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EVOLUTIONARY FORCES: CHANGES IN FOR-PROFIT AND NOT-FOR-PROFIT HEALTH CARE DELIVERY STRUCTURES; A REGENERATION OF TAX EXEMPTION STANDARDS†

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One sure way to determine the social conscience of a Government is to examine the way taxes are collected and how they are spent. And one sure way to determine the social conscience of an individual is to get his tax-reaction. Taxes, after all, are the dues that we pay for the privileges of membership in an organized society.

—Franklin D. Roosevelt, Campaign Address, Worcester, Massachusetts (Oct. 21, 1936)

INTRODUCTION

During the past several decades the structure of our nation's health care delivery system has changed dramatically. It has evolved from primarily fee-for-service health care to largely managed care. It has been marked increasingly by multi-institutional health care provider networks—horizontal networks of hospitals and integrated delivery systems—and decreasingly by independent, freestanding not-for-profit and for-profit hospitals.¹ The structure of physicians' medical practices has been altered. Increasingly, physicians have joined health maintenance organizations, preferred provider organizations, and independent practice associations;² independent practitioners and small

¹ See *infra* notes 79–80, 377–83, 446 and accompanying text.

² See *News Brief: More Doctors Joined Managed Care in 1994, Realized Financial Gains*, PSYCHIATRIC TIMES, July 1995, at 35.

groups of practitioners without particular affiliations are nearing extinction. Joint venture arrangements between hospitals and physicians have formed.³

These and other modifications in our nation's health care system have resulted from numerous factors. Medicare, Medicaid, and private insurers have implemented new reimbursement systems. Competition among health care providers has become fierce. Costs of developing and implementing technological and medical advances have skyrocketed. Large employers, insurance companies, federal and state governments, and health care providers have demanded managed care and managed competition.⁴

New issues have surfaced as challenges to our health care system. Medical school hospitals, once the most respected nurturers of medical advances, technological innovations, and sources of physician training programs, have been hit by hard economic times;⁵ some have been incorporated into for-profit hospital systems.⁶ Religious affiliated hospitals that have merged into secular health care provider systems have faced concerns over ethical positions.⁷ Quality of health care issues plague health care providers and patients.⁸ Debate continues on reforming Medicare and Medicaid.⁹ Legislators, scholars, commentators,

³ See *infra* notes 90-91 and accompanying text.

⁴ See *infra* notes 93, 95 and accompanying text.

⁵ See, e.g., Esther B. Fein, *G.O.P.'s Grim Prognosis for Teaching Hospitals: The Pain of Medicare Cuts Would Be Worse*, N.Y. TIMES, Sept. 23, 1995, § 1, at 9; Esther B. Fein, *Medical Schools Are Urged to Cut Admissions by 20%*, N.Y. TIMES, Nov. 17, 1995, at D2; Elisabeth Rosenthal, *Competition and Cutbacks Hurt Foreign Doctors in U.S.*, N.Y. TIMES, Nov. 7, 1995, at A1.

⁶ See M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035 (1992); Frank Rich, *The Unkindest Cut*, N.Y. TIMES, May 21, 1995, § 4, at 15; Elisabeth Rosenthal, *New Demands for Medical Affiliates*, N.Y. TIMES, May 8, 1995, at B1.

⁷ See, e.g., Tamar Lewin, *With Rise in Health Units Mergers, Catholic Standards Face Challenge*, N.Y. TIMES, Mar. 8, 1995, at B7.

⁸ See, e.g., Mark I. Levy, *'Opt Out' of Managed Care*, PSYCHIATRIC TIMES, July 1995, at 27; Holcomb B. Noble, *Quality is Focus for Health Plans*, N.Y. TIMES, July 3, 1995, § 1, at 1; Robert Pear, *H.M.O.'s Refusing Emergency Claims, Hospitals Assert*, N.Y. TIMES, July 9, 1995, § 1, at 1.

⁹ See, e.g., R.W. Apple, Jr., *G.O.P. Blitzkrieg on Health Care Shakes Capitol*, N.Y. TIMES, Sept. 23, 1995, § 1, at 1; Adam Clymer, *Wary of Congress on Medicaid, Governors Try to Find Unity on Medicaid: Cuts Are a Concern as Are Restrictions*, N.Y. TIMES, July 31, 1995, at A10; Martin Gottlieb, *In G.O.P. Plan, Some See a Widening Gap Between Sick and Healthy*, N.Y. TIMES, Nov. 18, 1995, § 1, at 9; Robert Pear, *Budget Cuts Stall Broader Services in Medicare Plan*, N.Y. TIMES, Nov. 26, 1995, § 1, at 1; Robert Pear, *Congress Preparing a Major Overhaul of Medicaid*, N.Y. TIMES, June 12, 1995, at B7 [hereinafter Pear, *Major Overhaul*]; Robert Pear, *G.O.P. Announces Plan to Overhaul Medicare System*, N.Y. TIMES, Sept. 15, 1995, at A1; Robert Pear, *Republican Governors Working with Congress to Shift Medicaid Authority to States*, N.Y. TIMES, Apr. 2, 1995, § 1, at 20 [hereinafter Pear, *Republican Governors*]; Hilary Stout & Laurie McGinley, *Medicare Premiums Are Taking Center Stage in Budget Battle Between Clinton, Republicans*, WALL ST. J., Nov. 14, 1995, at A16; Robin Toner, *Warning Against Quick Medicare Cuts*, N.Y. TIMES, July 11, 1995, at A16. It has been asserted that federal government spending for Medicare patients has produced too high profits for HMOs and other managed care organizations and insufficient savings for the govern-

and the popular media have criticized not-for-profit hospitals as too profit motivated, too businesslike, and forgetful of their "charitable" missions of providing health care to the medically indigent.¹⁰ These criticisms continue at a time when a significant percentage of Americans—recently reported as between fourteen and twenty-five percent—do not have health insurance at any one time;¹¹ fifty-five percent of women living at or below poverty level do not receive preventive care;¹² and forty-three percent of noncitizens living in this country lack health insurance.¹³ Furthermore, a National Academy of Science recommendation could broaden the definition of poverty, resulting in an even larger segment of the population qualifying for benefits under the current Medicaid system.¹⁴

ment. See, e.g., Erik Eckholm, *H.M.O.'s Are Changing the Face of Medicare*, N.Y. TIMES, Jan. 11, 1995, at A1; Milt Freudenheim, *Medicare, Jot This Down: Employers Offer Valuable Lessons on Saving Money with Managed Care*, N.Y. TIMES, May 31, 1995, at D1.

¹⁰ See, e.g., BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE* 61 (1991); Cyril F. Chang & Howard P. Tuckman, *The Profits of Not-For-Profit Hospitals*, 13 J. HEALTH POL., POL'Y & LAW 547 (1988); Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980); Kenneth W. Clarkson, *Some Implications of Property Rights in Hospital Management*, 15 J.L. & ECON. 363 (1972); Judith Feder et al., *Poor People and Poor Hospitals: Implications for Public Policy*, 9 J. HEALTH POL., POL'Y & LAW 237 (1984); Bradford H. Gray, *Nonprofit Hospitals and the For-Profit Challenge*, 66 BULL. N.Y. ACAD. MED. 366 (1990) [hereinafter Gray, *Nonprofit Hospitals*]; Stanley B. Jones et al., *Competition or Conscience? Mixed-Mission Dilemmas of the Voluntary Hospital*, 24 INQUIRY 110 (1987); Mark V. Pauly, *Nonprofit Firms in Medical Markets*, 77 AM. ECON. REV. 257 (1987); Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980); Susan Rose-Ackerman, *Unfair Competition and Corporate Income Taxation*, 34 STAN. L. REV. 1017 (1982); J. David Seay et al., *Holding Fast to the Good: The Future of the Voluntary Hospital*, 23 INQUIRY 253 (1986); J. Michael Watt et al., *The Comparative Economic Performance of Investor-Owned Chain and Not-for-Profit Hospitals*, 314 NEW ENG. J. MED. 89 (1986); William D. White, *Regulating Competition in a Nonprofit Industry: The Problem of Forprofit Hospitals*, 16 INQUIRY 50 (1979); A "Growing Concern" of Small Business: *Competition with Nonprofits*, "An Issue for the Eighties", PHILANTHROPY MONTHLY, Jan. 1984, at 5; Christina Kent, *A Nonprofit or For-Profit Health System: Does It Matter?*, MED. & HEALTH, Feb. 7, 1994, at S1; Douglass Seaver, *Are Hospitals Becoming Too Businesslike?*, HOSPITALS, Feb. 20, 1990, at 86. For a brief discussion of legislative consideration of these issues, see *infra* note 141.

¹¹ See 140 CONG. REC. H4867 (daily ed. June 22, 1994) (statement of Rep. DeLauro, Democrat from Conn., indicating that approximately 14% of Americans do not have health insurance); FDCH CONGRESSIONAL TESTIMONY, Oct. 9, 1994, available in LEXIS, Legis Library, CNGTST File (statement of Wilhelmina Robertson, Coordinator for Rural and Maternal and Child Health Care in Torrance County, N.M., noting that 25% of all Americans do not have health insurance); *The MacNeil/Lehrer News Hour: Harvest of Revenue?* (Educational Broadcasting, Transcript #4953, June 20, 1994) (reporting that more than 17% of Americans did not have health insurance in 1992).

¹² *Women Pay More for Health Care*, PSYCHIATRIC TIMES, Mar. 1994, at 3 (citing data released by the Women's Research and Education Institute). Women of childbearing age can expect to pay up to 70% more than men for health care, and twice as many women as men between 15 and 44 years old spend more than 10% of their incomes on health care. *Id.*

¹³ This figure was reported for 1993 and is based on the Census Bureau's March 1994 current population survey. *43% of Noncitizens Lack Health Care*, N.Y. TIMES, Jan. 25, 1995, at A13.

¹⁴ See Robert Pear, *A Proposed Definition of Poverty May Raise Number of U.S. Poor*, N.Y. TIMES, Apr. 30, 1995, § 1, at 1.

Despite the attention focused on the revolutionary changes in the health care sector and its structure, to some extent federal laws and regulations impacting the health care system have failed to keep up with the system's quickly evolving environment. Even the Internal Revenue Service ("IRS") has been criticized as slow to develop and disseminate guidance on tax exemption criteria crucial to new health care structures.¹⁵ Those standards announced and applied by the IRS are a conservative and narrow regeneration or revival of older criteria.¹⁶

This article begins in part I with a brief statement about the federal tax statutes that confer tax-exempt status on health care organizations. Part II discusses the historical development of our health care system. Parts III and IV outline the criteria applied by the IRS to the various health care delivery structures and focus on post-1955 standards. Part V advances a tax proposal intended to promote the improvement of health care delivery, quality, access, and research. It is designed to stimulate medical personnel training and medical technological advances. Further, it aims to enhance health care education to communities' populations and consumer education about health care organizations.

It is clear that the present federal income tax scheme impacts structural developments within the health care industry. Yet, it is not clear that the present tax strategy fosters socially and medically beneficial goals in our health care system. Nor is it evident that the current tax regime aids health care organizations' quests for financial efficiency and effectiveness. Immense challenges face the intersection of the current health care sector and any future federal tax program. In pursuit of our nation's daunting health care goals, it is hoped that this article will engender further discussion of the appropriate design of and interplay between the health care and federal tax systems.

I. BACKGROUND

The privilege of some form of tax exemption for hospitals, the first form of health care institution,¹⁷ predates the Revolutionary

¹⁵ See, e.g., *IRS Closing Agreement Raises Questions About Wider Application of Restrictions*, Daily Tax Rep. (BNA), at J-1, J-1 (Oct. 31, 1994), available in Westlaw, BNA-DTR file [hereinafter *IRS Closing Agreement*].

¹⁶ See *infra* part IV.F.6.

¹⁷ Pennsylvania Hospital in Philadelphia, Pa. was the first hospital in this country. It was formally established in 1751 to care for the mentally and physically ill. New York Hospital was organized in 1771, but it did not treat patients until the 1790s. Massachusetts General Hospital did not open until 1821. See CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* 18 (1987); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERI-*

War.¹⁸ Nonetheless, there has never been a provision in the Internal Revenue Code ("I.R.C.") that per se exempts hospitals or other health care organizations from federal income taxation. Today, I.R.C. § 501(a) is applied to confer exemption from federal income taxation on hospitals and other health care organizations, including component institutions of vertical and horizontal health care systems, described under I.R.C. § 501(c)(3) or (c)(4). Although certain tax benefits are granted to I.R.C. § 501(c)(4) organizations, preferential treatment is accorded to organizations qualifying for exemption under I.R.C. § 501(c)(3).¹⁹ While these two provisions have been part of the

CAN MEDICINE 150 (1982); WILLIAM H. WILLIAMS, *AMERICA'S FIRST HOSPITAL: THE PENNSYLVANIA HOSPITAL 1751-1841* (1976). For a brief discussion of almshouses, see *infra* note 21 and accompanying text.

¹⁸ W. HARRISON WELLFORD & JANNE G. GALLAGHER, *UNFAIR COMPETITION: THE CHALLENGE TO CHARITABLE TAX EXEMPTION* 119-20 (1988); David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J.L. & MED. 327, 334 (1990).

¹⁹ After the Civil War, not-for-profit organizations received certain benefits unavailable to for-profit organizations. For example, The Bankruptcy Act of 1867 exempted not-for-profit organizations from voluntary and involuntary bankruptcy, and as late as 1947 not-for-profit institutions were exempt from involuntary bankruptcy. Bankruptcy Act of March 2, 1867, ch. 176, 14 Stat. 517 (1867), *amended by* Act of June 25, 1910, ch. 412, § 4, 36 Stat. 838, 839 (1910), *repealed by* Bankruptcy Act of 1947, ch. 391, 61 Stat. 213 (1947). Favored treatment also extended to exemption from Social Security taxes (Social Security Act of 1935, ch. 531, § 907(c)(7), 49 Stat. 620, 643, (1935), *repealed by* Social Security Amendments of 1983, Pub. L. No. 98-21, § 102, 97 Stat. 65, 70-71 (1983)); federal unemployment insurance (Internal Revenue Code, ch. 9, subch. C, § 1607(c)(7), 53 Stat. 183, 187, (1939)); the minimum wage (per regulations, 29 C.F.R. § 779.214 (1970), and judicial interpretations of Fair Labor Standards Act of 1938, ch. 676, §§ 5-8, 12, 52 Stat. 1060, 1062-64 & 1067 (1938), *amended by* Fair Labor Standards Amendments of 1961, Pub. L. No. 87-30, § 2(r), 75 Stat. 65, 65 (1961)); securities registration (Securities Act of 1933, ch. 38, § 3(a)(4), 48 Stat. 74, 76 (1933) (codified at 15 U.S.C. § 77c(a)(4) (1994)); and unfair trade practice rules (Federal Trade Commission Act, ch. 311, § 5, 38 Stat. 717, 719 (1914) (codified as amended at 15 U.S.C. § 45 (1994))). Moreover, not-for-profits obtained favoritism under the copyright statutes, Copyright Act of 1947, ch. 391, § 1(c) & (e), 61 Stat. 652, 653 (1947), *expanded by* Copyright Act of 1976, Pub. L. No. 94-553, §§ 110-112 & 118(d)(3), 90 Stat. 2541, 2549, 2551, 2559 & 2567 *and by* Act of Oct. 25, 1982, Pub. L. No. 97-366, § 3, 96 Stat. 1759, 1759 (1982), and pursuant to antitrust laws, see *Marjorie Webster Junior College, Inc. v. Middle States Ass'n of Colleges & Secondary Sch., Inc.*, 432 F.2d 650, 654-55 (D.C. Cir.), *cert. denied*, 400 U.S. 965 (1970). Not-for-profit organizations were even protected from tort liability under the judicially created doctrine of charitable immunity. See W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* 1069 (5th ed. 1984); Note, *The Quality of Mercy: 'Charitable Torts' and Their Continuing Immunity*, 100 HARV. L. REV. 1382 (1987). For further discussion of the favored treatment of not-for-profit organizations during the period of 1850-1950, see Henry Hansmann, *The Evolving Law of Nonprofit Organizations: Do Current Trends Make Good Policy?*, 39 CASE W. RES. L. REV. 807, 810-11 (1988-89).

The list of favored treatment for not-for-profit organizations described in I.R.C. § 501(c)(3) (1994) has declined over the past 30 years. For example, the charitable immunity doctrine is largely unavailable. See Note, *supra*, at 1382, 1385. The antitrust laws now are applied with vigor to not-for-profit organizations. See Hansmann, *supra*, at 817. Enforcement of the antitrust laws to mergers, acquisitions, and joint ventures of hospitals and other health care institutions has been increased and has been given much attention lately. See, e.g., Kevin J. Arquit, *Developments and Trends in FTC Antitrust Enforcement*, in 2 35TH ANNUAL ANTITRUST LAW INSTITUTE, at 653 (PLI

statutory landscape for many years,²⁰ the applicability and evolution of key IRS interpretive criteria and standards with respect to hospitals,

Corp. L. & Prac. Course Handbook Series No. B-847, 1994); William T. Litland, *Monopolies and Joint Ventures*, in 1 35TH ANNUAL ANTITRUST LAW INSTITUTE, at 141 (PLI Corp. L. & Prac. Course Handbook Series No. B-846, 1994); Judy L. Whalley, *Mergers and Acquisitions Update*, in 1 35TH ANNUAL ANTITRUST LAW INSTITUTE, at 317 (PLI Corp. L. & Prac. Course Handbook Series No. B-846, 1994); see also Fredric J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107 (1994); William G. Kopit & Robert W. McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 J. HEALTH POL., POL'Y AND LAW 635 (1988); Dayna B. Matthew, *Doing What Comes Naturally: Antitrust Law and Hospital Mergers*, 31 HOUS. L. REV. 813 (1994); David L. Meyer & Charles F. (Rick) Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169 (1994); Owen S. Mudge, Jr. & Allan Gibofsky, *The Developing Application of Antitrust Laws to Hospital Mergers*, 15 J. LEGAL MED. 355 (1994).

However, § 501(c)(3) organizations do retain favored treatment in certain areas of the law. For example, copyright laws, 17 U.S.C. § 110(10) (1994), and minimum wage laws, 29 U.S.C. § 203(r) (1994), interpreted by 29 C.F.R. § 779.214 (1994), continue to favor these not-for-profit organizations.

Among the special tax benefits currently applicable to § 501(c)(3) organizations are the following: exemption from income taxation under I.R.C. § 501(a) (1994); eligibility for the receipt of charitable contributions that are deductible by donors in calculating income tax liability, I.R.C. § 170 (1994), and gift tax liability, I.R.C. § 2522 (1994), and that reduce estate tax liability by the value of a charitable bequest, I.R.C. § 2055(a)(2) (1994); eligibility to raise capital through the issuance of tax-exempt "qualified § 501(c)(3) bonds" under I.R.C. § 145 (1994); flexibility to structure certain employee compensation plans, such as tax sheltered annuities under I.R.C. § 403(b) (1994); exemption from the federal unemployment payroll tax pursuant to I.R.C. §§ 3301 & 3306(c)(8) (1994); and exemption from the communications services excise tax pursuant to I.R.C. § 4253(h) (1994). Although many jurisdictions continue to exempt § 501(c)(3) organizations from state and local sales, income, and property taxes, some jurisdictions have curtailed or have begun programs of scrutinizing this favoritism, especially with respect to "charitable" not-for-profit institutions. See, e.g., *Tex. Tax Code Ann.* § 11.18(d) (West 1995); *West Allegheny Hosp. v. Board of Prop. Assessment*, 455 A.2d 1170 (Pa. 1982); *School Dist. v. Hamot Medical Center*, 602 A.2d 407 (Pa. Commw. Ct. 1992); *Hospital Utilization Project v. Commonwealth*, 461 A.2d 894 (Pa. Commw. Ct. 1983); *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985); see also Mark F. Baldwin, *Legislatures, Agencies Debating Whether Not-For-Profit Hospitals Deserve Their Tax-Exempt Status*, MOD. HEALTHCARE, May 22, 1987, at 34; David A. Hyman & T.J. McCarthy, *Property Tax Exemptions: Headed for Extinction?*, HEALTH PROGRESS, Dec. 1988, at 32; *Strapped Governments Eye Nonprofit Hospitals*, 47 MED. & HEALTH, Aug. 2, 1993.

Furthermore, any § 501(c)(3) organization that is not a private foundation under I.R.C. § 509(a) (1994) but instead is considered a "public charity" currently is free from certain excise taxes, levied against private foundations involved in prohibited transactions, such as "self-dealing," and in certain investment activities. See I.R.C. §§ 4940-48 (1994) (relating to private foundations).

Unlike the class of organizations described under I.R.C. § 501(c)(3), those qualifying under I.R.C. § 501(c)(4) (1994) are not permitted to issue tax-exempt bonds pursuant to I.R.C. § 145 (1994); with certain limited exceptions, are not eligible to provide donors the opportunity to claim tax deductible charitable contributions under I.R.C. § 170 (1994); and often do not qualify under state laws for property tax exemptions. BRUCE R. HOPKINS, *THE LAW OF TAX EXEMPT ORGANIZATIONS* 564-68 (6th ed. 1992 & Supp. 1994).

²⁰ The earliest history of the income tax exemption dates to an administrative ruling issued during the Civil War, the only period prior to 1894 during which an income tax was imposed by the United States government. Pursuant to Treasury Decision 110, "the income of literary,

other health care organizations, and health care systems have been marked by periods of progression as well as stagnation.

II. HISTORICAL ROOTS OF HEALTH CARE ORGANIZATIONS

A. *The Eighteenth and Nineteenth Centuries*

To understand the evolutionary process of tax exemption applicable to health care organizations, one must begin at the roots of our contemporary health care institutions. Just as in western Europe and England, almshouses, which housed the ill, homeless, and poor until their deaths, were the predecessors of hospitals in the United States.²¹

scientific or other charitable institutions, in the hands of trustees or others, is not subject to income tax." Treas. Dec. 110 (May 1863), cited in *Tax Reform of 1969: Hearings on H.R. 13270 Before the Committee on Ways and Means, House of Representatives*, 91st Cong., 1st Sess. 1425, 1428 n.1 (1969) (Statement by Julius M. Greisman, Attorney, American Hospital Association; accompanied by John W. Kauffmann, Administrator, Princeton Hospital, and Chairman, American Hospital Association Council on Legislation, and Kenneth Williamson, Deputy Director). As part of The Tariff Act of 1894, Congress enacted the first federal income tax exemption for charitable organizations. Act of August 27, 1894, ch. 349, § 32, 28 Stat. 509, 556 (1894). One year later, the Supreme Court declared the Tariff Act unconstitutional. *Pollack v. Farmers' Loan & Trust Co.*, 158 U.S. 601 (1895). The Tariff Act of 1909, which generally imposed an excise tax on "every corporation, joint stock company, or association, organized for profit and having a capital stock represented by shares," exempted from the excise tax, among other organizations, "any corporation or association organized and operated exclusively for religious, charitable, or educational purposes, no part of the net income of which inures to the benefit of any private stockholder or individual." Tariff Act of 1909, ch. 6, § 38, 36 Stat. 11, 112-13 (1909). In 1913, Congress expanded the excise tax exemption to include "any corporation or association organized and operated exclusively for religious, charitable, scientific, or educational purposes." Revenue Act of 1913, ch.16, § II(G), 38 Stat. 114, 172 (1913). As part of the Internal Revenue Code of 1939, organizations exempt from income taxation included any "[c]orporation, and any community chest or fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary or educational purposes or for the prevention of cruelty to children or animals." Internal Revenue Code, ch. 9, subch. C, § 1607(c)(7), 53 Stat. 183, 187 (1939). The tax exemption for these organizations was recodified as § 501(c)(3) of the Internal Revenue Code of 1954, Pub. L. No. 591, 68A Stat. 3 (1954). Numerous legislative provisions expanded the reach of the tax exemption, to include such organizations as those that provide public safety testing, Revenue Act of 1948, ch. 168, 62 Stat. 110 (1948), and amateur sports organizations, Tax Reform Act of 1976, Pub. L. No. 94-455, 90 Stat. 1520 (1976). Prohibitions against legislative activities and lobbying have long been a part of the statutory requirements for tax exemption of charitable organizations—added first as part of the Revenue Act of 1934, Pub. L. No. 216, 48 Stat. 680 (1934), and expanded greatly in subsequent years, most recently in the Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330 (1987). For further detailed histories, see for example, Kenneth Liles & Cynthia Blum, *Development of the Federal Tax Treatment of Charities*, 39 LAW & CONTEMP. PROBS. 6 (1975); John P. Persons et al., *Criteria for Exemption Under Section 501(c)(3)*, in RESEARCH PAPERS SPONSORED BY COMMISSION ON PRIVATE PHILANTHROPY AND PUBLIC NEEDS 1909 (U.S. Dept. of Treas. 1977).

