directory of Multihospital Systems (1980-1987)* and the editions of the *AHA Guide* for the years 1988-1993.

69. Deloitte and Touche, *U.S. Hospitals and the Future of Health Care: A Continuing Opinion Survey--Fifth Edition 1994* (Philadelphia: Deloitte and Touche, 1994), p. 1.

70. Jay Greene, "The Costs of Hospital Mergers," *Modern Healthcare* (February 3, 1992), pp. 36-43.

Affiliations can take many forms, ranging from contractual relationships to fully integrated systems. Among tax-exempt institutions, vertical integration has commonly involved the acquisition by tax-exempt hospitals of for-profit physicians' groups to form a tax-exempt provider network or integrated delivery system. As of July 1994, the IRS had issued several rulings for tax-exempt IDSs under Section 501(c)(3) and was considering additional applications. The new rulings have granted tax-exempt status to foundation-model IDSs. According to an IRS spokesperson, IDSs are "the single biggest development" in the tax-exempt health care sector.⁷¹

The Ways and Means and the Senate Finance Committees' bills would preempt state prohibitions on the corporate practice of medicine and thereby make the formation of tax-exempt, vertically integrated systems a simpler process than it is in several states today. Preempting state laws that prohibit the corporate practice of medicine would make it possible for hospitals to hire physicians as employees and provide medical services directly. This might eliminate the need for hospitals in states with prohibitions against the corporate practice of medicine to use the foundation model in forming an IDS (that is, to establish a new legal entity that must get an exemption from the IRS before moving forward). Tax-exempt hospitals would then be able to acquire physicians' groups or HMOs more quickly and easily, and the growth of tax-exempt vertically integrated delivery systems could accelerate.⁷²

These new developments raise the issue of whether tax-exempt hospitals should continue to be able to acquire for-profit medical groups and operate the resulting integrated delivery system as a tax-exempt entity and, if so, on what basis. Tax-exempt IDSs are quite new. Reliable data do not exist to support or refute the view that just integrating hospital and physician services will benefit a community, either by providing services that had been previously unavailable or by eliminating duplication of procedures, thereby constraining the growth in costs.

The Growth in Tax-Exempt Financing

At the same time that hospital occupancy rates have been declining and hospitals have been reducing the number of their beds, tax-exempt new financing for acute care hospitals has been holding steady. By and large, the

71. T.J. Sullivan, Special Assistant for Health Care, Office of the Assistant Commissioner, Employee Plans and Exempt Organizations, in *Tax Notes* (April 18, 1994), p. 276.

72. Boisture, "Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs," p. 281.

purpose of new financing is to modernize existing facilities, purchase new equipment, and build new outpatient facilities.

Physicians' groups have also used tax-exempt financing, but to a much lesser extent than hospitals. Among physicians' groups, medical faculty practice plans have enjoyed the most favorable credit ratings. Most nonprofit physicians' groups have difficulty gaining access to the tax-exempt bond market unless they are affiliated with a university medical center or a tax-exempt hospital. If a tax-exempt hospital acquires a physicians' group, however, it may be able to use tax-exempt bonds to finance the expansion of clinical facilities.

The emergence of new forms of health care institutions, in particular integrated delivery systems, is likely to lead to increases in the use of tax-exempt financing. Removal of the per-institution limit on outstanding issues of tax-exempt bonds for facilities not integrally related to acute care could lead to further increases.