²¹ As early as 1713, almshouses provided shelter to ill poor persons, foundlings, the mentally unbalanced, the physically handicapped and even criminals. The first such almshouse was the

But as citizens recognized the need to provide health care for the poor suffering from physical and mental illnesses, the concept of hospitals began to change. Newer hospitals were founded in this country as places to treat the poor for physical and mental maladies.²² People of higher incomes continued to be treated by physicians either in the patients' homes or the physicians' clinics. Two separate health care provider systems were established: hospitals for the poor, largely supported by government subsidies and religious organizations, and physician-provided care, supported by patient fees.²³

At the end of the nineteenth century, when hospitals developed into more sanitary places to quarantine and care for persons with infectious diseases, and anesthesia and asepsis became available, people other than the poor began to receive health care outside of their homes or doctors' clinics.²⁴ Nevertheless, the health care system remained largely divided. Larger voluntary hospitals, typically supported by philanthropic contributions, served the poorer population, and small, doctor-owned, proprietary hospitals generally catered to self-paying wealthier individuals.²⁵

During the nineteenth century, medical education also took on a life of its own. Lengthy apprenticeships required by the guild system for physician training began to dissolve as medical schools were formed.²⁶ Medical training of physicians shifted to these new medical

Philadelphia Almshouse. See STANLEY JOEL REISER, *MEDICINE AND THE REIGN OF TECHNOLOGY* 152 (1978); ROSENBERG, *supra* note 17, at 116; STARR, *supra* note 17, 149-52; Robert S. Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237, 239 (1970). From almshouses arose hospitals, the first of which was Pennsylvania Hospital. See *supra* note 17.

²² See STARR, *supra* note 17, at 145-79; WILLIAMS, *supra* note 17, at 2. These hospitals were largely supported by religious organizations and government subsidies. See STARR, *supra* note 17, at 145-79; WILLIAMS, *supra* note 17, at 2; see also MARSHALL W. RAFFEL, *THE U.S. HEALTH SYSTEM: ORIGINS AND FUNCTIONS* 241-46 (1980); Rosemary Stevens, "A Poor Sort of Memory": *Voluntary Hospitals and Government Before the Depression*, 60 MILBANK MEMORIAL FUND Q. 551, 552-55 (1982).

²³ STARR, *supra* note 17, at 157, 160-61. Before the late 1800s, much of household medicine was identical with treatment that could be provided by hospitals. ROSENBERG, *supra* note 17, at 5. The hospital of this era was defined mostly by need and dependency. *Id.*

²⁴ See ROSENBERG, *supra* note 17, at 116-65.

²⁵ See ROSENBERG, *supra* note 17, at 116; Bromberg, *supra* note 21, at 239; Hansmann, *supra* note 19, at 813.

²⁶ America's earliest hospital wards were the training grounds for early physicians. See ROSENBERG, *supra* note 17, at 190-200. By 1810, there were five medical schools, including ones at the University of Pennsylvania, Harvard University, Dartmouth, and New York College of Physicians. *Id.* at 20; Carson W. Bays, *Why Most Private Hospitals Are Nonprofit*, 2 J. POL'Y ANALYSIS & MGMT. 366, 374 (1983). However, the curriculum at this time was entirely didactic, with a few formal lectures required for a medical degree. ROSENBERG, *supra* note 17, at 190-200. Clinical training was not part of the responsibility of the medical schools at this time. *Id.* By 1900, there were 160 medical schools. Bays, *supra*, at 374.

schools, most of which were proprietary.²⁷ By the latter part of the nineteenth century, medical education was marked by reform, triggered partly by the American Medical Association's success in having all states establish licensing standards for physicians.²⁸ In the 1870s, Harvard University and the University of Pennsylvania expanded their medical schools' curricula and physician training periods. In 1893, Johns Hopkins University opened its medical school, which incorporated unprecedented entry requirements and curricula programs for those training to be physicians.²⁹ A combination of education reforms and economic influences caused the virtual elimination of proprietary medical schools by the mid-1920s.³⁰

B. *The Twentieth Century*

1. Freestanding Hospitals

By the beginning of the twentieth century, hospitals had assumed a formal character and position in American society. The number of hospitals was divided almost evenly between doctor-owned ("proprietary") and charitable ("voluntary") hospitals.³¹ The bifurcation was largely regionally representative. Eastern and midwestern metropolitan areas were marked primarily by a small number of municipal hospitals, a few small ethnic and religious hospitals, and some larger nongovernmental, nonsectarian voluntary hospitals operated by volun-

²⁷ See *supra* note 26.

²⁸ In 1847 the American Medical Association ("AMA") began to lobby state legislatures to adopt AMA standards for licensing physicians. Between 1880 and 1900, the AMA was successful in accomplishing this goal. See Bays, *supra* note 26, at 374.

²⁹ Johns Hopkins required all entering students to have a college degree. It was the first medical school to institute a four-year program. See STARR, *supra* note 17, at 115.

³⁰ The 1910 publication of the Flexner Report, which spurred improvements in medical education standards, has been claimed as a major influence on the demise of proprietary medical education. ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (Carnegie Found. Bulletin No. 4, 1910), discussed in ROSENBERG, *supra* note 17, at 209-11; STARR, *supra* note 17, at 118-23; Bays, *supra* note 26, at 374; Mark Schlesinger et al., *Nonprofit and For-Profit Medical Care: Shifting Roles and Implications for Health Policy*, 12 J. HEALTH POL., POL'Y & LAW 427, 431 (1987).

³¹ By 1910, America had 4359 hospitals, which did not include mental or chronic disease hospitals, such as tuberculosis sanitariums. ROSENBERG, *supra* note 17, at 5. Of the 4359 hospitals, 2441 were proprietary hospitals. Bays, *supra* note 26, at 367. Much of the growth appeared to be in the number of proprietary hospitals, as state and local governments had begun to withdraw some of their subsidies. See Theodore R. Marmor et al., *A New Look at Nonprofits: Health Care Policy in a Competitive Age*, 3 YALE J. ON REG. 313, 322 (1986); Schlesinger et al., *supra* note 30, at 430; Stevens, *supra* note 22, at 565-66.

tary boards of trustees and largely supported by philanthropy.³² The government-subsidized municipal hospitals generally furnished health care to the poor. The voluntary hospitals, which often were aligned with medical schools, provided acute care to low-income and nonpaying patients (especially for teaching purposes) as well as to some paying patients.³³ Frontier communities of the West, where most of this country's expansion had occurred in the late nineteenth century, were primarily represented by small proprietary hospitals.³⁴

Even though the proprietary institutions were disproportionately represented in the fast-growing western region of the country, their relative number began to decline, and by 1928, proprietary hospitals represented only thirty-five percent of all hospitals in the United States.³⁵ At the same time, the number of voluntary hospitals had grown. Thus, between 1900 and 1930, the character of the health care sector had started to change;³⁶ the trend moved toward a diminished role for proprietary hospitals.³⁷ Yet, regardless of its nature, the hospital

³² See STARR, *supra* note 17, at 170-72, 219; ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY 20 (1989).

³³ STARR, *supra* note 17, at 112-23.

³⁴ In large part, proprietary hospitals were found in frontier communities because there were few funds to create not-for-profit hospitals, and a strong philanthropic tradition had not had time to develop. See STARR, *supra* note 17, at 170-71; Bruce Steinwald & Duncan Neuhauser, *The Role of the Proprietary Hospital*, 35 LAW & CONTEMP. PROBS. 817, 820 (1970). A rise in proprietary hospitals in the 1920s and 1930s is reported to be attributable to the establishment of hospitals by doctors who needed hospital privileges for their practice of medicine, but who were excluded from the medical staffs of not-for-profit hospitals for professional, ethnic, religious, or other reasons. STARR, *supra* note 17, at 165; Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U. L.J. 1015, 1024 (1988).

³⁵ In 1928, of 6852 hospitals in the United States, 2435 were proprietary. Bays, *supra* note 26, at 367. See Schlesinger et al., *supra* note 30, at 431.

³⁶ As summarized by one medical historian—

By the First World War, the hospital had grown markedly different from its antebellum predecessors, just as American Society itself had changed. Those traditional ties of deference, patronage, and social responsibility that had created an implicit structure for the hospital in Federalist America had faded by the end of the nineteenth century. Oversight by pious and paternalistic laymen had been largely replaced by the seemingly impersonal and neutral categories of medical diagnosis and the self-confident management of professional administrators and aspiring physicians. To many physicians and increasing numbers of laymen, the hospital had become the only appropriate place to practice medicine of the highest quality. . . . [By 1920, it] had become central to medical education and was well integrated into the career patterns of regular physicians; in urban areas it had already replaced the family as the site for treating serious illness and managing death. Perhaps most important, it had already been clothed with a legitimating aura of science and almost boundless social expectation.

ROSENBERG, *supra* note 17, at 9-10.

³⁷ It has been reported that all types of proprietary health care institutions took on a diminished role by the mid-1920s. See Schlesinger et al., *supra* note 30, at 431.

had become firmly established as a vital health care provider in the community.³⁸

By the mid-1940s, the number and significance of voluntary hospitals had increased and proprietary hospitals had declined substantially.³⁹ Some of the proprietary hospitals had closed; others had converted into not-for-profit institutions.⁴⁰ By 1946, nongovernment voluntary hospitals accounted for fifty-eight percent of all general acute-care hospitals, while proprietary hospitals accounted for only twenty-four percent.⁴¹

Many factors contributed to this transformation. There were innumerable drug and technological innovations, as well as new developments in diagnostic and laboratory procedures. Training for nurses and physicians became more sophisticated, and new medical specialties were created. Furthermore, the availability of health insurance contributed to the growth of the not-for-profit health care sector. The most influential forces behind this growth were limited public insurance provided under the Old Age and Survivor's insurance program,⁴² and private hospital and health insurance, initially provided through Blue Cross and Blue Shield.⁴³ These insurance programs reinforced the public's accessibility to hospital services.⁴⁴ Blue Cross and Blue

³⁸ See ROSENBERG, *supra* note 17, at 9-10, 310-36; Bromberg, *supra* note 21, at 239.

³⁹ See STARR, *supra* note 17, at 219. According to American Hospital Association ("AHA") Hospital Statistics, by 1946, to provide general and special acute-care services, there were 2584 nongovernment voluntary hospitals, 1076 proprietary hospitals, and 785 state and local government hospitals. Moreover, the bed capacities and actual patient admissions of the nongovernment voluntary hospitals far exceeded those of proprietary hospitals and government hospitals. AHA HOSPITAL STATISTICS, Table 4 (1994) [hereinafter AHA STATISTICS]. The nongovernment voluntary hospitals maintained 301,000 beds and admitted 9,554,000 patients; the proprietary hospitals had 39,000 beds available and admitted 1,408,000 patients; the governmental hospitals maintained 133,000 beds and admitted 2,694,000 patients in 1946. *Id.*

⁴⁰ STARR, *supra* note 17, at 219.

⁴¹ See *supra* note 39.

⁴² In 1935, Congress made available the federal Old Age and Survivor's insurance program, the predecessor of Medicare. See ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID, 13-14 (1974); Steven Golub, *The Role of Medicare Reimbursement in Contemporary Hospital Finance*, 11 AM. J.L. & MED. 501, 504 (1986); Maxwell J. Mehlman & Karen A. Visocan, *Medicare and Medicaid: Are They Just Health Care Systems?*, 29 HOUS. L. REV. 835, 840 n.12 (1992).

⁴³ See Mancino, *supra* note 34, at 1023; Schlesinger et al., *supra* note 30, at 431. In 1929, the concept of prepaid medical insurance, which initially had been opposed by the American Medical Association, was introduced by Blue Cross. Soon thereafter, Blue Shield was established to provide medical insurance. Both Blue Cross and Blue Shield were established as nonprofit corporations under state enabling laws, which effectively sanctioned the Blues as monopolies in providing "service benefit" plans. SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG? 8-9 (1974).

The genesis of Blue Cross is attributed to a hospital insurance plan formed in 1929 by Dr. Justin Ford Kimball at Baylor University Hospital. See STARR, *supra* note 17, at 295-98; RAFFEL, *supra* note 22, at 393-94.

⁴⁴ Congressional enactment of the Wagner Act in 1935, ch. 372, 49 Stat. 449 (1935) (codified

Shield particularly strengthened the dominant position of voluntary hospitals by negotiating lower reimbursement rates with proprietary hospitals.⁴⁵

After 1946, the number of independent voluntary hospitals increased and, by 1964, reached its zenith.⁴⁶ Perhaps the most momentous event that contributed to this achievement was the 1946 enactment of the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act.⁴⁷ This legislation was intended to subsidize construction of nonprofit and public health care facilities, allocating billions of dollars to the construction of acute-care general hospitals, health clinics, and nursing homes.⁴⁸

as amended at 29 U.S.C. §§ 151-69 (1994)), which enabled workers to bargain collectively was influential in increasing the availability of health insurance to workers as part of their employee benefits. See Golub, *supra* note 42, at 504.

By the early 1940s more than two-thirds of all health plans were provided by nonprofit plans. Marmor et al., *supra* note 31, at 324 (citing Mark Schlesinger, Public, For-Profit and Private Nonprofit Enterprises: A Study of Mixed Industries 79 (1984) (unpublished Ph.D. dissertation, University of Wisconsin (Madison))); Schlesinger et al., *supra* note 30, at 432.

⁴⁵ Marmor et al., *supra* note 31, at 324; Schlesinger et al., *supra* note 30, at 432.

⁴⁶ The number of voluntary hospitals increased by almost 1000 independent hospitals from 1946 through 1965. See *supra* note 39 (providing 1946 statistics on numbers of hospitals, beds and patient admissions for acute care based on nongovernment voluntary, proprietary, and government categories). In 1950, the relative percentages of acute-care hospitals were the same as for 1946, but by 1955, nongovernment voluntary hospitals had increased by a small margin. AHA STATISTICS, *supra* note 39. In 1950, of the acute-care hospitals registered with the AHA, 2871 were nongovernment voluntary, 1218 were proprietary, and 942 were government hospitals. *Id.* In the same year, nongovernment voluntary hospitals maintained 332,000 beds and admitted 11,629,000 patients; proprietary hospitals maintained 42,000 beds and admitted 1,661,000 patients; and government hospitals maintained 131,000 beds and admitted 3,374,000 patients. *Id.* In 1955, nongovernment voluntary hospitals maintained 389,000 beds and admitted 13,875,000 patients; proprietary hospitals maintained 37,000 beds and admitted 1,459,000 patients; and government hospitals maintained 142,000 beds and admitted 3,766,000 patients. *Id.* In 1960, a total of 3291 nongovernment voluntary hospitals maintained 446,000 beds and admitted 16,788,000 patients; 856 proprietary hospitals maintained 37,000 beds and admitted 1,550,000 patients; and 1260 government hospitals maintained 156,000 beds and admitted 4,632,000 patients. *Id.* By 1965, the number of nongovernment voluntary hospitals had peaked, although the number of patient admissions and beds would not reach their height until 1981 and 1983, respectively. *Id.* In 1965, a total of 3426 nongovernment voluntary hospitals maintained 515,000 beds and admitted 19,001,000 patients; 857 proprietary hospitals maintained 47,000 beds and admitted 1,844,000 patients; and 1453 government hospitals maintained 179,000 beds and admitted 5,617,000 patients. *Id.*

⁴⁷ Ch. 958, 60 Stat. 1040 (1946).

⁴⁸ *Id.* The express purpose of the Hill-Burton Act was to assist the states in modernizing health care facilities after World War II by furnishing "adequate hospital, clinic or similar services to all their people." *Id.*; see also *Hearings on § 191 Before the Senate Committee on Education and Labor*, 79th Cong., 1st Sess. 30, 190-91 (1945). This would be accomplished through government grants and loans. Congress authorized the Surgeon General to issue regulations requiring the provision of uncompensated care and community assurance as conditions to the receipt of funds under the Hill-Burton program. Pub. L. No. 79-725, § 622(f), 60 Stat. 1040, 1043 (1946). These

The availability of health insurance also affected the composition of our nation's hospitals after 1946. As hospital and health care insurance coverage reached more people, demand for health care accelerated.⁴⁹ The then-not-for-profit Blue Cross and Blue Shield continued to reimburse voluntary hospitals at rates exceeding those paid to proprietary hospitals.⁵⁰

Private commercial insurers had entered the marketplace, enticed many insureds away from Blue Cross and Blue Shield, and also developed favorable reimbursement programs.⁵¹ Thus, private commercial

conditions effectively limited the program to voluntary health care facilities. In exchange for Hill-Burton funds, each facility agreed to provide a "reasonable volume of free or reduced cost care" to "individuals unable to pay" and to "make their services available to all" persons on a nondiscriminatory basis who were residing in the general service area of the health care facility. *Id.* The Hill-Burton program was successful in channeling funds for hospital projects to smaller towns and rural areas. ROSEMARY STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* 509-10 (1971). Billions of dollars through the program were dedicated to adding hospital and nursing home beds, public health clinics, rehabilitation centers and other medical care facilities. *Id.* at 510 & n.21. For an in-depth analysis of the Hill-Burton legislative history, see James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 *IOWA L. REV.* 1227 (1984); Marilyn G. Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 *NW. L. REV.* 168 (1975); Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 *YALE L.J.* 243 (1978). For a detailed discussion of the community service and uncompensated care obligations, see Michael A. Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 *J. HEALTH POL., POL'Y & LAW* 153 (1987); Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Facilities*, 23 *B.C. L. REV.* 577 (1982).

⁴⁹ As explained by one author:

World War II also indirectly promoted the popularity of health insurance as an employee benefit, since wartime wage and price controls did not apply to fringe benefits. Hence, between 1940 and 1950, the number of people covered by hospitalization insurance increased from 12 million to 77 million. During the 1940s, as health insurance coverage increased in availability and scope, there was a concomitant rise in the development and use of new medical technology. As a result, both the demand for and cost of health care services accelerated.

Golub, *supra* note 42, at 504.

⁵⁰ Schlesinger et al., *supra* note 30, at 432 n.4.

⁵¹ Since inception, Blue Cross and Blue Shield, not-for-profit organizations, had offered private insurance with premiums based on the average of the actuarial medical experiences of all employee groups of different companies in an area ("community rating"). Entry of for-profit private commercial insurers into the marketplace profoundly affected the private health insurance industry. These for-profit private insurers offered health insurance at lower premiums than available through Blue Cross and Blue Shield. They based their premiums on the use of medical care in the community, which provided a broader base to spread their risk of loss, and hence enabled lower premiums to be offered. By the 1960s, Blue Cross and Blue Shield virtually abandoned community rating for experience rating based on smaller health insurance pools. See JOHN KRIZAY & ANDREW WILSON, *THE PATIENT AS CONSUMER* 40 (1974); STARR, *supra* note 17, at 295-310 (providing a comprehensive history of the development of Blue Cross and Blue Shield); James R. Bruner, *AIDS and ERISA Preemption: The Double Threat*, 41 *DUKE L.J.* 1115, 1120 & n.28 (1991); Marmor et al., *supra* note 31, at 327; Schlesinger et al., *supra* note 30, at 434.

insurers and Blue Cross and Blue Shield directly contributed to the voluntary hospital sector's growth.

2. Medicaid/Medicare and Private Insurer Reimbursement Systems

The enactment of Medicare and Medicaid in 1965 dramatically influenced the complexion of America's health care and Americans' attitudes toward its accessibility and provision.⁵² Under Medicare, which maintains health benefits for the elderly and disabled covered by the Social Security Act,⁵³ payments to hospitals and other health care providers were patterned after the reimbursement program used by Blue Cross and other private insurers. At that time, the Medicare program operated on a "cost-plus" reimbursement basis. It essentially was an open-end entitlement system with no limits on reimbursement amounts for covered medical services. Medicare reimbursements to hospitals were perceived as particularly generous as a result of its provisions for depreciation allowances for capital.⁵⁴ Under Medicaid, a joint federal- and state-funded program that provides health benefits

⁵² The Medicare Act provides hospital and medical insurance for the aged and is financed by federal payroll taxes. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102, 79 Stat. 286, 291-332 (1965) (current version at 42 U.S.C. §§ 1395-1395yy (1994)). The Medicaid Act provides matching federal funds for state medical assistance to the indigent. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (1965) (current version at 42 U.S.C. §§ 1396-1396v (1994)). The Medicare and Medicaid programs have been subject to much Congressional debate and discussion as of late. See, e.g., *Reforming our Nation's Health Care System: Hearings on S. 541 Before the Senate Comm. on Labor and Human Resources*, 98th Cong., 2nd Sess. 19 (1984) (statement of Dr. George Prothro, former president of the Tulsa Coalition for Older People); *Resolving Catastrophic Health Problems in the Medicare Program: Hearings on S. 401 Before the Senate Subcomm. on Government Efficiency, Federalism, and the District of Columbia of the Senate Comm. on Governmental Affairs*, 100th Cong., 1st Sess. 17 (1987) (statement of Robert Maxwell, Vice President, AARP); *Medicaid Issues Under Health Care Reform: Hearings on S. 361 Before the Senate Comm. on Finance*, 103d Cong., 2d Sess. 2 (1994) (statement of Raymond G. Scheppach, Executive Director, National Governors Association, Washington, D.C.); *Medicare Issues Under Health Care Reform: Hearings on S. 361 Before the Senate Comm. on Finance*, 103d Cong., 2d Sess. 6 (1994) (statement of Richard J. Davidson, President, American Hospital Association, Washington, D.C.).

⁵³ The Medicare program is composed of two distinct and complementary parts: Part A, the hospital insurance portion; and Part B, the supplemental medical insurance segment. See Beth-Ann Schauer & David B. Nash, *The Changing Face of Medicare and Medicaid*, in MEDICAL PRACTICE IN THE CURRENT HEALTH CARE ENVIRONMENT 68 (Janice C. Edwards ed., 1995) [hereinafter MEDICAL PRACTICE]. Part A finances four basic benefits, including 90 days of inpatient care in a benefit period, care in a skilled nursing facility for continued treatment or rehabilitation after discharge from the hospital, visits by a home health agency, and hospice care for terminally ill patients. *Id.* Medicare patients must pay a deductible for each benefit period when receiving services covered by Part A, and co-insurance is required for certain services, such as care in the skilled nursing facility. *Id.* at 68.

⁵⁴ 42 C.F.R. §§ 413.134-149 (1994). The depreciation allowance effectively adjusted the Medicare reimbursements for inflation. See JUDITH M. FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE 113-17 (1977); Marmor et al., *supra* note 31, at 328.

for low-income individuals,⁵⁵ reimbursement to health care providers was based on charges for medical services. An economic pattern developed: the unbridled reimbursement methods of third-party insurers were followed by providers' increased charges for health care services, which in turn, led to higher reimbursements from the insurers.

Perhaps proprietary health care providers recognized that profits could be made from the public and private health insurance systems.⁵⁶

⁵⁵ As originally designed, Medicaid was to cover persons receiving cash payments under a welfare program, either Aid to Families with Dependent Children ("AFDC") or Supplemental Security Income. Schauer & Nash, *supra* note 53, at 72. Individuals who do not receive cash assistance from one of these welfare programs are generally not entitled to Medicaid regardless of their income levels. Medicaid currently covers three groups of people: low-income elderly; severely mentally retarded, blind, and permanently and totally physically disabled persons; and low-income children from single-parent families and their parents. *Id.* at 70-71. Single persons and childless couples who are not aged or disabled cannot receive Medicaid benefits. Medicaid finances health care for children of low-income families, a group composed largely of families receiving aid through the AFDC program and of other low-income families (such as pregnant women with children) regardless of AFDC status. Thomas W. Reilly et al., *Trends in Medicaid Payments and Utilization, 1975-89*, HEALTH CARE FINANCING REV., 1990 Ann. Supp., at 15, 17. In 1989, children of low-income families accounted for nearly 44% of all Medicaid recipients but were attributed less than 13% of all Medicaid payments. *Id.* at 26-27. The elderly account for approximately 75% of all persons utilizing Medicaid for nursing care. KAREN DAVIS & DIANE ROWLAND, MEDICARE POLICY: NEW DIRECTIONS FOR HEALTH AND LONG TERM CARE 65 (1986). In 1987, Medicaid paid for 36% of all expenditures for nursing home care for the elderly. Daniel R. Waldo et al., *Health Care Financing Trends: Health Expenditures by Age Group, 1977 and 1987*, HEALTH CARE FINANCING REV., Summer 1989, at 111, 114.

Although certain federal requirements must be met, each of the 50 states and the District of Columbia in essence has its own Medicaid program. This means that the Medicaid program in each jurisdiction may differ as to who is covered, the scope of services reimbursed, and the rate of reimbursement. Although certain basic health services must be provided by the states, they may elect to provide other services, such as intermediate care facility services, prescription drug reimbursement, dental care and optometry services. Payments are made directly to the health care providers rather than to the Medicaid recipient. Because the methods of payment vary according to the jurisdiction, there are many varieties of payment. However, the health care provider must accept the Medicaid reimbursement rate as payment in full, even though such payments are often less generous than Medicare payments. In 1987, Congress required states to amend their Medicaid plans to provide a disproportionate share adjustment to hospitals that provide health care to a large number of low income individuals. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4112(a), 101 Stat. 1330, 1330-148 to -149 (1987) (codified at 42 U.S.C. §§ 1396r-4, 1396s (1994)).

Federal spending on Medicaid has quadrupled in the last decade, with 1994 expenditures totaling approximately \$82 billion. It currently costs about six times the amounts paid under AFDC. On average, states contribute 75 cents for each dollar received from the federal government for Medicaid, but states with high per capita incomes must match the federal funds dollar-for-dollar. See Pear, *Republican Governors*, *supra* note 8, at A20. Currently Congress is considering proposals for reducing Medicaid costs. See *id.*

For a general discussion of Medicare and Medicaid, see, for example, Schauer & Nash, *supra* note 53, at 59-85; Thomas C.W. Joe et al., *Arbitrary Access to Care: The Case for Reforming Medicaid*, HEALTH AFF., Spring 1985, at 59, 59-74.

⁵⁶ One feature of Medicare that might have contributed to this recognition by the proprietary hospitals was the policy of paying proprietary hospitals (and not nonprofit hospitals) a return on

During the initial period after enactment of Medicare and Medicaid, growth accelerated in the for-profit sector of health care providers; proprietary hospitals and nursing homes realized an increase in the relative share of health care services.⁵⁷ However, more pronounced growth in the for-profit sector was yet to come.⁵⁸

In an effort to curb rising health care costs, in 1972 Congress enacted the first limits on reimbursements under Medicare's cost-plus, fee-for-service system.⁵⁹ The Medicare "reasonable cost" limits on reimbursable amounts were rather arbitrary and of limited value as a deterrent against rising health care costs and reimbursements.⁶⁰ At the

equity payment. 42 C.F.R. § 413.157 (1995). This advantageous payment effectively was made to compensate investors in proprietary hospitals with a return for their investment risk. Prior to the Social Security Amendments of 1983, the return on equity payment was based on 150% of the current interest rate earned on funds in the federal government's hospital insurance trust fund. The Social Security Amendments of 1983 reduced by one-third the return on equity payments. See John K. Iglehart, *Medicare Begins Prospective Payment of Hospitals*, 308 NEW ENG. J. MED. 1428, 1431 (1983).

⁵⁷ See Marmor et al., *supra* note 31, at 327 (citing Schlesinger, *supra* note 44, at 79, 80); Schlesinger et al., *supra* note 30, at 433-34; Seay et al., *supra* note 10, at 253; see also AHA STATISTICS, *supra* note 39 (data indicating between 1965 and 1973 a slightly declining number of voluntary hospitals, increasing admissions and beds of proprietary and voluntary hospitals). Nonetheless, in 1975, proprietary hospitals accounted for only 12.9% of the nonfederal acute-care short-term hospitals and only 7.9% of the beds. *Id.* At the same time, voluntary hospitals accounted for 56.3% of all nonfederal acute-care short-term hospitals and 70.8% of the beds. *Id.*

One commentator suggested that Medicare and Medicaid encouraged the growth of proprietary hospitals in two ways: (1) by reducing the amount of unavoidable bad debts of hospitals, and (2) by substituting government payments for donations to not-for-profit hospitals. Richard W. Foster, *Hospitals and the Choice of Organizational Form*, 3 FIN. ACCOUNTABILITY & MGMT. 343, 350 (1987). He explained that the Medicare and Medicaid payments made the hospital industry more profitable and therefore more attractive to private investors. *Id.* Furthermore, he suggested that potential donors perceived a reduced need to make charitable donations to not-for-profit hospitals when government programs and subsidies assured health care access for the poor regardless of contribution levels. *Id.*

⁵⁸ The number of proprietary hospitals grew rapidly in the late 1970s and early 1980s, and the character of those hospitals changed significantly during the same period. Although in 1975 proprietary hospitals accounted for 12.9% of the nonfederal acute-care short-term hospitals and 7.9% of the beds, by 1984, proprietary hospitals accounted for 13.5% of the nonfederal acute-care short-term hospitals and for 9.4% of beds. AHA STATISTICS, *supra* note 39. From the mid-1960s to the mid-1980s, hospital beds operated by proprietary hospitals more than doubled. *Id.* During the same time frame, the number of hospital beds operated by voluntary hospitals increased by approximately 30%. *Id.* As a result of closures and the purchase of proprietary hospitals by investor-owned chains, the number of independent (freestanding) proprietary hospitals declined from 682 in 1975 to 303 in 1984. BRADFORD GRAY, FOR-PROFIT ENTERPRISE IN HEALTH CARE 28 (1986); Pearl Richardson, *CBO Report: Health Care Trends and the Tax Treatment of Health Care Institutions*, 10 EXEMPT ORG. TAX REV. 897, 900-01 (1994).

⁵⁹ Social Security Amendments of 1972, Pub. L. No. 96-203, § 223, 86 Stat. 1329, 1393 (1972) (codified as amended at 42 U.S.C. §§ 1395x, 1395cc (1994)). The amendments permitted Medicare to retrospectively reimburse physicians and related services on a fee-for-service basis and hospitals for any reasonable costs incurred. See Schauer & Nash, *supra* note 53, at 61.

⁶⁰ They were based on comparables, that is, a comparison of costs for the same health care

same time, public and private insurance benefits were being expanded to cover new medical services.⁶¹ As medical technology developed and these new technological innovations were implemented in hospitals, clinics, and laboratories,⁶² medical insurance often paid for their use. The availability of medical insurance was a double-edged sword: it assured better health care while it contributed to higher health care costs.

Health care costs and charges spiraled in the late 1960s and the 1970s, and Medicare and Medicaid became the fastest growing programs in the federal budget.⁶³ This spiral led to concern for "cost containment." In response, in the early 1980s Congress replaced Medicare's heretofore fee-for-service basis for reimbursing doctors and its dollar-for-dollar "reasonable cost" basis reimbursement system for inpatient hospital services. As part of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"),⁶⁴ ceiling limits were imposed on costs for Medicare hospitals' ancillary services, such as nursing and physical therapy. TEFRA called for the development of a prospective payment system ("PPS") for the Medicare program in order to cut costs and instill new economic incentives.⁶⁵ This goal was rapidly pursued. As part

services among hospitals grouped according to geographic location and capacity. Those hospitals whose costs exceeded a specific target, based on the comparables, received Medicare reimbursements limited to the target rate. Similarly, a method of limiting reimbursements was designed for the Medicaid program. See Donald W. Simborg, *DRG Creep: A New Hospital-Acquired Disease*, 304 NEW ENG. J. MED. 1602, 1602 (1981).

⁶¹ For example, in 1972, Medicare was expanded to include dialysis services. During the period of 1975 to 1980, states mandated private insurance coverage for medical services rendered in psychiatric hospitals. Medicare coverage for home health agencies was added in 1981. See Marmor et al., *supra* note 31, at 327 (citing Schlesinger, *supra* note 44, at 76-78, 80); Schlesinger et al., *supra* note 30, at 433-34; see also Frank A. Sloan & Robert A. Vraciu, *Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues*, HEALTH AFF., Spring 1983, at 25, 25-37.

⁶² During the 1970s, state and local governments, patients and third-party payers increasingly pressured hospitals to provide more sophisticated technology and services. Mancino, *supra* note 34, at 1027. Health care expenditures rapidly rose in excess of general inflation rates. *Id.* at 1027 n.40. For example, between 1965 and 1975, the percentage of gross national product spent on health care increased from 5.9% to 8.3%. In addition, hospital expenditures as a percent of total health care rose from 33.3% to 39.2% over the same time period. *Id.* (citing CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS, 1986 HOSPITAL FACT BOOK 3 (11th ed. 1986) (Table 1.1)); see also Mark S. Freeland & Carol E. Schendler, *Health Spending in the 1980s: Integration of Clinical Practice Patterns with Management*, HEALTH CARE FINANCING REV., Spring 1984, at 1, 1; Schlesinger et al., *supra* note 30, at 435.

⁶³ See Iglehart, *supra* note 56, at 1429.

⁶⁴ Pub. L. No. 97-248, 96 Stat. 324 (1982) (codified as amended in scattered sections of I.R.C.).

⁶⁵ As explained in a report submitted to Congress on December 28, 1982 by former Department of Health and Human Services Secretary Richard S. Schweiker:

Currently Medicare reimburses hospitals under a cost-based system. In cost-based reimbursement, hospitals are paid essentially whatever they spend. There is no

of the Social Security Amendments of 1983,⁶⁶ Congress approved a Medicare PPS for most inpatient hospital services.⁶⁷ Rather than making payments on the former "reasonable cost" basis, the new PPS was based on a predetermined price per patient discharged in accordance with an assignment to one of 468 established "diagnosis-related groups" ("DRG").⁶⁸ By the end of the initial phase-in period, there was a standard, fixed national price for each DRG, with payment to each hospital adjusted in accordance with the hospital's geographic area.⁶⁹ Therefore, this new payment system set certain predetermined targeted amounts for reimbursement, which acted as an incentive for hospitals to control costs. A hospital incurring medical care costs for a patient below the target limit was reimbursed the target amount and

incentive for hospitals to operate more efficiently since all allowable costs are fully reimbursed. In fact, cost-based reimbursement encourages just the opposite behavior. The larger a hospital's costs, the larger will be its Medicare reimbursement. Thus, there exists an incentive to spend because the current system provides no incentive to save. It is not surprising, therefore, that hospital expenditures are increasing. During 1982, inflation in the hospital sector increased three times faster than the overall rate of inflation. Medicare expenditures for hospital care have increased 19 per cent per year during the last three years.

See Iglehart, *supra* note 56, at 1429-30.

⁶⁶ Pub. L. No. 98-21, § 601, 97 Stat. 65, 149-63 (1983) (codified as amended at 42 U.S.C. §§ 1395f, 1395y, 1395ww (1994)).

⁶⁷ For a definition of the prospective payment system ("PPS"), see *infra* Glossary. The PPS applied to inpatient hospital costs under Medicare Part A, including general routine services, ancillary services and intensive care services. Therefore, PPS did not extend initially to hospital outpatient expenses. Capital depreciation and graduate medical education expenses were also exempt and reimbursed on a reasonable costs basis under Medicare's Part B. See Iglehart, *supra* note 56, at 1431. However, payment for physician services, such as anesthesiology and radiology, which previously were reimbursed under Medicare Part A, were included in the hospital's PPS. Psychiatric, rehabilitation, and children's hospitals (or units dedicated thereto) as well as long-term care facilities are excluded from the PPS. See Schauer & Nash, *supra* note 53, at 61-64.

⁶⁸ For a definition of "diagnostic-related groups," see *infra* Glossary; J.S. Thompson et al., *Case Mix and Resource Use*, 12 INQUIRY 300 (1975). There are 467 specific DRGs and one catchall DRG representing "other" procedures.

⁶⁹ Although the goal of the PPS was to standardize payments to hospitals at one national rate, there were three basic standardized payments, depending on whether the hospital was located in a rural, large urban or other urban geographic area. 42 U.S.C. § 1395ww(d)(3)(A) (1994). The basic standardized amounts were subject to further adjustments. First, the payments were adjusted for wage variances dependent on the geographic location of the hospital. 42 U.S.C. § 1395ww(d)(3)(E) (1994). Teaching hospitals were to receive an adjustment for the higher "indirect" costs of training residents and for direct medical education costs. 42 U.S.C. § 1395ww(d)(5)(B) (1994). Payments were also adjusted for patients whose length of stay ("LOS") or costs of care proved abnormal relative to other cases within the same DRG. 42 U.S.C. § 1395ww(d)(5)(A) (1994). Hospitals treating a disproportionate share of low income patients were to receive an increased payment per case if the calculated "disproportionate patient percentage" exceeded specified levels. 42 U.S.C. § 1395ww(d)(5)(F) (1994). Furthermore, hospital capital costs were excluded initially from the reimbursement rates of the PPS and were to be folded into the PPS over time. 42 U.S.C. § 1395 ww(g) (1994).

therefore earned a surplus. On the other hand, a hospital that incurred costs for a patient in excess of the target limit, and hence below the reimbursed amount, assumed financial losses. As one commentator explained, this payment system was intended as:

[a] more tightfisted approach . . . [to] allow the government to establish Medicare's annual hospital spending plan in advance, thus capping a budget that has proved uncontrollable despite repeated efforts to hold it in check. The new policy will also compel physicians and hospital administrators to work together more closely to moderate expenditures because hospitals—not the government or the patient—will be at risk for costs above Medicare's prospective rate.⁷⁰

In effect, Medicare's PPS was a rationing device; it shifted responsibility of inpatient health care costs to hospitals. The new system transformed acute-care general hospitals, whether not-for-profit or for-profit, from revenue centers to cost centers.⁷¹

The new Medicare reimbursement system exempted psychiatric, rehabilitation, oncology, and pediatric hospitals (or discrete units), and long-term care facilities, such as nursing homes, from the PPS.⁷² Consequently, the structure of the new Medicare system and financial pressures provided incentives to increase the utilization of hospitals' outpatient services⁷³ and to develop or expand new service areas, such

⁷⁰ Iglehart, *supra* note 56, at 1428.

⁷¹ Because the new Medicare payment system shifted the risk of cost to hospitals, numerous commentators anticipated that hospital incentives for increased profitability could lead to profound changes in the structure and behavior of hospitals. See, e.g., S.E. Berki, *DRGs, Incentives, Hospitals, and Physicians*, HEALTH AFF., Winter 1985, at 70, 74-76; John E. Wennberg et al., *Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?*, 311 NEW ENG. J. MED. 295 (1984); Simborg, *supra* note 60, at 1602. The critics expressed concern that the DRG-based PPS would entice hospitals to reduce the amount and quality of care to inpatients, shorten patients' hospital LOS, and restructure patient case-mix through such methods as selectively granting staff privileges to those physicians more likely to admit the more profitable case types and de-emphasizing special technology and support services for the management of less profitable or unprofitable case types. For a more detailed discussion and criticism of DRGs and Medicare's PPS, see, for example, Berki, *supra*; Iglehart, *supra* note 56; Wennberg et al., *supra*.

⁷² These hospitals were excluded from the mandatory PPS because of the unique group of patients they serve. Unless the PPS is elected, these hospitals are reimbursed on a reasonable cost basis, which is limited by costs in a base year, adjusted for inflation. 42 U.S.C. § 1395ww(d)(1)(B) (1994). The base year was determined to be generally the later of 1982 or the year in which the hospital began operations. 42 C.F.R. § 413.40 (1994). Later cancer hospitals were given the opportunity to choose 1987 as the base year if that year resulted in increased payments. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6004(b), 103 Stat. 2106, 2159-60 (1989) (codified as amended at 42 U.S.C. § 1395ww (1994)). See generally Schauer & Nash, *supra* note 53, at 62.

⁷³ See Mancino, *supra* note 34, at 1029 (describing third-party payers, both private and

as ambulatory care, satellite clinics, family planning services, drug therapy programs, home health assistance, rehabilitation services, psychiatric clinics, and the like.⁷⁴ Incorporating these medical services provided potential opportunities for increased revenues. The health care system had new evolutionary impetus.

3. Managed Health Care and Cost Containment

Competitive pressures mounted through the 1980s. Premiums for private health insurance escalated,⁷⁵ even while private insurers were switching from reimbursements based on "reasonable costs" to reimbursements based on some form of PPS.⁷⁶ It became more difficult, but far from impossible, for hospitals to continue to cross-subsidize patient care and medical services for the poor and uninsured through increased charges to private payers—that is, paying patients and their private insurers.⁷⁷ Although restrictions were imposed to impede "patient dumping"—the transfer of indigent patients, generally the sickest

governmental, and patients, as well as technological advances, as influencing the move toward outpatient care by hospitals); Schlesinger et al., *supra* note 30, at 438–39 (describing the technological, policymaking, third-party payer and patient influences on expansions into outpatient care and other services).

⁷⁴ See *infra* note 81 and accompanying text.

⁷⁵ From 1950 to 1979, premiums paid to private health insurance companies increased by 2900%. Marjory Smith Carroll & Rose H. Arnett, III, *Private Health Insurance Plans in 1978 and 1979: A Review of Coverage, Enrollment, and Financial Experience*, HEALTH CARE FINANCING REV., Sept. 1981, at 55, 84. In 1950, total health care expenditures were 4.4% of gross national product ("GNP"). KAREN DAVIS ET AL., HEALTH CARE COST CONTAINMENT I (1990). By 1986, however, such expenditures had risen to 10.8% of GNP. John Copeland & Gabriel Rudney, *Federal Tax Subsidies for Not-For-Profit Hospitals*, 46 TAX NOTES 1559, 1560 (1990) (citing STATISTICAL ABSTRACT OF THE UNITED STATES, Tables 136, 137, 688 (1989)).

⁷⁶ See JAMES C. DECHENE, PUBLIC HEALTH CARE REIMBURSEMENT PROGRAMS (PLI Comm. Practice Course Handbook Series No. A4-4428, 1993); Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 394–96 (1994); Susan E. Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325, 329 (1992); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 437–38, 443 (1988).

⁷⁷ See Marmor et al., *supra* note 31, at 331; Schlesinger et al., *supra* note 30, at 443–45; Homer H. Schmitz, *Preferred Provider Organizations*, in MEDICAL PRACTICE, *supra* note 53, at 43.

Studies have documented that during the 1980s and early 1990s private payers continued to cross-subsidize hospital health care for the poor. See, e.g., Larry M. Manheim & Joe Feinglass, *Hospital Cost Incentives in a Fragmented Health Care System*, 19 HEALTH CARE MGMT. REV. 56, 57 (1994) (citing 1991 figures of the Prospective Payment Assessment Commission indicating private insurers pay approximately 1.3 times actual hospital costs whereas Medicare pays 10% less than actual hospital costs); Arnold M. Epstein, *US Teaching Hospitals in the Evolving Health Care System*, 273 JAMA 1203, 1204 (1995) (citing 1992 data of the Prospective Payment Assessment Commission that hospital payments by Medicare beneficiaries average only 89% of their costs and that shortfalls are covered by additional payments by private payers).

and most costly of patients, to other hospitals before treatment—proprietary and voluntary hospitals continued to transfer these patients to public institutions after providing stabilizing emergency services.⁷⁸ In an attempt to find new sources of profitable patients and to attain financial stability, the health care sector, which previously had started to move into multi-institutional chains,⁷⁹ began expanding into diversified networks of health care providers.⁸⁰ These networks permitted the consolidation of existing resources, the augmentation of equipment and facilities, and the broadening of ranges of services. Not-for-profit and for-profit short-term acute-care general hospitals began providing ambulatory care or long-term care services, or both; some acute-care general hospitals affiliated with specialty hospitals focused on such services as drug abuse rehabilitation, alcohol therapy, orthopedics, oncology, or pediatric care.⁸¹ Additionally, acute-care general hospitals

⁷⁸ Prior to 1985, there had been persistent allegations of "patient dumping" by hospitals. Hospitals had been accused of refusing treatment to indigents in need of emergency care. In response, Congress enacted the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164 (1986) (codified as amended at 42 U.S.C. § 1395dd (1994)), which included a requirement that all hospitals participating in Medicare accept nonpaying patients in their emergency rooms. Moreover, COBRA mandated that hospitals with Medicaid agreements must admit Medicaid patients without discrimination. 42 U.S.C. § 1395dd(g) (1994).

⁷⁹ Although very few proprietary hospitals were part of multi-institutional corporations during the 1960s, most hospitals that were part of such structures were owned by investor-owned companies such as Hospital Corporation of America, Inc., Humana, Inc., National Medical Enterprises, Inc., American Medical International, Inc., and companies that these corporations acquired, including American Medisorp (acquired by Humana, Inc.) and Hospital Affiliates International (acquired by Hospital Corporation of America). See Gray, *Nonprofit Hospitals*, *supra* note 10, at 367. Many of these multi-hospital organizations were created in part as an attempt to reduce costs and achieve some economies of scale. Mancino, *supra* note 34, at 1028. By 1970, these multi-institutional corporations were operating in earnest. *Id.* at 1030.

⁸⁰ By the mid-1980s, 35% of all acute-care hospital beds were part of multi-institutional facilities. Mark Schlesinger et al., *The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services*, 65 MILBANK Q. 25, 28 (1987). By 1987, multi-institutional corporations operated 50% of the private psychiatric hospitals, 25% of the renal dialysis centers, and almost 40% of the prepaid health care plans. *Id.* In 1987, approximately 80% of the for-profit general hospitals and nearly all of the proprietary psychiatric hospitals were affiliated with multi-institutional organizations. *Id.* At that time, a single investor-owned corporation operated more than one-third of the for-profit renal dialysis facilities in the United States. *Id.*

Between 1983 and 1992, the number of hospital systems as a result of horizontal mergers increased from 243 (representing 1958 hospitals with 366,000 beds) to 300 (representing 2826 hospitals with 540,000 beds). AMERICAN HOSPITAL ASSOCIATION, *DIRECTORY OF MULTIHOSPITAL SYSTEMS* (4th ed., 1984); AMERICAN HOSPITAL ASSOCIATION *GUIDE TO THE HEALTH CARE FIELD* at B3 (1993).

⁸¹ See Dan Erman & Jon Gabel, *Multihospital Systems: Issues and Empirical Findings*, HEALTH AFF., Spring 1984, at 50, 52 (relating the growth of the multi-hospital systems); Mancino, *supra* note 34, at 1026-31 (discussing the general trends of horizontal and vertical integration by freestanding and multi-institutional hospitals); Robert V. Pattison & Hallie M. Katz, *Investor-*

took part in alternative delivery systems.⁸² Involvement in these alternative delivery systems reflected a national trend toward managed health care and cost containment strategies and an availability of pre-paid health care plans that consolidated qualities of insurance with medical services. For example, enrollment in health maintenance organizations ("HMO"), which were perceived as a means of channeling patients to doctors, clinics, and hospitals on the basis of competitive prices and costs, grew more than three-fold from 1975 to 1985.⁸³

Owned and Not-For-Profit Hospitals, 309 NEW ENG. J. MED. 347 (1983) (describing the trend of proprietary hospitals toward a multi-institutional system); Reiman, *supra* note 10, at 963 (describing rise in for-profit industry that supplies health care services); Stephen M. Shortell et al., *The Effects of Hospital Ownership on Nontraditional Services*, HEALTH AFF., Winter 1986, at 97, 98-111 (examining the impact of the health care environment on alternative services offered by hospitals and multi-institutional systems).

The rapid growth of the multi-institutional systems was not only attributable to the acquisition of financially distressed independent hospitals, but also to the acquisition of financially viable nursing homes and psychiatric hospitals. From 1978 to 1982, multi-institutional systems acquired nursing homes at an annual rate of 38.4% and psychiatric hospitals at an annual rate of 25.4%. *Id.* at 53-54.

In the presence of highly competitive conditions, one study found that both investor-owned system hospitals and not-for-profit system hospitals were found to offer more alternative services, such as ambulatory care, geriatric care, long-term home health care, outpatient diagnostic services, and health promotion educational programs. Shortell et al., *supra*, at 105. However, regardless of competition, not-for-profit system hospitals were found to offer more alternative services than investor-owned systems. *Id.*

⁸² Economic pressures, technological advances, the availability of capital, and demands and expectations of patients, third-party payers, and employers influenced the creation of alternative delivery systems. Regulatory pressures were also a contributing factor to the development of alternative delivery systems. For example, the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974) (repealed Jan. 1, 1987), provided for the creation of state and local health planning agencies which, among other purposes, were intended to regulate and restrict capital expenditures and the expansion of hospital services unless certain facilities or services were needed in a community or region. See generally JAMES B. SIMPSON & TED BROGUE, *THE GUIDE TO HEALTH PLANNING LAW: A TOPICAL DIGEST OF HEALTH PLANNING AND CERTIFICATE OF NEED CASE LAW* (4th ed. 1986); John D. Colombo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 WAKE FOREST L. REV. 215, 215-16 (1994).

⁸³ For a definition of "HMO," see *infra* Glossary; GROUP HEALTH ASSOCIATION OF AMERICA, INC., NATIONAL DIRECTORY OF HMOs 23 (1993) [hereinafter 1993 DIRECTORY OF HMOs]; Janine C. Edwards, *Health Maintenance Organizations*, in MEDICAL PRACTICE, *supra* note 53, at 20. Enrollment in HMOs numbered less than six million enrollees in 1975, nine million enrollees in 1980, and by 1985, enrollment had increased to 21 million people. See NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH UNITED STATES 1992, 84 (1992) [hereinafter HEALTH U.S. 1992].

In 1973, Congress enacted the Health Maintenance Organization Act ("HMOA"), Pub. L. No. 93-222, 87 Stat. 914 (1973), amended by, Pub. L. No. 94-960, 90 Stat. 1945 (1976), Pub. L. No. 95-559, 92 Stat. 2131 (1978), Pub. L. No. 97-35, 95 Stat. 572 (1981) (all codified as amended at scattered sections of 42 U.S.C.), which instituted federal grant and loan programs to finance the creation of nonprofit HMOs and which established structural, solvency, pricing, enrollment and other requirements for HMOs. The HMOA represented the federal government's first concerted effort to assist in the development of an alternative to fee-for-service medicine. See

As a means of directing patients to a single or small group of doctors and other providers, an assortment of arrangements, such as "preferred provider organizations"⁸⁴ and "exclusive provider organizations,"⁸⁵ were negotiated in return for price discounts.⁸⁶ Joint ventures and partnership arrangements between hospitals and physicians emerged in the 1980s as vehicles for providing patients to these health care providers and for increasing revenues.⁸⁷

John K. Iglehart, *The Future of HMOs*, 307 NEW ENG. J. MED. 451 (1982) [hereinafter Iglehart, *The Future*]; John K. Iglehart, *Managed Competition*, 328 NEW ENG. J. MED. 1208, 1209 (1993) [hereinafter Iglehart, *Managed Competition*]. For discussion of the tax-exempt status of various models of HMOs, see *infra* notes 206-08 and accompanying text. See also Glossary (defining various models of HMOs).

Numerous writings have speculated whether HMOs actually are economically beneficial. For some earlier pieces, see generally LAWRENCE D. BROWN, *POLITICS AND HEALTH CARE ORGANIZATION: HMOs AS FEDERAL POLICY* (1983); HAROLD S. LUFT, *HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS AND PERFORMANCE* (1981); Harold S. Luft, *How Do Health Maintenance Organizations Achieve Their "Savings"?*, 298 NEW ENG. J. MED. 1336, 1342 (1978). Among the more recent comprehensive studies, the Rand Corporation compared incidents of health care and associated costs of two fee-for-service plans to a large HMO plan. Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505 (1984). The study found that hospitalization rates were lower for the HMO enrollees but that preventive visits to physicians were more numerous when enrollees did not have to contribute to the payment of the visit. The study concluded that the HMO physicians' practices were different in that they implemented less costly styles of practicing medicine than physicians paid under more traditional fee-for-service plans. More recently, a study found that HMO physicians are more likely to avoid discretionary hospital admissions than fee-for-service physicians; the researchers indicated that this difference accounted for lower costs of health care by HMOs. Albert L. Siu et al., *Use of the Hospital in a Randomized Trial of Prepaid Care*, 259 JAMA 1343 (1988).

⁸⁴ For a definition of a "preferred provider organization" ("PPO"), see *infra* Glossary; Schmitz, *supra* note 77, at 42-50.

A 1994 study, which included 1191 hospital participants, reported that 85% of the participants have arrangements with PPOs, compared with 78% in 1992. DELOITTE & TOUCHE, U.S. HOSPITALS AND THE FUTURE OF HEALTH CARE: A CONTINUING OPINION SURVEY 10, 26 (1994). The report indicated that in 1994, 17% of the participating investor-owned hospital systems derive 15% or more of their patients from PPO arrangements. *Id.* at 11. Forty-five percent of the participant hospital systems expected to derive at least 15% of their patients from PPO arrangements in 1996. *Id.* at 11-12. The study further reported that only a very small percentage (four percent) of participant hospitals work exclusively with one PPO or HMO. *Id.* at 10-11.

⁸⁵ For a definition of an "exclusive provider organization," see *infra* Glossary; Homer H. Schmitz, *The Financial Dynamics of the U.S. Health Care System*, in MEDICAL PRACTICE, *supra* note 53, at 1, 6.

⁸⁶ For further discussion of the PPO arrangements, see Daniel Callahan, *Rationing Medical Progress, the Way to Affordable Health Care*, 322 NEW ENG. J. MED. 1810 (1990); John Gabel & Dan Erman, *Preferred Provider Organizations: Performance, Problems and Promise*, HEALTH AFF., Spring 1985, at 24, 24-27, 35-37; Thomas Rice et al., *The State of PPOs: Results from a National Survey*, HEALTH AFF., Winter 1985, at 25, 26-28, 33-39; Schlesinger et al., *supra* note 30, at 436; Schmitz, *supra* note 77, at 42-58.

⁸⁷ These joint ventures and partnership arrangements varied, but typically the hospitals participated in them to make the physician-investors content. Internal Revenue Service, *IRS Issues Health Care ISP Digest*, reprinted in 9 EXEMPT ORG. TAX REV. 877, 879 (1994) [hereinafter *IRS*

During the tail-end of the 1980s and the early 1990s, a variety of new health care relationships formed. Competition led to new types of compensation arrangements and recruitment incentive packages between physicians and hospitals.⁸⁸ The popular media reported that physicians were selling their medical practices in record numbers to investor-owned public corporations.⁸⁹ Physicians and hospitals entered innovative joint venture arrangements in a variety of forms,⁹⁰ including those formally known as physician-hospital organizations ("PHO").⁹¹ The prior health care provider matrix gave way to new multi-dimensional and multi-specialty health care enterprises, affiliations, and horizontal hospital networks created to manage the comprehensive health care needs of a population of enrolled patients in return for a fixed dollar amount. Vertically integrated health care systems, generically known as integrated delivery systems ("IDS"),⁹² developed not only to

Issues Health Care ISP Digest] (citing U.S. GEN. ACCOUNTING OFFICE, NONPROFIT HOSPITALS: FOR-PROFIT VENTURES POSE ACCESS AND CAPACITY PROBLEMS (1993)). Typical of these arrangements were the sale of the net or gross revenue stream of a hospital department or service (such as an outpatient surgical unit) to be earned during a defined future time frame. The sale would be to a joint venture between a not-for-profit hospital (or a subsidiary) and physicians on the hospital staff. The hospital would continue to own and operate the department or service. The physician-investors would have financial incentive to refer more patients to the department or service in order that the revenues from it would increase. *Id.*

Effective January 1, 1995, providers are prohibited from billing Medicare for certain services rendered to patients as a result of referral by physicians having a financial relationship with the providers. *Id.* This restriction has resulted in the restructuring or destruction of some of these hospital-physician joint ventures. *Id.*; see *infra* part IV.D.1.

⁸⁸ For further discussion of this topic, see *infra* notes 306-29 and accompanying text.

⁸⁹ See, e.g., Milt Freudenheim, *Physicians Are Selling Practices to Companies as Changes Loom*, N.Y. TIMES, Sept. 1, 1993, at A1.

⁹⁰ See *supra* note 2 and *infra* note 292 and accompanying text.

⁹¹ For definition of "physician-hospital organization," see *infra* Glossary. For a description, see Priv. Ltr. Rul. (unnumbered) (Sept. 29, 1994), *reprinted in* 10 EXEMPT ORG. TAX REV. 1323 (1994).

⁹² For a definition of "IDS," see *infra* Glossary; INTERNAL REVENUE SERVICE, 1992 IRS EXEMPT ORGANIZATIONS CPE TECHNICAL INSTRUCTION PROGRAM, at Topic H4 (for fiscal year 1993), available in LEXIS, Fedtax library, TNT file, 94 TNT 70-22 [hereinafter IRS-CPE TEXTBOOK]. For general discussions, see Mark A. Hall, *Managed Competition and Integrated Health Care Delivery Systems*, 29 WAKE FOREST L. REV. 1, 4-5 (1994); Gerald R. Peters, *Integrated Healthcare Systems*, in 3 HEALTH LAW PRACTICE GUIDE 28-1, 28-3 (1993); Amy L. Woodhall, *Integrated Delivery Systems: Reforming the Conflicts Among Federal Referral, Tax Exemption, and Antitrust Laws*, 5 HEALTH MATRIX 181, 185-87 (1995). IDSs have expanded rapidly, with many physicians selling their practices to companies or planning on joining IDSs. See, e.g., Freudenheim, *supra* note 89; Patrick W. Philbin, *From the Ground Up: Planting the Seeds of Network Development*, HOSP. & HEALTH NETWORKS, June 5, 1993, at 46.

As described by one scholar, the IDSs of the 1990s—

Differ fundamentally from the types of vertical integration and joint ventures that arose in the 1980's in response to declining hospital occupancies and Medicare's prospective payment system. These earlier systems were designed to replace lost

attract patients to maximize revenues, but also to foster managed health care or "managed competition,"⁹³ or both.

4. Summary

Dramatic changes in the health care industry as a result of the focus on managed care and managed competition have marked the 1970s, 1980s, and early 1990s.⁹⁴ Many factions, including large employ-

sources of revenue and to encourage physicians to send their patients to a particular facility

. . . [T]he new networks cover a much broader range of services [T]he affiliations of the past tended to be overlapping and nonexclusive. A physician might have staff privileges at several hospitals and investments in a half-dozen competing ventures. This characteristic might be shared by the new networks for a time, but analysts anticipate that market pressures will eventually force most providers into separate health plans or contracting networks. . . .

The most fundamental new characteristic of integrated delivery systems is the incorporation of insurance risk. The ventures typical in the 1980's were designed to operate within a fee-for-service system or within a form of prospective payment that is sensitive to the number of hospital admissions. The new forms of affiliations anticipate selling health care services in a system of capitated payment.

Hall, *supra*, at 4-6.

For further discussion of IDSs, see Robert S. Bromberg, *The Foundation Model*, 8 EXEMPT ORG. TAX REV. 335, 335-36 (1993); Harry G. Gourevitch, *Tax Aspects of Health Care Reform: The Tax Treatment of Health Care Providers* (Congressional Research Service Report), reprinted in 9 EXEMPT ORG. TAX REV. 1317, 1321 (1994); Hall, *supra*, at 8; *IRS Issues Health Care ISP Digest*, *supra* note 87, at 880; Michael W. Peregrine & Bernadette M. Broccolo, *IRS Issues Guidance on Integrated Delivery Systems*, 7 EXEMPT ORG. TAX REV. 391 (1993); Peters, *supra*, at 28-3 to 28-54; Ross Stromberg & James G. Harrigan, *Hospital-Affiliated Group Practices: The Use of Medical Foundations and Management Services Organizations*, 14 WHITTIER L. REV. 43 (1993). For further discussion of the tax status of IDSs, see *infra* part IV.F.

In a 1994 study of 1191 hospitals, Deloitte & Touche reported that only 24% of participating hospitals belonged to an IDS. DELOITTE & TOUCHE, *supra* note 84, at 21. However, an additional 47% of the hospitals indicated their involvement in IDS development. *Id.* A major conclusion of the report was that IDSs are the "primary vehicle" for future health system reform. *Id.* at 23.

⁹³ Managed competition is price competition, with the focal point being the total annual premium paid for comprehensive health care services. One scholar has stated that—

[t]he essence of managed competition is to present individual subscribers with a range of enrollment options among private health plans in an environment that manages the selection process and makes individuals pay for the differences in price among the insurance options they choose. Managed competition attempts to achieve universal health insurance coverage and health care cost containment via a hybrid between the opposite extremes of a completely socialized system of health insurance . . . and a largely unregulated private insurance market. . . .

Hall, *supra*, at 1-2 (citation omitted).

For a detailed discussion of managed competition, see Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 24, 29-46; Jeff Goldsmith, *Hospital/Physician Relationships: A Constraint to Health Reform*, HEALTH AFF., Fall 1993, at 160, 166-69; Igelhart, *Managed Competition*, *supra* note 83.

⁹⁴ In pursuit of managed care and managed competition goals, several milestones were reached in the health care sector during 1993 and 1994 alone. These landmarks include: (1) the

ers, insurance companies, the federal and state governments, and health care providers, have fostered these conceptual and structural changes.⁹⁵ These changes resulted in a myriad of arrangements.⁹⁶ Both

enrollment of a majority of privately insured Americans in managed care plans that limit choice of doctors and treatment; (2) the enrollment of 65% of all workers in medium and large companies in managed care plans; (3) the growth of for-profit HMOs and of their enrollments to cover a majority of all HMOs' enrollees; (4) increased managed care physician arrangements, with 89% of all doctors in group practices sharing in managed care contracts. See Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at A1.

⁹⁵ See, e.g., Milt Freudenheim, *10 Companies Join in Effort to Lower Bids by HMO's*, N.Y. TIMES, May 23, 1995, at D2 (indicating that large companies can be effective in negotiating reduced premiums for enrolling their employees in HMOs); Michael Quint, *Health Plans Are Forcing Change In the Method for Paying Doctors*, N.Y. TIMES, Feb. 9, 1995, at A1 (describing methods used to reduce fees paid to physicians); Elizabeth Rosenthal, *Hospital Agency is Striving to Adapt in a Competitive Era*, N.Y. TIMES, Feb. 27, 1995, at A1 (indicating steps taken in New York to reduce health care costs through negotiations); Pear, *Major Overhaul*, *supra* note 9 (indicating costs to provide health care to Medicaid recipients and Congressional proposals to reduce federal costs); see also Robert A. Boisture, *Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs*, 9 EXEMPT ORG. TAX REV. 271, 272 n.2 (1994) (citing INTEGRATED HEALTHCARE REPORT 2 (1993) (stating insurers are acquiring or creating their own provider networks to maximize control and deliver cost-effective benefits)). But see Freudenheim, *supra* note 9, at D1 (indicating that the federal government pays more than it should for Medicare patients enrolled in HMOs and should employ negotiating methods used by large employers to reduce health care premiums for enrollees).

A number of federal health care reforms have been proposed by the administration and various Congressmen during the past three years in an attempt to assure health care to Americans at affordable costs. See, e.g., Health Security Act, H.R. 3600, S.1757, S. 1775, 103d. Cong., 1st Sess. (1993) (proposing a health alliance system, an employer mandate, a cap of health care expenditures). Even though none of these proposed legislative reforms were enacted, the failed proposals turned more public attention to managed competition and managed care. Yet, some affirmative actions by the federal government have contributed to the new health care climate. For example, the federal government's Medicare payment system for physicians has been undergoing revisions which have contributed to the managed care climate. Under the "resource-based relative value unit" payment system, payments to physicians are intended to decline, and funds should be redistributed from specialized physicians to primary care physicians. See William C. Hsiao et al., *Estimating Physicians' Work for a Resource-Based Relative Value Scale*, 319 NEW ENG. J. MED. 881 (1988); John K. Iglehart, *Health Policy Report: The New Law on Medicare's Payments to Physicians*, 322 NEW ENG. J. MED. 1247, 1247 (1990). Moreover, beginning in fiscal year 1992, hospitals' capital costs are prospectively determined under Medicare, a departure from the prior method of reimbursement on a cost basis for capital expenditures. See Prospective Payment System for Inpatient Hospital Capital-Related Costs, 56 Fed. Reg. 43,358 (1991); DECHENE, *supra* note 76; Schauer & Nash, *supra* note 53, at 67.

⁹⁶ For example, HMO enrollment experienced explosive growth not only from 1975 to 1985, but also through 1994. See *supra* note 83 (detailing the growth of HMOs from 1975 to 1985). From 1985, when HMO enrollment numbered 21 million people, enrollment increased to at least 34 million people in 1990 and to nearly 41.5 million enrollees in 1992. By 1994, 541 HMOs enrolled 45.2 million people. Thus, in the decade between 1985 and 1995, HMOs experienced a two-fold rise in enrollment. HEALTH U.S. 1992, *supra* note 83, at 84; GROUP HEALTH ASSOCIATION OF AMERICA, HMO INDUSTRY PROFILE 1993, at 310 (1993); 1993 DIRECTORY OF HMOs, *supra* note 83 at 23; see also Bruce Japsen, *Creation of New HMOs Picks Up Steam, Fueled by Reform Market Forces*, MOD. HEALTHCARE, June 13, 1994, at 46. For discussion of other arrangements, see *supra* notes 84-93 and accompanying text.

the for-profit and the not-for-profit sectors strived for managed care and managed competition goals and therefore participated in the evolution of America's health care industry. In the for-profit health care sector, horizontal mergers occurred, with HMO mergers representing but one highly visible example.⁹⁷ Investor-owned hospital companies acquired independent, freestanding proprietary hospitals,⁹⁸ nonprofit teaching hospitals,⁹⁹ and other hospital companies.¹⁰⁰ Vertical integration, even within investor-owned multi-institutional systems, was common.¹⁰¹ Trends in the not-for-profit health care sector mirrored those in the for-profit sector. It was typical to find diversification, horizontal mergers among hospitals, the growth of multi-institutional systems, vertical integration, as well as managed care and managed competition arrangements.¹⁰²

In sum, the twentieth century has been marked by a change in the architecture of America's health care. By the beginning of the 1990s, the health care system had evolved from dependence on the

⁹⁷ For example, in early 1995, two California HMOs, Wellpoint Health Networks and Health Systems International, agreed to merge. See, e.g., Milt Freudenheim, *2 California Health Care Providers Agree to a \$1.8 Billion Merger*, N.Y. TIMES, Mar. 28, 1995, at D1; Milt Freudenheim, *New Partners in Health Care Focus on Cost: Nationwide Strategy for Lower Prices*, N.Y. TIMES, Apr. 4, 1995, at D4.

⁹⁸ See Mancino, *supra* note 34, at 1028-29; Milt Freudenheim, *Hospitals Are Tempted but Wary As For-Profit Chains Woo Them*, N.Y. TIMES, Jan. 4, 1995, at A1.

⁹⁹ During the early 1980s, investor-owned companies acquired such major teaching hospitals as Wesley Medical Center in Wichita, Kansas, St. Joseph Medical Center in Omaha, Nebraska, and Presbyterian-St. Luke's Hospital in Denver, Colorado. See Mancino, *supra* note 34, at 1031.

¹⁰⁰ Between 1978 and 1982, the number of for-profit multi-institutional hospitals increased 3.4% annually and added beds at an annual rate of 4.8%. Erman & Gabel, *supra* note 81, at 52. The for-profit multi-institutional systems averaged 23 hospitals per system and tended to span numerous states. *Id.* at 52. Much of the rapid growth of the for-profit multi-institutional systems from 1975 through 1982 was attributable to the purchase of financially distressed independent hospitals; however, after 1981, growth was also achieved by multi-institutional systems through acquisitions of other investor-owned multi-institutional companies. See *id.* at 53 & n.9 (citing Lewin & Associates, *A Study of Investor-Owned Hospitals* 22 (1976) (unpublished report to Health Services Foundation)). For a brief review of the Columbia/HCA Healthcare network and its recent acquisitions, see Allen R. Myerson, *Now, It's the Rick Scott Health Plan*, N.Y. TIMES, Oct. 30, 1994, § 3, at 1.

¹⁰¹ See *supra* note 84. Among the recent multi-institutional developments, has been the merger of some nursing home chains. See, e.g., Allen R. Myerson, *\$1.5 Billion Is Bid to Create Big Nursing Home Chain*, N.Y. TIMES, Jan. 27, 1995, at D1.

¹⁰² In 1982, one-third of all American hospitals belonged to a multi-institutional hospital system. Erman & Gabel, *supra* note 81, at 51. These hospitals accounted for 36% of all hospital beds. *Id.* Between 1978 and 1982, nonprofit multi-institutional systems added hospitals at a rate of 11.4% annually and added beds at a rate of 3.5% annually. *Id.* at 52. Most of the growth of nonprofit systems was largely through the acquisition of fiscally troubled independent hospitals. *Id.* at 53. The nonprofit systems were found in all regions of the United States, with individual nonprofit systems averaging seven hospitals per system, most of which were located in one or two states. *Id.* at 52.

hospital as the vital center of health care to greater reliance on networks of health providers for the provision of a full array of health care services.¹⁰³ As the evolutionary trend continues in the health care sector, the mid-1990s are marked by attempts to formulate new managed care options, including hybrid health care plans and horizontal networks of physicians.¹⁰⁴

III. HISTORICAL ROOTS OF TAX EXEMPTION

Like the historical seeds of America's modern health care organizations, which had their genesis in the hospices of Western Europe and England in the Middle Ages and the succeeding almshouses,¹⁰⁵ so too the seeds of a tax exemption for America's "charitable" health care organizations can be traced to fourteenth-century England.¹⁰⁶ It was

¹⁰³ The new architecture of organizations of health professionals could loosely be likened to full service gasoline stations which consumers can utilize for a variety of services related to the same underlying purpose. In the case of the gasoline station, the services are associated with the vehicle and its operations; in the case of the health care system, the services are associated with the person's mental and physical being.

The ten largest IDSs in 1992 included both not-for-profit and for-profit multi-institutional systems. Jay Greene & Judith Nemes, *Not-For-Profits Lead Rise in Income Growth*, MOD. HEALTHCARE, May 24, 1993, at 27, 27. IDSs set records for profitability in the late 1980s and early 1990s. In contrast to 1991, when profit margin increases were primarily attributable to investor-owned hospital chains, in 1992, profit margin increases were principally fueled by increased operating profits of not-for-profit systems. *Id.* at 27-28. Both not-for-profit and for-profit systems increased their surpluses by holding down expense increases, raising charges for full-paying patients, using downsizing strategies, and increasing investment income. *Id.* at 27.

¹⁰⁴ As recently reported: "On the horizon are new efforts to improve community health services, new service linkages and information systems, evolving hospital/physician partnerships, further development of managed care, new products with which institutions can address local health care delivery problems, and greater recognition of ethical issues in health care." DELOITTE & TOUCHE, *supra* note 84, at 25; see also DAVID SHACTMAN & STUART H. ALTMAN, MARKET CONSOLIDATION, ANTITRUST, AND PUBLIC POLICY IN THE HEALTHCARE INDUSTRY: AGENDA FOR FUTURE RESEARCH (1995) (stating potential antitrust problems associated with horizontal physician networks and reasons for their formation); Milt Freudenheim, *A New Formula for Health Plans*, N.Y. TIMES, July 28, 1995, at D1 (describing new hybrid health care plans that include the use of an HMO or network plus the ability to utilize outside physicians or hospitals).

¹⁰⁵ ROSENBERG, *supra* note 17, at 15.

¹⁰⁶ In approximately 1362, William Langland wrote a poem, "The Vision of Piers the Plowman," which chronicles in one portion a means for wealthy merchants to save their souls by dedicating their fortunes to:

- repair hospitals
- help sick people
- mend bad roads
- build up bridges that had been broken down
- help maidens to marry or to make them nuns
- find food for prisoners and poor people
- put scholars to school or to some other crafts
- help religious orders, and
- ameliorate rents or taxes.

not until the seventeenth century, however, that the first formal comprehensive list of worthy charitable uses for money and property was enumerated. The preamble to the English Statute of Charitable Uses enacted in 1601¹⁰⁷ cited among the uses appropriate for a charitable trust "relief of aged, impotent and poor people, . . . maintenance of sick and maimed soldiers and mariners, . . . [and] aid and help of . . . persons decayed."¹⁰⁸

Relying on this enumeration of appropriate charitable uses, a confused body of judicially created precedents developed in England concerning the parameters of the legal concept of charity for trust law purposes.¹⁰⁹ At the end of the nineteenth century, a decision written by Lord McNaughten in the now famous *Commissioners of Income Tax v. Pemsel*¹¹⁰ presented a unifying theme for conceptualizing appropriate charitable uses under the laws of trusts:

"Charity" in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads. The trusts last referred to are not the less charitable in the eye of the law, because incidentally they benefit the rich as well as the poor, as in-

Persons et al., *supra* note 20, at 1912 & n.8 (quoting the modern English version of the "B" text of the poem which was edited from numerous manuscripts by the Rev. Walter W. Skeat, 1:228, Oxford, 1886).

¹⁰⁷ The Statute of Charitable Uses, 43 Eliz., ch. 4 (1601), was enacted as a supplement to the comprehensive system of the Elizabethan Poor Laws adopted by Parliament in 1597 and restated in 1601. Act for the Relief of the Poor, 43 Eliz., ch. 2 (1601). Under the 1597 laws, which addressed problems faced by destitute populations in urban England, responsibility for relief of poverty was primarily imposed on local communities. The communities had the power to tax for purposes of relieving poverty. Persons et al., *supra* note 20, at 1913. The Statute of Charitable Uses addressed whether a trust which had no specific beneficiary should be recognized at common law when its intention was to serve the poor or to maintain a local roadway rather than a specific beneficiary. See Oliver A. Houck, *With Charity for All*, 93 YALE L.J. 1415, 1422 n.4 (1984). The statute deemed that such a trust should be permitted. See *id.* See generally MICHAEL CHESTERMAN, CHARITIES, TRUSTS AND SOCIAL WELFARE 56-57 (1979); GARETH JONES, HISTORY OF THE LAW OF CHARITY 1532-1827 (1969); GEORGE W. KEETON & L.A. SHERIDAN, THE MODERN LAW OF CHARITIES 8-9 (3d. ed. 1983).

¹⁰⁸ Persons et al., *supra* note 20, at 1912-13 (citing GEORGE G. BOGERT & GEORGE T. BOGERT, TRUSTS AND TRUSTEES § 321, at 638 n.2 (1965)). This enumeration of charitable uses in the preamble to the English Statute of Charitable Uses also included such activities as maintaining schools of learning, repairing bridges, educating and aiding orphans, and helping the poor pay taxes. *Id.* at 1912-13. The preamble was not intended to be an exclusive list of charitable purposes. *Id.* at 1913. Moreover, it has been determined that the list should be viewed in the disjunctive, so that relief of the distress of the aged is an appropriate charitable purpose per se. See Bromberg, *supra* note 21, at 240-41.

¹⁰⁹ See Persons et al., *supra* note 20, at 1914-15; Bromberg, *supra* note 21, at 240-41.

¹¹⁰ 1891 App. Cas. 531.

deed, every charity that deserves the name must do so either directly or indirectly.¹¹¹

After the *Pemsel* decision, the English courts adopted this same concept of charity for determining an organization's entitlement to income tax exemption as a charitable organization.¹¹²

Initially, charitable trusts were the principal form of organization for charitable activities.¹¹³ By the second half of the nineteenth century, corporations were used increasingly for charitable activities.¹¹⁴ After the Revolutionary War, many of the first American states repealed English statutes and rejected traditional English structures.¹¹⁵ As a result, the accepted legal form in many states in early America for charitable activities became the corporation. Most states encouraged the incorporation of private associations that engaged in essential public services.¹¹⁶ Therefore, when America's first federal income tax on corporations was adopted in 1894, it exempted from income taxation those "corporations, companies, or associations organized and conducted solely for charitable, religious or educational purposes, . . . [and any] stocks, shares, funds, or securities held by any fiduciary or trustee for charitable, religious, or educational purposes."¹¹⁷ Because American public charitable entities continued to be formed typically as corporations rather than as trusts, subsequent income tax acts contained similar provisions.¹¹⁸

The current I.R.C. § 501(a) permits exemption from income taxation for a variety of organizations, including those that qualify under

¹¹¹ *Id.* at 583.

¹¹² Charitable organizations have been entitled to income tax exemption in England since enactment of the first Income Tax Act of 1842. *See* Persons et al., *supra* note 20, at 1919.

¹¹³ *Id.* at 1917. The reason cited for primary use of the trust form was the flexibility available to individuals to create trusts, whereas power to form corporations was concentrated in the State. *Id.*

¹¹⁴ *Id.*

¹¹⁵ Some of the American states rejected English laws *en masse*, among them the Statute of Charitable Uses. *See* Persons et al., *supra* note 20, at 1914. Some of the states also rejected the charitable trust as the legal form for operating charitable activities. *Id.*

However, corporations had been formed to conduct charitable activities in the American colonies as early as the seventeenth century. *See* James J. Fishman, *The Development of Nonprofit Corporation Law and an Agenda for Reform*, 34 EMORY L.J. 617, 630 (1985).

¹¹⁶ Fishman, *supra* note 115, at 631-37; *see also* RONALD E. SEAVOY, *THE ORIGINS OF THE AMERICAN BUSINESS CORPORATION 1784-1855: BROADENING THE CONCEPT OF PUBLIC SERVICE DURING INDUSTRIALIZATION* 255 (1982).

¹¹⁷ Revenue Act of 1894, ch. 349, § 32, 28 Stat. 509, 556-57 (1894).

¹¹⁸ *See supra* note 107 (discussing statutory history of income tax exemption); *see also infra* notes 150, 154 (discussing whether I.R.C. § 501(c)(3) term "charitable" was intended to be synonymous with term "charity" for trust law purposes).

subsections (c)(3) and (c)(4). In relevant part, I.R.C. § 501(c)(3) applies to:

[c]orporations, . . . or foundation[s], organized and operated exclusively for religious, charitable, scientific . . . or educational purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, . . . and which does not participate in, or intervene in . . . any political campaign on behalf of . . . any candidate for public office.

I.R.C. § 501(c)(4) applies to “organizations not organized for profit but operated exclusively for the promotion of social welfare, . . . and the net earnings of which are devoted exclusively to charitable, educational, or recreational purposes.”

Both subsections of I.R.C. § 501(c) have been applied to exempt health care organizations from federal income taxation. Although on the face of the statutes the tests that a health care organization must satisfy to qualify for exemption under either subsection appear similar, the courts and the IRS have applied more stringent requirements under I.R.C. § 501(c)(3) than under I.R.C. § 501(c)(4). Moreover, the standards applied under the former subsection are clearer than those utilized with respect to the latter provision.

IV. CONTEMPORARY REQUIREMENTS FOR INCOME TAX EXEMPTION OF HEALTH CARE ORGANIZATIONS

A. *In General*

To qualify for income tax exemption under I.R.C. § 501(c)(3), a health care organization must satisfy six general tests—five statutory tests and one test added by judicial gloss:¹¹⁹ (1) the organizational test, i.e., pursuant to its organizing or creating documents, such as its articles of incorporation, it must be organized as a not-for-profit corporation and its purpose must be limited to an appropriate tax-exempt

¹¹⁹ It is debatable as to whether there are five or six separate tests. The statute sets forth five tests, and the Supreme Court has articulated a public policy test. Whether the public policy test is a separate test or subsumed within one of the statutory tests is arguable. For discussion of *Bob Jones Univ. v. United States*, 461 U.S. 574 (1983), and the prohibition against violation of public policy, see *infra* notes 330–35 and accompanying text.

purpose, such as a "charitable" purpose;¹²⁰ (2) the operational test, i.e., it must pursue and be operated "exclusively" for the same tax-exempt purpose as that used to satisfy the organizational test;¹²¹ (3) the "private inurement" test, i.e., no portion of the organization's net earnings may inure to any "insider";¹²² (4) the "private benefit" test, i.e., measured quantitatively and qualitatively, private benefit to any individual or

¹²⁰Treas. Reg. § 1.501(c)(3)-1(b)(1) (as amended in 1990). See generally BORIS I. BITTKER & LAWRENCE LOKKEN, 4 FEDERAL TAXATION OF INCOME, ESTATES AND GIFTS ¶ 100.2 (2d ed. 1992); HOPKINS, *supra* note 19, at 109-17; PAUL E. TREUSCH, TAX-EXEMPT CHARITABLE ORGANIZATIONS 90-91 (3d ed. 1988); IRS, Litigation Guideline Memorandum, TL-11 (1995), discussed in 70 TAX NOTES 264-65 (1996) [hereinafter LGM TL-11].

Most health care organizations are granted tax exemption because they satisfy the "charitable" purpose standard of I.R.C. § 501(c)(3). See *infra* parts IV.B.2 and IV.F (discussing charitable purpose). However, presumably, if the health care organization, e.g., a hospital, is affiliated with a university, as are many teaching hospitals, it should be able to qualify if operated "exclusively" for "educational" or "scientific" purposes within the meaning of I.R.C. § 501(c)(3). Treas. Reg. § 1.501(c)(3)-1(d)(3) (as amended in 1990) defines an "educational organization" as one that instructs or trains a person "for the purpose of improving or developing his capabilities" or instructs the "public on subjects useful to the individual and beneficial to the community." The regulations further provide that such "educational organizations" include private and public colleges, and professional or trade schools. Treas. Reg. § 1.501(c)(3)-1(d)(3)(ii) (as amended in 1990). IRS interpretations of the I.R.C. § 501(c)(3) term "scientific" have linked it with the terms "educational" or "charitable" when referring to university teaching hospitals or research hospitals. See, e.g., Priv. Ltr. Rul. 84-45-007 (Jul. 24, 1984) (laboratory facility undertaking major industry research projects granted tax-exemption as "educational organization" because research resulted in 90 publications, 99 scientific presentations and 56 undergraduate and post-graduate degrees); Priv. Ltr. Rul. 79-36-006 (May 23, 1979) (medical college granted tax-exemption because its research, funded by private industry, significantly contributed to school's basic purposes of promoting and teaching medical science); Rev. Rul. 76-455, 1976-2 C.B. 150 (organization held tax-exempt as educational and scientific organization because it assisted in establishing a regional health data system, engaged in studies concerning quality, utilization and effectiveness of health care, and educated health care professionals); Rev. Rul. 65-298, 1965-2 C.B. 163 (organization held tax-exempt as educational organization because it conducted research to develop scientific methods for diagnosis, prevention and treatment of diseases and to disseminate research findings to physicians and public). But see Priv. Ltr. Rul. 80-28-004 (Mar. 26, 1980) (university student conducted research funded by commercial sponsor was primarily for benefit of sponsor, did not significantly contribute to tax-exempt purpose of university, and considered incidental to education of students). See generally Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299, 333-35 (1976); John D. Colombo & Mark A. Hall, *The Future of Tax Exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1, 22 (1992); James T.Y. Yang, *Collaboration Between Nonprofit Universities and Commercial Enterprises: The Rationale for Exempting Nonprofit Universities from Federal Income Taxation*, 95 YALE L.J. 1857, 1862-63, nn.37-38 (1986).

¹²¹Treas. Reg. § 1.501(c)(3)-1(c) (as amended in 1990). Although the statute utilizes the term "exclusively," the courts and the regulation permit a charitable organization to engage in activities unrelated to its charitable purpose as long as limited and "insubstantial." See generally 4 BITTKER & LOKKEN, *supra* note 120, ¶ 100.2; HOPKINS, *supra* note 19, § 6.2; TREUSCH, *supra* note 120, at 101-07.

¹²²I.R.C. § 501(c)(3); see Treas. Reg. § 1.501-1(c)(2)-1(c)(3) (as amended in 1990). See generally 4 BITTKER & LOKKEN, *supra* note 120, ¶ 100.4; HOPKINS, *supra* note 19, § 13.1-6; TREUSCH, *supra* note 120, at 241-47; *infra* part IV.D.

small group must be incidental to public benefit;¹²³ (5) the political lobbying and legislation test, i.e., the organization must comply with limits on political lobbying and campaign activities;¹²⁴ and (6) the public policy test.¹²⁵ For purposes of this article, at the heart of tax exemption for health care organizations are four of these six tests: the operational test, the private inurement test, the private benefit test, and the public policy test. Subsumed within these tests are numerous judicially and administratively created requirements and standards.¹²⁶

B. *Operational Exclusivity Requirement*

To be considered a tax-exempt organization within the meaning of I.R.C. §§ 501(a) and (c)(3), an organization must be not only organized "exclusively" for tax-exempt purposes, but also operated "exclusively" for the identical tax-exempt purposes. In 1924 and again in 1945, the Supreme Court interpreted the applicable predecessor statutory language requiring the organization to be "operated exclusively" in a less stringent manner than its plain and ordinary meaning.¹²⁷ The Supreme Court determined that the "operational exclusivity requirement" mandated only that an organization must serve "primarily" the tax-exempt purpose for which it is organized.¹²⁸ This requirement prohibits the organization from engaging in any substantial non-exempt purpose, but permits a "negligible" or "incidental" amount of activity unrelated to its exempt purpose.¹²⁹ An organization would

¹²³ Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (as amended in 1990); *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989). See generally HOPKINS, *supra* note 19, § 13.7; TREUSCH, *supra* note 120, at 257-61; *infra* notes 288-93 and accompanying text.

¹²⁴ I.R.C. § 501(c)(3); see Treas. Reg. §§ 1.501(c)(3)-1(c)(3) (as amended in 1990), 1.501(h) (1990), 56.4911 (1990). See generally BRITTKER & LOKKEN, *supra* note 120, ¶ 100.5; HOPKINS, *supra* note 19, §§ 14.1-15.8; TREUSCH, *supra* note 120, at 263-329; Laura B. Chisolm, *Exempt Organization Advocacy: Matching the Rules to the Rationales*, 63 IND. L.J. 201 (1987) [hereinafter Chisolm, *Exempt Organization Advocacy*]; Laura B. Chisolm, *Politics and Charity: A Proposal for Peaceful Coexistence*, 58 GEO. WASH. L. REV. 308 (1990) [hereinafter Chisolm, *Politics and Charity*].

¹²⁵ See *infra* part IV.E.

¹²⁶ See, for example, the financial ability standard and the community benefit standard discussed *infra* notes 157-79 and accompanying text.

¹²⁷ *Trinidad v. Sagrada Orden de Predicadores*, 263 U.S. 578, 581-82 (1924); *Better Business Bureau of Washington, D.C., Inc. v. United States*, 326 U.S. 279, 283-84 (1945).

¹²⁸ *Trinidad*, 263 U.S. at 581; see *Better Business Bureau*, 326 U.S. at 286; see also *North Am. Sequential Sweepstakes v. Commissioner*, 77 T.C. 1087, 1094 (1981) (if activity serves both tax-exempt and nonexempt purposes, operational exclusivity test satisfied only if predominant motivations underlying the activity is exempt purpose).

¹²⁹ Treas. Reg. § 1.501(c)(3)-1(e)(1) (as amended in 1990); see *Trinidad*, 263 U.S. at 581-82; *Living Faith, Inc. v. Commissioner*, 950 F.2d 365, 370 (7th Cir. 1991); *Scripture Press Found. v. United States*, 285 F.2d 800 (Ct. Cl. 1961); *Virginia Professional Standards Review Found. v. Blumenthal*, 466 F. Supp. 1164 (D.C.D.C. 1979); LGM TL-11, *supra* note 120. Whether the activity

not be operated "exclusively" as a tax-exempt organization within the meaning of I.R.C. §§ 501(a) and (c)(3) if a single "nonexempt purpose" exists.¹³⁰ Although the operational exclusivity requirement applies to an organization's purposes,¹³¹ conformance with this requisite is demonstrated by substantial adherence to activities performed in furtherance of the organization's exempt purpose.¹³²

1. Commerciality Doctrine

Under the judicially created "commerciality doctrine,"¹³³ the courts and the IRS have considered that an activity conducted in a

is insubstantial commercial activity will be determined by taking into account a number of elements. *See infra* note 137 and accompanying text (delineating the factors considered by the courts under the commerciality doctrine).

¹³⁰ If an organization conducts substantial non-exempt activity, the IRS will deny tax-exempt status if the organization is initially seeking such preferred status. If the IRS previously had granted tax-exempt status to the organization, the IRS will revoke the favored status if the organization engages in substantial non-exempt activity. On the other hand, if an organization that otherwise qualifies for tax exemption under I.R.C. § 501(c)(3) engages in an insubstantial amount of non-exempt activity, and derives net income from such "unrelated business activity," that "unrelated business taxable income" is subject to corporate income taxation pursuant to I.R.C. §§ 501(b), 511-13 (1994). *See* Treas. Reg. §§ 1.511-1 to 1.513-6. For discussion of "unrelated business activity" and "unrelated business taxable income" see generally 4 BITTKER & LOKKEN, *supra* note 120; HOPKINS, *supra* note 19, §§ 40.1-42.2; TREUSCH, *supra* note 120, at 331-406; Henry B. Hansmann, *Unfair Competition and the Unrelated Business Income Tax*, 75 VA. L. REV. 605 (1989); Marcus S. Owens, *Current Developments in the Unrelated Business Area—IRS Perspective*, 4 EXEMPT ORG. TAX REV. 923 (1991).

¹³¹ As the Tax Court has bluntly stated:

Under the operational test, the purpose towards which an organization's activities are directed, and not the nature of the activities themselves, is ultimately dispositive of the organization's right to be classified as a section 501(c)(3) organization exempt from tax under section 501(a). . . . Rather, the critical inquiry is whether petitioner's primary purpose for engaging in its sole activity is an exempt purpose, or whether its primary purpose is the nonexempt one of operating a commercial business producing net profits for petitioner.

Sound Health Ass'n. v. Commissioner, 71 T.C. 158, 190 (1978) (quoting *B.S.W. Group, Inc. v. Commissioner*, 70 T.C. 352, 358 (1978)).

¹³² Therefore, the activities of the charitable organization need not be inherently charitable, but must be performed in furtherance of the exempt purpose. *See Better Business Bureau*, 326 U.S. at 283; *see also* Tommy F. Thompson, *The Unadministrability of the Federal Charitable Tax Exemption: Causes, Effects and Remedies*, 5 VA. TAX REV. 1, 16 (1985).

¹³³ *Trinidad*, 263 U.S. at 581-82 (in which the doctrine was first created in the context of a religious order that IRS alleged engaged in activities that were not tax-exempt but "operated also for business and commercial purposes" and the Court stated there was no "competition" although the "transactions yield some profit" which was deemed "in the circumstances a negligible factor"); *see also Better Business Bureau*, 326 U.S. at 283-84 (in which the doctrine was formally articulated and connected with the "exclusivity requirement" and tax exemption was denied because the organization had a "commercial hue" and its activities were "largely animated by this commercial purpose"); *Church of Scientology of Cal. v. Commissioner*, 83 T.C. 381 (1984) (discussing and applying doctrine to a religion founded by L. Ron Hubbard). For discussion of the commerciality

"commercial manner" is not in furtherance of an exempt purpose and hence is a "nonexempt activity."¹³⁴ A major problem with the commerciality doctrine is that it provides no precise guidelines for determining when an activity crosses the line between classification as an "exempt activity" and as a "nonexempt activity."¹³⁵ The courts generally have viewed the activity from the perspective of the consumer and have suggested that if the activity cannot be differentiated from that of a for-profit counterpart organization, the activity is considered commercial in nature.¹³⁶ The courts have enumerated a number of factors in evaluating the facts and circumstances to determine whether the activity is "commercial in nature":¹³⁷ (1) the scope of the organization's net profits; (2) the extent of the organization's accumulated surplus revenue (capital); (3) amounts expended for tax-exempt functions; (4) the type of activities and whether the activities are in "direct competition" with a for-profit enterprise; (5) the organization's pricing method; (6) the organization's promotion method; (7) whether the organization's hours of operation are basically the same as for-profit enterprises; (8) whether management has "business ability"; (9) whether the organization utilizes volunteers or employs individuals in the conduct of the activity; and (10) whether the organization receives charitable contributions. To date, although application of the commerciality doctrine rarely has precluded the tax exemption of a health care type organization,¹³⁸ General Accounting Office officials have commented on the

doctrine, see, for example, HOPKINS, *supra* note 19, §§ 38.2-4; James Bennett & Gabriel Rudney, *A Commerciality Test to Resolve the Commercial Nonprofit Issue*, 36 TAX NOTES 1095 (1987); Bruce R. Hopkins, *The Most Important Concept in the Law of Tax-Exempt Organizations Today: The Commerciality Doctrine*, 5 EXEMPT ORG. TAX REV. 459 (1992) [hereinafter Hopkins, *The Commerciality Doctrine*]; Paul J. Streer, *Obtaining and Preserving Tax-Exempt Status Under Section 501(c)(3): Judicially Developed Factors for Detecting the Presence of Substantial Nonexempt Activities*, J. AM. TAX ASS'N., Spring 1985, at 63.

¹³⁴ See *supra* note 133.

¹³⁵ An objective means of determining this line could be constructed, but its fairness would be in question. For such an attempt, see Bennett & Rudney, *supra* note 133, at 1097-98; John D. Colombo, *Why Is Harvard Tax-Exempt? (and Other Mysteries of Tax Exemption for Private Educational Institutions)*, 35 ARIZ. L. REV. 841, 849 n.51 (1993).

¹³⁶ See, e.g., *Living Faith, Inc. v. Commissioner*, 950 F.2d 365, 372-75 (7th Cir. 1991).

¹³⁷ See, e.g., *Living Faith*, 950 F.2d at 372; *Federation Pharmacy Servs., Inc. v. Commissioner*, 625 F.2d 804 (8th Cir. 1980); *Elisian Guild, Inc. v. United States*, 412 F.2d 121 (1st Cir. 1969); *American Inst. for Economic Research v. United States*, 302 F.2d 934 (Ct. Cl. 1962); *Scripture Press Found. v. United States*, 285 F.2d 800, 803-04 (Ct. Cl. 1961); *Industrial Aid for the Blind v. Commissioner*, 73 T.C. 96 (1979); *Peoples Translation Serv. Newsfront Int'l v. Commissioner*, 72 T.C. 42 (1979); *B.S.W. Group, Inc. v. Commissioner*, 70 T.C. 352 (1978); *Pulpit Resource v. Commissioner*, 70 T.C. 594 (1978); see also HOPKINS, *supra* note 19, at 835-42; Hopkins, *The Commerciality Doctrine*, *supra* note 133, at 462-63; Streer, *supra* note 133, at 64-69.

¹³⁸ See, e.g., *Federation Pharmacy Servs., Inc.*, 625 F.2d at 809 (tax-exempt status denied an

I.R.C. §§ 501(c)(3) and (c)(4) organizations' movement away from more "traditional sources of revenue" and toward commercial activities.¹³⁹ In light of this emerging trend, the commerciality doctrine may assume greater importance and force in the future with respect to health care organizations.

2. Meaning of the Term "Charitable"

As above mentioned, although I.R.C. § 501 does not provide a per se means of exempting health care organizations from income tax exemption, the IRS has long recognized the exemption of hospitals as "charitable" organizations.¹⁴⁰ Attempts to define the term "charitable" for I.R.C. § 501(c)(3) purposes has consumed much time and effort of legislators,¹⁴¹ the

organization whose only activity was the sale of prescription drugs to the general public, i.e., a pharmacy); see also *supra* note 136.

¹³⁹ *Exempt Organization Finance Panel's Look at AARP Foreshadows General Inquiry into Tax-Exempt Status*, Daily Tax Rep. (BNA), at G-1, G-2 (June 14, 1995), available in Westlaw, BNA-DTR file; accord Ryan Donmoyer, *Unrelated Business Income of EOs Reached 3.4 Billion in 1991*, 68 TAX NOTES 145 (1995).

¹⁴⁰ Administrative rulings regarding the income tax exemption generally date to Treas. Dec. 110 (May 1863). See *supra* note 20. Administrative rulings applicable to hospitals as exempt "charitable" organizations date at least to 1928. I.T. 2421, 7-2 C.B. 150 (1928). But see *supra* note 120 (discussing teaching and research hospitals that might also qualify as "educational" or "scientific" organizations).

¹⁴¹ The first lengthy consideration of the term "charitable" by legislators occurred in 1924 in the Senate, when, during debate, Senator Willis of Ohio informed his fellow senators that the Bureau of Internal Revenue ("Bureau"), predecessor to the IRS, used the term to include only organizations with activities limited to aiding the poor. Senator Willis considered the Bureau's definition too narrow and sought to expand the statute (which for all intents and purposes was identical to the current statute) to parenthetically define "charitable" to include organizations that provide "preventive and constructive service for relief, rehabilitation, health, character building and citizenship." 65 CONG. REC. 8171 (1924). Senators objected to the addition of the parenthetical phrase because of its potential expansiveness and its effect of making such organizations per se "charitable" and thus automatically tax-exempt regardless of services provided to the poor. Senator Smoot objected to Senator Willis's inclusion of "health" in the proposed definition. *Id.* at 8172-73. The debate resulted in Senator Willis withdrawing his proposed statutory amendment. For further discussion of this legislative endeavor, see Marilyn G. Rose, *The Internal Revenue Service's "Contribution" to the Health Problems of the Poor*, 21 CATH. U. L. REV. 35, 46-51 (1971).

More recently, in 1969, the American Hospital Association ("AHA") suggested in hearings before the House Ways and Means Committee that not-for-profit hospitals should be per se tax-exempt organizations. *Tax Reform Act of 1969: Hearings on H.R. 13270 Before the House Comm. on Ways and Means*, 91st Cong., 1st Sess. 1425, 1432-33 (1969) (statement by AHA attorney Julius M. Greisman). The House granted the AHA request in its report. H.R. REP. NO. 413, 91st Cong., 1st Sess. 43 (1969). The Senate Finance Committee deleted the House provision granting per se exemption to hospitals, which the joint committee accepted. S. REP. NO. 552, 91st Cong., 1st Sess. 61 (1969); H.R. REP. NO. 782, 91st Cong., 1st Sess. 289-90 (1969). However, as the Senate Finance Committee promised, the matter was again considered in connection with Medicare and Medi-

IRS,¹⁴² the judiciary,¹⁴³ and commentators.¹⁴⁴ Its definition is historically based but has defied precision. The virtual absence of relevant and clearly informative legislative history concerning the scope of the term contributes greatly to this lack of precision.¹⁴⁵ This void has engendered a wealth of literature speculating on the term's appropriate breadth and the possible rationale for exempting "charitable" organizations from income taxation.¹⁴⁶ The IRS in-

caid legislation. See STAFF OF SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID—PROBLEMS, ISSUES AND ALTERNATIVES 58 (Comm. Print 1970); *Hearings on Medicare and Medicaid Before the Senate Finance Comm.*, 91st Cong., 2d Sess. (1970).

The issue has surfaced more recently. See, e.g., *Tax Reform Act of 1986, Part III: Hearings on S. 361 Before the Senate Comm. on Finance*, 99th Cong., 2d Sess. 29–67 (1986) (statement of Bernard R. Tresnowski, President, Blue Cross and Blue Shield Organization, Chicago, Ill.). Mr. Tresnowski voiced objections to repeal of the Federal tax exemption for Blue Cross and Blue Shield plans. *Id.* Most recently, in hearings involving the proposed Health Security Act, S. 1757, 103d Cong., 1st Sess. (1993), the Joint Committee on Taxation examined the tax treatment of not-for-profit hospitals in the context of their role in furthering charitable purposes. STAFF OF JOINT COMM. ON TAXATION, 103D CONG., 1ST SESS., DESCRIPTION AND ANALYSIS OF TITLE VII OF H.R. 3600, S. 1757, AND S. 1775 ("HEALTH SECURITY ACT") (Comm. Print 1993). The Committee recognized that a not-for-profit medical care organization, in order to qualify for tax exemption, must demonstrate that its activities are targeted to a charitable class. *Id.* at 82. The Committee further noted that the precise nature of that charitable class has been and continues to be a source of controversy. *Id.*

¹⁴² See *infra* notes 148–56 and accompanying text.

¹⁴³ See *infra* notes 148–56 and accompanying text.

¹⁴⁴ See, e.g., MARION R. FREMONT-SMITH, FOUNDATIONS AND GOVERNMENT 41–43 (1965); HOPKINS, *supra* note 19, at 123–76; Bitker & Rahdert, *supra* note 120, at 331–33; Houck, *supra* note 107, at 1424–25; Persons et al., *supra* note 20, at 1932–49; see also *infra* note 146.

¹⁴⁵ But see *supra* note 141 (indicating some of the legislative debate over the term "charitable").

¹⁴⁶ The rationales that commentators have proposed to explain the income tax exemption of "charitable" organizations generally fall into two basic categories: conventional and academic theories. The first classification is based upon the notion that "charitable" organizations relieve the government of burdens by providing essential services which otherwise the government would be responsible to deliver, and such organizations deserve subsidizing. This theory is labeled the "subsidy theory." See, e.g., Rob Atkinson, *Altruism in Nonprofit Organizations*, 31 B.C. L. REV. 501, 605–10 (1990) (describing traditional subsidy theory as encompassing the generation of conventional goods and services beneficial to the public by altruistic not-for-profit organizations, which also produce "metabenefits," i.e., have the capacity to deliver such goods or services "more efficiently, more innovatively, or otherwise better than other suppliers"); Note, *Developments in the Law, Nonprofit Corporations*, 105 HARV. L. REV. 1579, 1620–21 (1992) (explaining subsidy theory, scrutinizing its shortcomings, and suggesting a tax expenditure analysis reveals its weaknesses). In essence, it is a combined market and social theory based on numerous assumptions and factors, but is premised on the notion that charitable purposes and organizations are worthy of promotion. The theory provides that charitable organizations deliver "charity," which includes health care services, to the poor free of charge because, in part, the provision of such services is recognized as a community benefit under traditional trust law, and it relieves the government of the burden of providing such services. See Bromberg, *supra* note 21, at 241–56; Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 332–84 (1991) [hereinafter Hall & Colombo, *Charitable Status*].

tentionally has avoided assigning a fixed and immutable defini-

These are the same factors used by the IRS and courts in determining whether an organization deserves tax-exempt status as a "charitable" organization.

Scholars have proposed academic theories as a response to the shortcomings of the subsidy theory in explaining the rationale of the income tax exemption. There are basically four academic theories: (1) the income measurement theory; (2) the capital formation theory; (3) the "altruism theory"; and (4) the donative theory. The income measurement theory, proposed by Professor Boris I. Bittker and George K. Rahdert in 1976, was a response to several of the practical problems of the subsidy theory. Bittker & Rahdert, *supra* note 120, at 302-04. Bittker and Rahdert suggested that not-for-profit organizations are exempt from income taxation because there is no practical and traditional accounting method of measuring their net income—it is difficult for a not-for-profit entity to classify certain income, such as donations, and to categorize certain expenses which would be I.R.C. § 162 (1994) ordinary and necessary business expenses to a for-profit enterprise. *Id.* at 305-19. However, the income measurement theory has not been favored by other academics. See Atkinson, *supra*, at 611-16; Hall & Colombo, *Charitable Status*, *supra*, at 385-86; Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 59-62 (1981) [hereinafter Hansmann, *Rationale*].

The capital formation theory was formulated by Professor Henry Hansmann in response to perceived inadequacies of the income measurement theory. Hansmann, *Rationale*, *supra*, at 55. In his capital formation theory, Professor Hansmann suggests that the income tax exemption is appropriate for not-for-profit organizations because it compensates them for their inadequate access to capital. *Id.* at 72-75. Moreover, he argues that not-for-profit organizations are the most efficient providers of goods and services as a result of "contract failure," which more often occurs within the framework of for-profit enterprises because consumers of for-profit businesses may not have ready access to information and may have difficulty evaluating for-profit providers. *Id.* at 86-91; Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 848-54 (1979) [hereinafter Hansmann, *Nonprofit Enterprise*]. He suggests that the income tax exemption may encourage the development and growth of not-for-profit organizations in industries characterized by contract failure. Hansmann, *Rationale*, *supra*, at 74. However, Professor Hansmann admits that such contract failure assumptions do not apply in the case of most hospital services because physicians assist patient-consumers in making health care service decisions. Hansmann, *Rationale*, *supra*, at 89; Hansmann, *Nonprofit Enterprise*, *supra* at 866-68.

Academics criticized Professor Hansmann's capital formation theory for numerous reasons, among which was a lack of historical consistency, a deficiency in strong supportive evidence, the absence of consideration of concepts of philanthropy and charity, and the treatment of all consumers, patrons, customers, and donors alike. See Atkinson, *supra*, at 623; Ira Mark Ellman, *Another Theory of Nonprofit Corporations*, 80 MICH. L. REV. 999, 1000, 1008-18 (1982); Hall & Colombo, *Charitable Status*, *supra*, at 387-89. However, the capital formation theory as well as the subsidy theory served as a foundation on which others could build theories. First, Professor Rob Atkinson developed an "altruism theory." Atkinson, *supra*, at 618. The altruism theory rests on the premise that the favorable tax treatment of altruistic not-for-profit organizations demonstrates an affirmative preference for something those entities provide, including direct primary benefits to consumers and "metabenefits," (above discussed) i.e., broader benefits beneficial to society such as pluralism and diversity. *Id.*; see also James Andreoni, *Giving with Impure Altruism: Applications to Charity and Ricardian Equivalence*, 97 J. POL. ECON. 1447 (1989) (concluding that people derive some utility and "warm glow" from the act of contributing, which makes government subsidies imperfect substitutes for gifts).

Refining and expanding these prior theories, Professors Mark A. Hall and John D. Colombo developed the donative theory. Hall & Colombo, *Charitable Status*, *supra*, at 388, 390 n.300; Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. 1379, 1383-84 (1991) [hereinafter Hall & Colombo, *Donative Theory*]. The donative theory suggests that the primary rationale for the income tax exemption for "charitable" organizations

tion;¹⁴⁷ consequently, its development has depended on judicial and administrative decisions. The IRS and judicial interpretations have referred to types and categories of endeavors entitled to be considered "charitable" and to such themes as redistribution of wealth and services.¹⁴⁸ As will become apparent through the following discussion, however, the term's inexact, but somewhat fluid, definition over the past forty years has been neither totally stagnant nor consistently progressive.

a. *Broad Construction*

Since the turn of the twentieth century and the enactment of the federal tax statute permitting tax exemption to "charitable" organizations,¹⁴⁹ debate has persisted as to whether Congress intended the term "charitable" to be limited to its narrow, "popular and ordinary" construction—that is, relief to poor, disadvantaged, and distressed persons—or to be accorded the broad, common law meaning—that is, "everything that is within the letter and spirit of the [Statute of Charitable Uses], considering such spirit to be broad enough to include whatever will promote, in a legitimate way, the comfort, happiness, and improvement of an indefinite number of persons."¹⁵⁰ Early Treasury

is to subsidize those capable of attracting substantial donative support. Hall & Colombo, *Charitable Status*, *supra*, at 316, 390; Hall & Colombo, *Donative Theory*, *supra*, at 1390–1416, 1446–50. Professors Hall and Colombo also reason that the exemption is a response to market failure resulting in free-rider problems and to the government's inability to provide all necessary services. Hall & Colombo, *Charitable Status*, *supra*, at 391–94. However, they suggest that the exemption is appropriate because charitable donations alone cannot satisfy the organizations' financial ability to deliver all public needs; however, they recommend that not-for-profit entities should attain certain threshold levels of donations (30% donation levels for hospitals) before qualifying for tax-exempt treatment. *Id.* at 394–409.

¹⁴⁷ Assistant Secretary of the Treasury for Tax Policy, Edwin S. Cohen, stated in hearings before the House Ways and Means Committee: "We have tried to avoid interpreting the word 'charitable' in a fixed, immutable fashion. As the courts have done in many nontax settings, we have tried to give it meaning that changes and expands as the needs of society change and expand." *Legislative Activity by Certain Types of Exempt Organizations: Hearings before the House Comm. on Ways and Means*, 92d Cong., 2d Sess. 5 (1972).

¹⁴⁸ See *infra* parts IV.B.2 and IV.F (describing IRS pronouncements and court cases that interpret the term "charitable" and the I.R.C. § 501(c)(3) requirements); see also STAFF OF SENATE COMM. ON FINANCE, 89TH CONG., 1ST SESS., TREASURY DEP'T REPORT ON PRIVATE FOUNDATIONS 12–13 (Comm. Print 1965) (asserting that federal government benefits from charitable endeavors).

¹⁴⁹ See *supra* notes 107, 120 (describing the history of the income tax exemption applicable to charitable organizations).

¹⁵⁰ *Harrington v. Pier*, 82 N.W. 345, 357 (1900); see GEORGE G. BOGERT & GEORGE T. BOGERT, LAW OF TRUSTS 200 (5th ed. 1973); HOPKINS, *supra* note 19, at 69–70. The argument that Congress intended a broad interpretation was promoted in 1958 by Assistant Chief Counsel of the IRS, Herman T. Reiling. See Herman T. Reiling, *Federal Taxation: What Is a Charitable*

pronouncements consistently interpreted the term in its "popular and ordinary" sense.¹⁵¹ Over time this sentiment of the Treasury changed, and by 1959, the Treasury regulations reflected a broader construction.¹⁵² Since that time, the regulations have continued to provide that the term be used broadly in "its generally accepted legal sense."¹⁵³

Because the term "charitable" when used in its legal sense can be traced to English antecedents of American law—that is, the common law of charitable trusts—it is perhaps natural that interpretations for our federal income tax purposes have drawn on the broad common law principles of charitable trusts and charity.¹⁵⁴ The American judi-

Organization?, 44 A.B.A. J. 525 (1958) (suggesting that the statutory list as a whole is meant to expand to the outer reaches of the common law legal definition of "charity"). Not surprisingly, the 1959 Treasury Regulations reflected Reiling's perspective. See Treas. Reg. § 1.501(c)(3)-1(d)(2) (1959) (reproduced *infra* note 152 in relevant part); see also Chisolm, *Exempt Organization Advocacy*, *supra* note 124, at 256-59 (discussing the broad and narrow potential interpretations of the term). For a recent judicial discussion of reasons for adherence to a broad interpretation, see *Eastern Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1287-89 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976). See also *infra* notes 181-88 and accompanying text.

¹⁵¹ I.T. 1800, 2-2 C.B. 152, 153 (1923); Treas. Reg. 65, Art. 517 (interpreting provision under Revenue Act of 1924); Treas. Reg. 69, Art. 517 (interpreting provision under Revenue Act of 1926); Treas. Reg. 74, Art. 527 (interpreting provision under Revenue Act of 1928); Treas. Reg. 77, Art. 527 (interpreting provision under Revenue Act of 1932); Treas. Reg. 86, Art. 101(6)-1 (interpreting provision under Revenue Act of 1934); Treas. Reg. 94, Art. 101(6)-1 (interpreting provision under Revenue Act of 1936); Treas. Reg. 101, Art. 101(6)-1 (interpreting provision under Revenue Act of 1938); see HOPKINS, *supra* note 19, at 75 & n.32; Chisolm, *Exempt Organization Advocacy*, *supra* note 124, at 257 n.240; see also *Eastern Ky. Welfare Rights Org. v. Shultz*, 370 F. Supp. 325, 331-32 (D.D.C. 1973) (in which the district court stated that Congress intended the term to be interpreted in its narrow sense), *rev'd sub nom.* *Eastern Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278 (D.C. Cir. 1974) *vacated*, 426 U.S. 26 (1976).

¹⁵² Treas. Reg. § 1.501(c)(3)-1(d)(2) (1959) in relevant part provided:

Charitable defined.—The term "charitable" is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as and limited by the separate enumeration in 501(c)(3) of other tax-exempt purposes which may fall within the broad outlines of "charity" as developed by judicial decisions. Such term includes: Relief of the poor and distressed and underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat community deterioration and juvenile delinquency.

For a brief discussion of the position asserted in support of this broad interpretation, see *supra* note 150.

¹⁵³ Treas. Reg. § 1.501(c)(3)-1(d)(2) (as amended in 1990) (using the same language as the Treasury regulations promulgated in 1959).

¹⁵⁴ See *supra* notes 107-18 (discussing the Statute of Charitable Uses and the development of corporations as the generally accepted form for charitable entities in America after the Revolutionary War); see also *Bob Jones Univ. v. United States*, 461 U.S. 574, 585-88 (1983) (expressly adopting view that common law of charitable trusts guided enactment of I.R.C.

ary and the IRS have indicated that a strong similarity exists between charitable trust law and tax law.¹⁵⁵ However, the judiciary and the IRS appear to recognize that the analogy is limited and does not control entirely the meaning of the term "charitable" for tax exemption purposes; other elements must be considered.¹⁵⁶

b. *Revenue Ruling 56-185: Financial Ability Standard Applied to Hospitals*

Because under I.R.C. § 501(c)(3) health care providers were not considered per se "charitable" according to an exact formula arising from charitable trust law,¹⁵⁷ in 1956 the IRS issued a revenue ruling to guide hospitals as to the applicable tax exemption criteria.¹⁵⁸ Pursuant to Revenue Ruling 56-185, the IRS indicated that in addition to satisfying the private inurement and private benefit prohibitions,¹⁵⁹ a hospital must be organized and operated exclusively to care for the sick, and it must comply with a "financial ability standard."¹⁶⁰ In accordance with the financial ability standard, to be deemed "charitable," a hospi-

§ 501(c)(3) and that when interpreting a statute, courts should not look merely to a particular clause, but should take in connection with it, the whole statute and the objects and policy of the law). But see Miriam Galston, *Public Policy Constraints on Charitable Organizations*, 3 VA. TAX REV. 291, 297-316 (1984) (arguing distinctions exist between trust law and federal tax statutes, indicating that trust law definitions of charity merely overlap and should not be equated with intended meaning for federal tax purposes).

¹⁵⁵ See, e.g., *Bob Jones Univ.*, 461 U.S. at 585-88; *Girard Trust Co. v. Commissioner*, 122 F.2d 108, 110 (3d Cir. 1941); *Green v. Connally*, 330 F. Supp. 1150, 1157-61 (D.D.C. 1971), *aff'd mem. sub. nom. Coit v. Green*, 404 U.S. 997 (1971); Rev. Rul. 67-325, 1967-2 C.B. 113; see also Galston, *supra* note 154, at 298.

¹⁵⁶ See, e.g., *Bob Jones Univ.*, 461 U.S. at 585-99 (purposes and practices of charitable organization cannot violate local law nor public policy); *Girard Trust Co.*, 122 F.2d at 110; *Tax Exemptions for Charitable Organizations Affecting Poverty Programs: Hearings Before the Subcomm. on Employment, Manpower and Poverty of the Senate Comm. on Labor and Public Welfare*, 91st Cong., 2d Sess. 54 (1970) (testimony of Randolph W. Thrower, Commissioner of Internal Revenue Service); Statement by Randolph W. Thrower Before the Ways and Means Committee on Tax-Exempt Status of Racially Discriminatory Private Schools, *reprinted in* 35 TAX LAW. 701 (1982); see also Galston, *supra* note 154, at 298. But see *Bob Jones Univ.*, 461 U.S. at 612-17 (Rehnquist, J., dissenting) (arguing that I.R.C. § 501(c)(3) should be construed as setting forth sole criteria Congress established for tax-exempt status and disagreeing with interpretive gloss requiring organization to comport with public policy).

¹⁵⁷ See *supra* notes 119-25 and accompanying text.

¹⁵⁸ Rev. Rul. 56-185, 1956-1 C.B. 202. Although revenue rulings do not have the force and effect of Treasury regulations, they reflect at least the current position and policies of the IRS. See I.R.C. § 7805(a) (authorizing promulgation of regulations); see also Linda Galler, *Emerging Standards for Judicial Review of IRS Revenue Rulings*, 72 B.U. L. REV. 841 (1992).

¹⁵⁹ Rev. Rul. 56-185, *supra* note 158, at 202. The revenue ruling also specified that the organization must be a public charitable organization chartered as a nonprofit charitable corporation. *Id.*

¹⁶⁰ *Id.* at 202.

tal must be "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."¹⁶¹ The revenue ruling effectively stated that a hospital cannot refuse to accept patients needing care but unable to pay; however, the "fact that [the hospital's] charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability."¹⁶² Therefore, a hospital would be under no obligation to engage in a high level of charitable activity to qualify for exemption.¹⁶³ In fact, the IRS recognized that the lack of demand for services at below cost should not disqualify the hospital from eligibility for tax-exempt status.¹⁶⁴ In the context of hospitals, the IRS described the concept of charity as (1) the provision of health care services at either below cost rates or free of charge, and (2) the earmarking of funds to improve facilities.¹⁶⁵ In specifically addressing a community hospital, although enunciated in terms of the financial ability standard, the IRS hinted at a forthcoming policy concern. In particular, it suggested that a community hospital will need to confer benefit on the general community:

[A community hospital] is formed for the purpose of furnishing hospital facilities to all persons in the community at the lowest possible cost and necessarily accepts patients who are unable to pay for hospital facilities in order to retain the support of the community. A nominal charity record for a given period of time, in the absence of charitable demands of the community, will not affect its right to continued exemption.¹⁶⁶

Over the next thirteen years, this policy signal would develop into the "community benefit standard."¹⁶⁷

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ However, in several private letter rulings issued soon after Rev. Rul. 56-185, the IRS stated that the provision of free care to fewer than five percent of a hospital's patients was insufficient for it to grant tax-exempt status to a hospital. See Richardson, *supra* note 58, at 904.

However, over the next several years, the financial ability standard was interpreted sufficiently broadly to permit hospitals that did not refuse to admit indigents to satisfy the operational test of I.R.C. § 501(c)(3) even in the absence of local demand for below cost or free of charge health care services. See *id.* at 904 n.26 (citing Note, *Federal Income Tax Exemption for Private Hospitals*, 36 FORDHAM L. REV. 758 (1968)).

¹⁶⁴ Rev. Rul. 56-185, *supra* note 158, at 202.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ See *infra* parts IV.B.2.c-h and IV.F (describing evolution of community benefit standard).

c. *Revenue Ruling 69-545: Community Benefit Standard Applied to Hospitals*

In 1969, the IRS issued Revenue Ruling 69-545,¹⁶⁸ which enunciated the community benefit standard as applied to hospitals.¹⁶⁹ The revenue ruling described nonprofit Hospital A, which failed to provide free or reduced rate nonemergency inpatient or outpatient services to indigents.¹⁷⁰ The IRS ruled that Hospital A qualified as a tax-exempt charitable organization. In support of its decision, the IRS relied on the general law of charity,¹⁷¹ which considers the promotion of health care to be per se a "charitable purpose."¹⁷² Although not referring to Treasury regulation section 1.501(c)(3)-1(d)(2),¹⁷³ which requires the not-for-profit organization to be "charitable" in the "generally accepted legal sense" of the term, the IRS presented the essence of the regulation:

In the general law of charity, the promotion of health is considered to be a charitable purpose. A nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose. If it meets the other requirements of section 501(c)(3) . . . it will qualify for exemption from Federal income tax under section 501(a).

Since the purpose and activity of Hospital A, apart from its related educational and research activities and purposes, are providing hospital care on a nonprofit basis for members of

¹⁶⁸ 1969-2 C.B. 117.

¹⁶⁹ The IRS previously had applied the community benefit standard in other contexts. See, e.g., Rev. Rul. 67-325, 1967-2 C.B. 113, 115 (discussing issue of deductibility under I.R.C. § 170 of contributions to a recreational facility operated by township without charge to local residents but racially restricted).

¹⁷⁰ The IRS described this practice in the facts, as follows:

The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

Rev. Rul. 69-545, *supra* note 168, at 117.

¹⁷¹ *Id.* at 118 (citing RESTATEMENT (SECOND) OF TRUSTS, §§ 368, 372, and IV SCOTT ON TRUSTS §§ 368, 372.2 (3d ed. 1967)).

¹⁷² Rev. Rul. 69-545, *supra* note 168, at 118.

¹⁷³ See *supra* note 152 and accompanying text (citing language of Treas. Reg. § 1.501(c)(3)-1(d)(2)).

its community, it is organized and operated in furtherance of a purpose considered "charitable" in the generally accepted legal sense of that term.¹⁷⁴

The IRS enunciated its community benefit standard in the context of a balancing approach:

The promotion of health care, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole, even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, provided that the class is not so small that its relief is not of benefit to the community.¹⁷⁵

Applying this standard, the IRS found the class of persons benefited in the community sufficiently broad because the hospital operated a generally accessible emergency room open to all persons, regardless of ability to pay.¹⁷⁶ However, the IRS did not require that the hospital accept indigent patients on an inpatient basis for any purpose other than its emergency room.¹⁷⁷ At the end of the revenue ruling, the IRS modified Revenue Ruling 56-185 "to remove therefrom the requirements relating to caring for patients without charge or at rates below cost."¹⁷⁸ The ruling further noted several factors, none of which were controlling, to indicate that the hospital served a public rather than private interest: (1) the board of trustees represented the community at large because its composition included independent civic leaders; (2) the hospital operated with an open medical staff; and (3) the hospital utilized surplus funds to improve the quality of patient care, expand its facilities, and advance medical training, education, and research.¹⁷⁹

d. *Controversy over Community Benefit Standard*

This new revenue ruling proved controversial. Less than one year after its publication, the staff of the Senate Finance Committee recom-

¹⁷⁴ Rev. Rul. 69-545, *supra* note 168, at 118 (citation omitted).

¹⁷⁵ *Id.* (citation omitted).

¹⁷⁶ The IRS also determined that Hospital A satisfied the private inurement and private benefit tests. *See infra* parts IV.C-D (discussing private inurement and private benefit tests).

¹⁷⁷ *See supra* note 170 (quoting language of revenue ruling to this effect).

¹⁷⁸ Rev. Rul. 69-545, *supra* note 168, at 119.

¹⁷⁹ *Id.* at 118. Several of these factors seem to address the prohibitions against private inurement and private benefit as much as or more than the issue of community benefit.

mended that it be revoked and that Revenue Ruling 56-185 be restored until Congress could act.¹⁸⁰ Congress did not act on the Senate Finance Committee staff's suggestion.

Several years later, the Eastern Kentucky Welfare Rights Organization, representing a group of indigents who had been refused treatment in tax-exempt hospitals because of their inability to pay, brought a class-action lawsuit challenging the community benefit standard.¹⁸¹ The plaintiffs sought to have Revenue Ruling 69-545 declared invalid and to enjoin its implementation. The District Court for the District of Columbia upheld the challenge and stated that Congress intended the term "charitable" to be limited to its narrow, ordinary and "popular" sense—that is, relief to the poor.¹⁸² On appeal, the United States Court of Appeals for the District of Columbia Circuit reversed the district court's decision, declaring the revenue ruling valid.¹⁸³ The circuit court found that the term "charitable" should not be restricted to its narrow meaning and considered the law of charitable trusts to support a broad interpretation of the term.¹⁸⁴ It regarded a narrow construction of the term as "inflexible" and as failing to "recognize the changing economic, social and technological precepts and values of contemporary society."¹⁸⁵ Finally, the circuit court concluded that Revenue Ruling 69-545 "rather than overruling Revenue Ruling 56-185 simply provides an *alternative* method whereby a nonprofit hospital can qualify as a tax-exempt charitable organization."¹⁸⁶ On appeal, the Supreme Court held that the federal courts lacked jurisdiction to hear the case because the plaintiffs lacked standing.¹⁸⁷ Therefore, the district court and circuit court judgments were nullified, leaving the opinions open to debate.¹⁸⁸

¹⁸⁰ STAFF OF SENATE COMM. ON FINANCING, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAIDE: PROBLEMS, ISSUES, AND ALTERNATIVES (Comm. Print 1970).

¹⁸¹ Eastern Ky. Welfare Rights Org. v. Shultz, 370 F. Supp. 325, 325 (D.D.C. 1973), *rev'd sub nom.* Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976).

¹⁸² *Id.* at 330.

¹⁸³ Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1278 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976).

¹⁸⁴ *Id.* at 1287-88.

¹⁸⁵ *Id.* at 1288. The court indicated that health care had evolved dramatically over the years and that the rationale for a narrow definition of "charitable" had largely disappeared. *Id.*

¹⁸⁶ *Id.* at 1289 (emphasis added).

¹⁸⁷ Simon v. Eastern Ky. Welfare Rights Org., 426 U.S. 26 (1976).

¹⁸⁸ In a case before the Sixth Circuit, not long after the Circuit Court for the District of Columbia rendered its opinion in *Eastern Kentucky Welfare Rights Organization*, Chief Judge Harry Phillips declined to entertain the question of the validity of Revenue Ruling 69-545. *Harding Hospital, Inc. v. United States*, 505 F.2d 1068, 1076 (6th Cir. 1974). He stated that the issue was neither before the court on argument nor was it briefed. However, he noted that it would have been unnecessary to address the issue because the court would have held the psychiatric hospital

e. *Revenue Ruling 83-157: Modification of Community Benefit Standard Applied to Hospitals*

In 1983, the IRS faced the community benefit standard in the context of a hospital that did not operate an emergency room. Under the facts of Revenue Ruling 83-157,¹⁸⁹ the nonprofit hospital was identical to Hospital A described in Revenue Ruling 69-545 except that because a state or local government planning agency determined it would be duplicative of emergency service facilities otherwise provided in the community, the hospital did not operate an emergency room. The IRS recognized that the operation of an emergency room and the community access to it is merely one factor evidencing a hospital's benefit to the community. It suggested that other "significant factors" enter into the community benefit determination. These included "a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like medicare and medicaid, and application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research."¹⁹⁰ In recognition that certain specialized hospitals, such as eye hospitals and oncology hospitals, may not need to maintain an emergency room, the IRS extended this ruling to cover those institutions.¹⁹¹ Finally, the IRS instructed that Revenue Ruling 83-157 was intended to "amplify" Revenue Ruling 69-545.¹⁹²

in the instant case to be undeserving of tax-exempt status. *Id.* The court based this conclusion on several factors: (1) sufficient evidence to find that the hospital did not hold itself out to the public as a charitable institution; (2) the absence of a specific plan or policy for the treatment of charity patients, regardless of its statistical records showing the provision of up to 7.78% of "uncompensated care"; (3) physicians practicing at the hospital derived substantial private benefits from the hospital's existence and operation; and (4) the medical group partnership benefited from the hospital. *Id.* at 1077-78. Although part of the reasoning for denial of the tax exemption was violation of the prohibitions against private inurement and private benefit, clearly the circuit court did not consider the hospital to serve sufficiently the general community.

In 1980, the Sixth Circuit considered a case in which a group of low income persons brought a class action against the Secretary of the Treasury, the Commissioner of Internal Revenue, and seven Ohio hospitals challenging Revenue Ruling 69-545 and the hospitals' tax exemptions. *Lugo v. Miller*, 640 F.2d 823 (6th Cir. 1981). Although the plaintiffs in this case had sought to overcome the difficulties encountered by the plaintiffs in *Eastern Kentucky Welfare Rights Organization*, the court found that these plaintiffs also did not have standing to challenge the validity of Revenue Ruling 69-545 nor to enjoin the grant of tax-exempt status to the defendant hospitals. *Id.* at 831.

¹⁸⁹ 1983-2 C.B. 94.

¹⁹⁰ *Id.* at 95.

¹⁹¹ *Id.*

¹⁹² *Id.*

f. Summary of Revenue Rulings

It is clear from the revenue rulings that many factors enter into the determination of whether a hospital's purposes and activities are deemed to serve a sufficient community benefit. It appears that no one factor is controlling and that all facts and circumstances must be weighed. The revenue rulings provide no guidance as to a means of quantitatively or qualitatively measuring the factors present in any given situation. Numerous attempts by legislators and suggestions by academicians have been made for the purpose of clarifying, quantifying, and qualifying the community benefit standard in some way.¹⁹³

¹⁹³ Proposed legislation has attempted to modify or abandon the current community benefit standard. See, e.g., H.R. 790, 102d Cong., 1st Sess. (1991) (introduced by Representative Edward R. Roybal to move toward relief of poverty or charity standard); H.R. 1374, 102d Cong., 1st Sess. (1991) (introduced by Representative Brian J. Donnelly to move toward relief of poverty or charity standard); Health Security Act of 1993, H.R. 3600/S. 1757, § 7601(a), 103d Cong., 1st Sess. (1993) (attempting to establish that at least annually, the health care organization assess, with the assistance of community leaders, the health needs of its community and develop a plan to meet those needs); see also U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SELECT COMMITTEE ON AGING, HOUSE OF REPRESENTATIVES, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION (1990) [hereinafter GAO, BETTER STANDARDS]; see also Colombo, *supra* note 82, at Addendum; Colombo & Hall, *supra* note 120 at 22-23; J. David Seay, *Community Benefit Prevails*, 73 HEALTH PROGRESS 42 (1992); J. David Seay, *Tax Exemption for Hospitals: Towards an Understanding of Community Benefit*, 2 HEALTH MATRIX 35 (1992); J. David Seay & Robert M. Sigmond, *Community Benefit Standards for Hospitals: Perceptions and Performance*, 5 FRONTIERS OF HEALTH SERVS. MGMT. 3 (1989); Renee Blankenau, *Measuring Up: Congress Reconsiders Tax-Exemption Standards Under Reform*, 68 HOSP. & HEALTH NETWORKS, Jan. 5, 1994, at 14.

Organizations and academicians have proposed community benefit standards that involve self-assessment activities and reflect a means of assisting hospitals to define and attain community benefit goals. For example, pursuant to a W.K. Kellogg Foundation grant, two professors have developed the Hospital Community Benefit Standards Program ("HCBSP"), an approach that is subjective and not quantifiable. Anthony R. Kovner & Paul A. Hattis, *Benefitting Communities*, HEALTH MGMT. Q., 4th Q. 1990, at 6. The HCBSP sets forth the following four standards for hospitals to follow: (1) a hospital must show evidence of the hospital's formal commitment to a community benefit program for a designated community; (2) the scope of the hospital programs would include hospital-sponsored projects for the designated community in each of the following areas: (a) improving health status, (b) addressing health problems of minorities, the poor and other medically underserved populations, and (c) containing the growth of community health care costs; (3) the hospital's programs would include activities designated to stimulate other organizations and individuals to join in carrying out a broad health agenda in the designated community; and (4) the hospital must foster an internal environment that encourages hospital-wide involvement in the program. *Id.* at 7.

Another approach has been developed by the Catholic Health Association ("CHA"). See David Hyman, *Catholic Health Association Standards for Community Benefit*, 9 EXEMPT ORG. TAX REV. 1254, 1254-57 (1994). The CHA takes the position that its health care provider organizations should:

(1) Issue mission statements that reflect a commitment to benefit the community and the policies and practices consistent with the statements, including "[c]onsideration of operational and policy decisions in light of their impact on the community served, especially the poor, the

Some individuals have suggested that the community benefit standards adopted by state courts and legislatures should serve as models for a federal standard.¹⁹⁴

frail elderly and the vulnerable. Adoption of charity care policies that are made public and are consistently applied. Incorporation of community healthcare needs into regular planning and budgeting processes." *Id.* at 1254.

(2) Have the organization's governing board adopt, make public and implement a community benefit plan that—

Defines the organization's mission and the community being served.

Identifies unmet healthcare needs in the community, including needs of the poor, frail elderly, minorities and other medically underserved and disadvantaged persons.

Describes how the organization intends to take a leadership role in advocating community-wide responses to healthcare needs in the community.

Describes how the organization intends to address, directly and in collaboration with physicians, other individuals and organizations:

—particular or unique healthcare problems of the community;

—healthcare needs of the poor, frail elderly, minorities and other medically underserved and disadvantaged persons.

Describes how the organization sought the views of the community being served and how community members and other organizations were involved in identifying needs and the development of the plan.

Id. at 1254-55.

(3) Provide community benefits to the poor and the broader community that are designed to comply with the community benefit plan, improve health status in the community, promote access to healthcare services to all persons in the community, and to contain healthcare costs. *Id.* at 1254.

(4) Make available to the public an annual community benefit report describing the scope of community benefits provided directly and in collaboration with others. *Id.* at 1257-58.

¹⁹⁴ Historically many states have permitted tax exemptions, whether income, property or sales tax exemptions, based on a not-for-profit organization's obtaining a tax exemption from the IRS. See James P. Buchele, *Justifying Real Property Tax Exemptions in Kansas*, 27 WASHBURN L.J. 252 (1988); William R. Ginsberg, *The Real Property Tax Exemption of Nonprofit Organizations: A Perspective*, 53 TEMP. L.Q. 291 (1980); Note, *Nonprofit Hospitals and the State Tax Exemption: An Analysis of the Issues Since Utah County v. Intermountain Health Care, Inc.*, 9 VA. TAX REV. 599, 599 (1990); Roger C. Nauert et al., *Hospitals Face Loss of Federal Tax-Exempt Status*, HEALTHCARE FIN. MGMT. REV., Sept. 1988, at 48, 52. However, the near automatic state grant has been curtailed in some states, and some states' laws regarding tax exemption now diverge significantly from that of I.R.C. § 501(c)(3). See Baldwin, *supra* note 19; Hyman & McCarthy, *supra* note 19; John W. O'Donnell & James H. Taylor, *The Bounds of Charity: The Current Status of the Hospital Property Tax Exemption*, 322 NEW ENG. J. MED. 65 (1990); Margaret A. Potter & Beaufort B. Longest, Jr., *The Divergence of Federal and State Policies on the Charitable Tax Exemption of Nonprofit Hospitals*, 19 J. HEALTH POL., POL'Y & LAW 393 (1994). For example, the Texas legislature recently enacted new provisions significantly restricting the property tax exemption for charitable nonprofit organizations and narrowly defining the terms "nonprofit hospital" and "charitable" in connection with care for indigents. TEX. CONST. art. VIII, § 2(a) (1995); TEX. TAX CODE ANN. § 11.18 (West 1995); TEX. HEALTH & SAFETY CODE ANN. § 311.043 (West 1995).

In other states, based on existing statutes, the judiciary has established specific criteria for the determination of whether hospitals are "charitable" and entitled to some type of tax exemption. For example, the Utah Supreme Court interpreted a clause in the Utah Constitution to require that hospitals prove entitlement to a property tax exemption on an annual basis. *Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985). Now, not-for-profit hospitals in

All of this concern has returned to and largely focused on the notion presented by the plaintiffs in the *Eastern Kentucky Welfare Rights Organization* case—that is, a “charitable” health care organization should provide a certain amount of charity care as a form of community benefit required for tax exemption.¹⁹⁵ A popular expectation and

Utah must submit annual financial and operating information for examination by county tax assessors to determine whether the hospitals satisfy the Utah Supreme Court’s multi-factor test of charitability and thus warrant tax exemption for the year. The multi-factor test set forth by the court is used to measure the size of the hospitals’ charity levels to their communities. To warrant property tax exemption, the levels of charity must exceed the property taxes that the hospitals would otherwise be obligated to pay. The Utah Supreme Court’s multi-factor test of charitability includes the following: (1) whether a hospital’s governing instrument identifies as its purpose activities and services to others that are consistent with a “charitable” use and which preclude inurement of financial benefit to others; (2) whether and to what extent the hospital is supported by donations and gifts; (3) whether recipients of the hospital’s services are required to pay, in whole or in part, for the assistance received; (4) whether income from all hospital sources exceeds its operating and maintenance expenses (and if so, this suggests the hospital is not “charitable” even if the surplus is used for capital improvements and new equipment); (5) whether beneficiaries of the hospital services are restricted in any way, and if so, whether the restriction bears a reasonable relation to the hospital’s charitable objectives; (6) whether dividends or other forms of financial benefit, or assets on dissolution, are available to private interests; and (7) whether the hospital is organized and operated so that any commercial activities are subordinate to or incidental to the charitable activities. *Id.* at 269–70.

For a discussion of these factors and the Utah Supreme Court opinion, see, for example, Jerry J. McCoy, *Health Care and the Tax Law: Reorganizations, Structural Changes, and Other Contemporary Problems of Tax-Exempt Hospitals*, 44TH ANN. N.Y.U. TAX INST. § 58.04 (1986); O’Donnell & Taylor, *supra* at 66; Phelon S. Rammell & Robert J. Parsons, *Utah County v. Intermountain Health Care: Utah’s Unique Method for Determining Charitable Property Tax Exemptions—A Review of its Mandate and Impact*, 22 J. HEALTH & HOSP. L. 73, 77–80 (1989); Note, *supra* at 618.

Other state judiciaries have reacted similarly to the Utah Supreme Court. See, e.g., *Hospital Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985); *West Allegheny Hosp. v. Board of Property Assessment*, 455 A.2d 1170 (Pa. 1982); *School Dist. of Erie v. Hamot Medical Ctr.*, 602 A.2d 407 (Pa. Commw. Ct. 1992); *Medical Ctr. Hosp. of Vt. v. City of Burlington*, 566 A.2d 1352 (Vt. 1989).

¹⁹⁵ Numerous studies and articles have been produced concerning a suitable definition of “charity care” for not-for-profit hospitals, the appropriate amount of charity care to be deserving of tax-exempt status, and the means of measuring whether the obligation of providing charity care has been satisfied. Generally, charity care is equated with the term “uncompensated care”; however, not all persons agree on how to define this term nor on how to measure it. See INSTITUTE OF MEDICINE, *FOR-PROFIT ENTERPRISE IN HEALTH CARE* (Bradford H. Gray ed., 1986); Barbara Arrington & Cynthia Carter Haddock, *Who Really Profits from Not-For-Profits?*, 25 HEALTH SERVS. RESEARCH 291 (1990); Bradford H. Gray & Walter J. McNerney, *For-Profit Enterprise in Health Care: The Institute of Medicine Study*, 314 NEW ENG. J. MED. 1523 (1986); Regina E. Herzlinger, *Setting the Record Straight: Are Voluntary Hospitals Caring for the Poor?*, *To the Editor*, 319 NEW ENG. J. MED. (1988); Lawrence S. Lewin et al., *Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals*, 318 NEW ENG. J. MED. 1212 (1988); Susan M. Sanders, *Does Mission Really Matter? Measuring and Examining Charity Care and Community Benefit in Nonprofit Hospitals*, in *HEALTH INSURANCE AND PUBLIC POLICY: RISK, ALLOCATION AND EQUITY* (Miriam K. Mills & Robert H. Blank, eds. 1992) [hereinafter Sanders, *Does Mission Really Matter*]; Susan M. Sanders, *Measuring Charitable Contributions: Implications for the Nonprofit*

perception is that voluntary hospitals are not business enterprises and thus should be providing charity care to warrant tax-exempt status as a "charitable" organization.¹⁹⁶ As will be discussed below in part IV.F., the IRS recently has seized upon the concerns for charity care. It now incorporates charity care as part of the community benefit test for an IDS.¹⁹⁷

Nonetheless, the IRS's stance with respect to the charity care element does not appear to have been adopted universally. The Third

Hospital's Tax-Exempt Status, 38 HOSP. & HEALTH SERVS. ADMIN. 401, 403-05 (1993) [hereinafter Sanders, *Measuring Charitable Contribution*]; Frank A. Sloan et al., *Identifying the Issues: A Statistical Profile*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 16 (Frank A. Sloan et al. eds., 1986); Steinwald & Neuhauser, *supra* note 34, at 817; Regina E. Herzlinger & William S. Krasker, *Who Profits from Nonprofits?*, 65 HARV. BUS. REV., Jan.-Feb. 1987, at 93; Uwe E. Reinhardt, *Flawed Methods Cripple Study on Not-for-Profits*, HOSPITALS, Apr. 20, 1987, at 136.

Commentators and studies differ on the aggregate amount of charity care that not-for-profit hospitals as opposed to for-profit hospitals provide, whether the poor actually receive charity care, the characteristics of hospitals supplying the greatest amount of charity care, the impact of charity care on a hospital's efficiency or inefficiency, and a host of other considerations. In addition to the above cited works, see Richardson, *supra* note 58, at 910-13; Kenneth E. Thorpe & Charles E. Phelps, *The Social Role of Not-For-Profit Organizations: Hospital Provision of Charity Care*, 29 ECON. INQUIRY 472, 481-82 (1991); GAO, BETTER STANDARDS, *supra* note 193; U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE HONORABLE SAM NUNN, UNITED STATES SENATE, PUBLIC HOSPITALS: SALES LEAD TO BETTER FACILITIES BUT INCREASED PATIENT COSTS 38-49 (1986).

¹⁹⁶ These expectations and perceptions stem from the legal distinctions between the not-for-profit corporate form and the for-profit corporate form. The common perception is that for-profit corporations, including hospitals, have an obligation to shareholders to maximize their profits, which generally would be inconsistent with the provision of charity care. Providing free or below cost care to indigents would only serve to reduce profits. On the other hand, a popular perception (albeit incorrect in the author's opinion in that not-for-profit corporations can make profits which are referred to as a surplus in traditional accounting terms) is that not-for-profit entities, including hospitals, are not supposed to make a profit. (Part of this viewpoint stems from legal prohibitions which arise from the structure of not-for-profit entities—that is, the prohibition against (1) raising capital by offering equity interests; (2) disbursement of any revenues in excess of debt costs and production costs to members in the form of dividends, liquidated assets, or otherwise; (3) payment of surplus revenues to managers in excess of reasonable salaries; and (4) violating fiduciary duties to members and the public.) These persons believe that not-for-profit hospitals generally should be altruistic in nature. Therefore, providing charity care to the poor would be consistent with this perception. Moreover, because not-for-profit organizations are granted favored tax treatment, it is commonly believed that the provision of charity care is a *quid pro quo* for the preferred tax-exempt status. Finally, although the perception is changing or has changed, a common belief was that not-for-profit hospitals are not business enterprises and therefore should not compete with one another nor with for-profit hospitals for patients. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Bays, *supra* note 26, at 367-73; Clarkson, *supra* note 10, at 363-70; Eugene F. Fama & Michael C. Jensen, *Agency Problems and Residual Claims*, 26 J.L. & ECON. 327 (1983); Foster, *supra* note 57, at 343-49; Gray & McNerney, *supra* note 195, at 1524-25; Hansmann, *Nonprofit Enterprise*, *supra* note 146, at 837-40; Hansmann, *Rationale*, *supra* note 146, at 55-71; Stanley B. Jones et al., *supra* note 10, at 113-18; Marmor et al., *supra* note 31, at 315-17; Pauly, *supra* note 10, at 257-60; Schlesinger et al., *supra* note 30, at 427-29.

¹⁹⁷ See *infra* notes 408-09 and accompanying text.

Circuit in *Geisinger Health Plan v. Commissioner* ("Geisinger I")¹⁹⁸ explained that "no clear test [of community benefit] has emerged to apply to nonprofit hospitals seeking [federal income] tax exemptions"¹⁹⁹ and that the alternative standards of Revenue Ruling 56-185 and Revenue Ruling 69-545, as amplified by Revenue Ruling 83-157, persist.²⁰⁰ Thus, the provision of nonemergency inpatient charity care by hospitals is not yet an absolute and undisputed requirement pursuant to the community benefit standard for tax exemption under I.R.C. § 501(c)(3).

g. *General Counsel Memorandum 39,862: Other Factors Influencing Community Benefit Standard Applied to Hospitals*

In 1991, the IRS issued General Counsel Memorandum 39,862 ("GCM 39,862"),²⁰¹ which involved joint venture arrangements between hospitals and physicians.²⁰² In discussing the major issue—whether the joint venture arrangements jeopardized the hospitals' tax-exempt status as a "charitable" organization under I.R.C. § 501(c)(3)—the IRS listed four community benefits that might arise from those arrangements deemed compatible with the hospitals' "charitable" purposes. The four contributing factors enumerated were: (1) the improvement of patient convenience; (2) increased accessibility of physicians to patients; (3) the creation of new or improved providers to meet the health care needs of the community; and (4) the improvement in, or reduction of cost of, treatment modalities.²⁰³ Perhaps more importantly, the IRS indicated that several characteristics potentially arising from such joint venture arrangements would not be deemed to benefit the community and would be considered incompatible with any hospital's "charitable" purpose. Those factors rejected by the IRS included: (1) the enhancement of the hospital's financial health; (2) increased efficiencies; (3) greater utilization of facilities; (4) increased referrals; and (5) limiting or avoiding competition.²⁰⁴ Therefore, the IRS clearly took the position that hospital activities

¹⁹⁸ 985 F.2d 1210 (3d Cir. 1993).

¹⁹⁹ *Id.* at 1217.

²⁰⁰ *Id.*

²⁰¹ Gen. Couns. Mem. 39,862 (Nov. 22, 1991), available in LEXIS, Fedtax library, GCM file, 1991 IRS GCM LEXIS 39.

²⁰² See *infra* NOTES 203-04 and accompanying text and part IV.D.1 (discussing Gen. Couns. Mem. 39,862).

²⁰³ Gen. Couns. Mem. 39,862, *supra* note 201.

²⁰⁴ *Id.*

conducted for the purpose of contributing to the hospital's efficiency and survival are not deemed community benefits.

h. *Community Benefit Standard Applied to I.R.C. § 501(c)(3) Health Care Organizations*

As far as the IRS and courts are concerned, the community benefit standard and concepts enunciated in Revenue Rulings 56-185, 69-545, and 83-157 apply as a starting point to consider whether any freestanding or affiliated health care organization pursuing initial tax-exempt status or seeking to retain tax exemption under I.R.C. § 501(c)(3) deserves such tax-exempt treatment.²⁰⁵ However, as illustrated by GCM 39,862, and as indicated in the following discussion of stand alone HMOs, as well as in the later discussion of IDSs, horizontal hospital networks, and physician-hospital arrangements, the IRS has extended its inquiry beyond the four walls of these revenue rulings when determining whether a health care organization deserves I.R.C. § 501(c)(3) tax-exempt status. The expanded inquiry necessitated by an evolving health care environment reflects a revival or regeneration of certain concepts leading to a more refined definition of the community benefit standard.

(1) Stand Alone HMOs and I.R.C. §§ 501(c)(3) and (c)(4)

For the most part, contemporary HMOs are for-profit enterprises. As of 1993, approximately 180 enjoyed tax-exempt status under either I.R.C. § 501(c)(3) or (c)(4).²⁰⁶ Of those HMOs that have been granted

²⁰⁵ See, e.g., *Geisinger Health Plan v. Commissioner*, 100 T.C. 394 (1993), *aff'd* 30 F.3d 494 (3d Cir. 1994) [hereinafter *Geisinger II*] (HMO seeking I.R.C. § 501(c)(3) status); *Sound Health Ass'n v. Commissioner*, 71 T.C. 158 (1978) (HMO seeking I.R.C. § 501(c)(3) status); *University of Mass. Medical Sch. Group Practice v. Commissioner*, 74 T.C. 1299 (1980) (incorporated faculty practice of medical school seeking I.R.C. § 501(c)(3) status); *B.H.W. Anesthesia Found., Inc. v. Commissioner*, 72 T.C. 681 (1979) (incorporated anesthesiology department within teaching hospital of Harvard Medical School seeking I.R.C. § 501(c)(3) status); Gen. Couns. Mem. 39,828 (Aug. 30, 1990), available in LEXIS, Fedtax Library GCM file, 1990 IRS GCM LEXIS 24; Priv. Ltr. Rul. 95-11-035 (Dec. 19, 1994) (merging hospitals seek to retain I.R.C. § 501(c)(3) status); Priv. Ltr. Rul. (Mar. 31, 1993) [hereinafter *Facey Ruling*], reprinted in 7 EXEMPT ORG. TAX REV. 828 (1993) (*Facey Medical Foundation*, a foundation model IDS seeking I.R.C. § 501(c)(3) status); Priv. Ltr. Rul. (Jan. 29, 1993), reprinted in 7 EXEMPT ORG. TAX REV. 490 (1993) [hereinafter *Friendly Hills Ruling*] (*Friendly Hills Healthcare Network*, a foundation model IDS seeking I.R.C. § 501(c)(3) status).

²⁰⁶ Philip S. Neal & Suzanne M. Papiewski, *Taxation of HMOs Now and Under Health Care Reform—Separating Fact From Fiction*, 8 INS. TAX REV. 637, 640 (1994) (citing 1993 DIRECTORY OF HMOs, *supra* note 83; INTERNAL REVENUE SERVICE CUMULATIVE LIST OF ORGANIZATIONS DESCRIBED IN SECTION 170(c) OF THE INTERNAL REVENUE CODE OF 1986 (Pub. No. 78) [hereinafter CUMULATIVE LIST]).

tax-exempt status, 130 have been granted tax exemptions as "social welfare" organizations under I.R.C. § 501(c)(4),²⁰⁷ while fifty HMOs enjoy the more favorable treatment of tax-exempt "charitable" organizations under I.R.C. § 501(c)(3).²⁰⁸ HMOs seeking exemption either as I.R.C. § 501(c)(3) or (c)(4) organizations must demonstrate that they satisfy the community benefit standard. Although satisfaction of the community benefit standard is a requisite for either type of tax-exempt HMO, the standard appears to be stricter for HMOs seeking to qualify initially for or retain I.R.C. § 501(c)(3) tax-exempt status. Assuming that a not-for-profit HMO satisfies the community benefit standard for tax exemption under I.R.C. § 501(a), it must also satisfy the requirements of I.R.C. § 501(m). To do so, no "substantial part" of the HMO's activities can be "commercial-type insurance." I.R.C. § 501(m) is untested to date with respect to I.R.C. § 501(c)(3) HMOs.

In 1978, in *Sound Health Ass'n v. Commissioner*,²⁰⁹ a case of first impression, the Tax Court was confronted with the issue of whether a not-for-profit HMO qualified for tax exemption as an I.R.C. § 501(c)(3) "charitable" organization. Sound Health Association ("SHA"), had as its primary, but not sole, purpose the provision of health care services to members on a prepaid basis.²¹⁰ It served only members who could afford to pay a set premium plus a \$200 capital dues levy.²¹¹ In order to become a member of the HMO, an individual was required to pass a physical examination, even if the individual belonged to SHA through a group membership.²¹² SHA employed only two physicians

²⁰⁷ Neal & Papiewski, *supra* note 206, at 640. For approximately 60 years, the IRS has recognized the tax-exempt status of prepaid health care plans. Boisture, *supra* note 95, at 282. The IRS had recognized Blue Cross and Blue Shield, which introduced the concept of prepaid medical insurance, as tax-exempt social welfare organizations until 1986. At that time, Congress withdrew the tax-exempt status of Blue Cross and Blue Shield because they were considered "commercial-type" insurers. Tax Reform Act of 1986, Pub. L. No. 99-514, § 1012(a), 100 Stat. 2085, 2390 (1986) (codified at I.R.C. § 501(m) (1994)). However, as part of the Tax Reform Act of 1986, Congress accorded special tax accounting treatment of reserves to Blue Cross and Blue Shield. Pub. L. No. 99-514, § 1012(b)(1), 100 Stat. 2085, 2391 (1986) (codified at I.R.C. § 833 (1994)). For a discussion of Blue Cross, see *supra* notes 45, 50-51; *infra* note 258.

For a definition and an explanation of the purpose and functions of HMOs, see *infra* Glossary. For discussion of the explosive growth of HMOs in recent years, see *supra* note 83 and accompanying text.

²⁰⁸ Neal & Papiewski, *supra* note 206, at 640.

²⁰⁹ 71 T.C. 158 (1978).

²¹⁰ *Id.* at 168-69.

²¹¹ *Id.* at 169-70. This fee structure might have prohibited low income individuals from joining the HMO; however, the Tax Court considered the potential class of members of the HMO as the entire community. *Id.* at 185.

²¹² *Id.* at 169-70. The physical test requirement for group members was a means of screening for any "pre-existing condition." *Id.* at 170. The physical examination requirement for members

and was considered a staff model HMO. However, SHA physicians were able to refer patients to an SHA "courtesy staff," initially consisting of sixteen physicians, who worked on a fee-for-service basis for SHA but did not exclusively treat SHA patients.²¹³ Membership on the "courtesy staff" was open to all physicians who applied, and no physicians had been refused privileges.²¹⁴ Consistent with a long line of cases and general counsel memoranda,²¹⁵ the IRS argued that SHA provided preferential treatment to members and failed the organizational and exclusive operational requirements. To this end, the IRS suggested that SHA was not formed to provide medical services to the community-at-large. The IRS further alleged that the HMO failed the community benefit test because it failed to deliver medical services to the community-at-large.

The Tax Court rejected the IRS's arguments. The court indicated that one need not conclude that because an HMO is a membership organization it necessarily is organized and operated for private benefit rather than public benefit.²¹⁶ The court stated, "[The] requirement that the community must benefit from a charity's activities has, as its natural corollary, that private interests must not so benefit in any substantial degree."²¹⁷ Relying on the community benefit standard of

desiring to join the HMO on an individual basis had the potential of excluding "high risk" individuals and individuals with pre-existing conditions. *Id.* at 169. For group members, the pre-existing condition clause could be waived upon satisfaction of four requirements, one of which was passing the entrance physical examination. *Id.* at 170.

²¹³ *Id.* at 172.

²¹⁴ *Sound Health Ass'n*, 71 T.C. at 172.

²¹⁵ See, e.g., *American Women Buyers Club, Inc. v. U.S.*, 338 F.2d 526 (2d Cir. 1964); *Commissioner v. Lake Forest, Inc.*, 305 F.2d 814 (4th Cir. 1962); *United States v. La Societe Francaise De Bienfaisance Mutuelle*, 152 F.2d 243 (9th Cir. 1945), *cert. denied*, 327 U.S. 793 (1946); *Hassett v. Associated Hosp. Serv. Corp.*, 125 F.2d 611 (1st Cir.), *cert. denied*, 316 U.S. 672 (1942); *New York State Ass'n of Real Estate Bds. Group Ins. Fund v. Commissioner*, 54 T.C. 1325 (1970), *nonacq.*, 1974-2 C.B. 5; Gen. Couns. Mem. 36,734 (May 19, 1976); Gen. Couns. Mem. 22,554, 1941-1 C.B. 243.

²¹⁶ *Sound Health Ass'n*, 71 T.C. at 184-91. In *Sound Health Ass'n*, the Tax Court indicated that the HMO was not precluded from tax-exempt treatment as a membership organization. Contrary to the IRS's position, the court found that the private benefits to members were insubstantial when compared to the public benefits. The court considered the "extension of the [private benefit] 'insider test'" of Treasury Reg. § 1.501(c)(3)-1(d)(1)(ii) inappropriate for application to a membership based HMO representative of the community. 71 T.C. at 186.

In 1976, in Gen. Couns. Mem. 36,734, *supra* note 215, the IRS concluded that a prepaid medical service plan did not qualify for tax exemption because it failed the community benefit test. Although the IRS incorporated into the community benefit standard consideration of whether the plan's prepaid premiums were based on a community rating, the failure of the plan to satisfy the community benefit standard was based on the plan's service to members only; it did not provide services to nonmembers.

²¹⁷ *Sound Health Ass'n*, 71 T.C. at 181.

Revenue Ruling 69-545,²¹⁸ the court concluded that the HMO satisfied the community benefit test and did not violate the prohibition against excessive private benefit.²¹⁹ The court reviewed the factors listed in Revenue Ruling 69-545, assigning the most importance and the greatest weight to the community benefited.²²⁰ It considered the potential eligible membership class of the HMO to be sufficiently broad. In its view, for all practical purposes HMO membership was open to the entire community because the HMO had a subsidized dues program.²²¹

The court considered a number of other factors: (1) the HMO provided emergency and nonemergency medical care to individuals unable to pay;²²² (2) the HMO had an open medical staff policy;²²³

²¹⁸ See *supra* part IV.B.2.c.

²¹⁹ *Sound Health Ass'n*, 71 T.C. at 184-91; see *infra* part IV.D (discussing the private benefit test).

²²⁰ *Sound Health Ass'n*, 71 T.C. at 187.

²²¹ The court stated:

[T]he class of persons eligible for membership, and hence eligible to benefit from the [HMO's] activities, is practically unlimited. The class of possible members of the [HMO] is, for all practical purposes, the class of members of the community itself. The major barrier to membership is lack of money, but a subsidized dues program demonstrates that even this barrier is not intended to be absolute. The subsidized dues program seems designed for such persons as Medicare and Medicaid recipients, and all those of lesser means.

Id. at 185. For an explanation of the subsidized dues program and treatment of nonmembers on a reduced fee-for-service basis, see *id.* at 172-75. Moreover, the court noted that in "an action more charitable than any undertaken by Hospital A [in Revenue Ruling 69-545], the [HMO] adopted a plan to establish a fund to receive contributions which would be used to help subsidize persons who wanted membership but who could not make the full monthly payments required for membership." *Id.* at 184. The court considered a "substantial benefit" to arise from the HMO's community rated fee structure because it appeared to assure the spreading of the risk of illness throughout the HMO's full membership. *Id.* at 189. In a summary statement, the Tax Court stated, "[W]hen possible membership is so broad, benefit to the membership is benefit to the community." *Id.* at 190.

²²² The court found that—

the [HMO] offers an open emergency room, has a subsidized dues program for the "near poor," and has provided some free care to the poor. It is clear that those latter services go far beyond the mere emergency room services offered by respondent's hospital A [in Revenue Ruling 69-545].

If the charitable hospital can, except for emergency cases, restrict its treatment to paying patients, the [HMO] should be able to restrict itself to paying members. If the charitable hospital can obligate itself to treat only the financially responsible ill, the Association should be able to obligate itself to treat only the financially responsible, when and if they become ill. . . . In neither the case of the [HMO] nor the hospital [in Revenue Ruling 69-545] can the emergency patient be refused aid. . . . If anything, the [HMO] has a stronger claim to public benefit than hospital A [in Revenue Ruling 69-545].

Id. at 187-88. The facts in the case indicated that the HMO provided medical care at its clinic and in its emergency room to patients unable to pay the full charges. *Id.* at 172-73.

²²³ *Id.* at 184. The court noted that the courtesy staff was open to all qualified physicians and

(3) the HMO's board of directors was composed of prominent citizens of the community;²²⁴ and (4) the HMO offered a public educational program.²²⁵ Thus, for purposes of determining whether SHA was a "charitable" health care organization under I.R.C. § 501(c)(3), the Tax Court essentially adopted the factors that the IRS had established as its guidelines for the community benefit standard applicable to hospitals under Revenue Ruling 69-545.²²⁶

Approximately two years later, the IRS issued General Counsel Memorandum 38,735 ("GCM 38,735"),²²⁷ which relied on *Sound Health Ass'n* and modified another general counsel memorandum.²²⁸ In GCM 38,735, the IRS conceded that an HMO membership organization such as SHA may be considered a "charitable" organization under I.R.C. § 501(c)(3) if: (1) it has a "truly open" membership program;²²⁹ (2) it *directly* provides medical services to members and nonmembers, including Medicare and Medicaid patients; (3) it is not actively engaged in providing insurance because its salaried physicians and secondary health care providers are compensated a fixed amount without variance for the nature or frequency of services performed during a contract period; (4) it has an emergency room open to members and nonmembers;²³⁰ (5) it has health research and education programs open to the members and nonmembers; and (6) it has a subsidized dues program.²³¹

no one had been denied admission to that staff. The court did not address the policy with respect to the employed physicians.

²²⁴ *Id.* at 171-72, 184-85.

²²⁵ *Sound Health Ass'n*, 71 T.C. at 174.

²²⁶ See *supra* part IV.B.2.c.

²²⁷ Gen. Couns. Mem. 38,735 (May 29, 1981), available in LEXIS, Fedtax library, GCM file, 1981 IRS GCM LEXIS 190.

²²⁸ Gen. Couns. Mem. 37,043 (Mar. 14, 1977), available in LEXIS, Fedtax library, GCM file, 1977 IRS GCM LEXIS 386.

²²⁹ The Tax Court had ignored in *Sound Health Ass'n* that the HMO's membership practices seemed rather restrictive and had the potential for "cherry picking,"—that is, refusing enrollment to high risk individuals. For a discussion of the Tax Court view of the open membership, see *supra* note 221. In Gen. Couns. Mem. 38,735, citing facts relied upon by the Tax Court, the IRS appears to accept the Tax Court's view of *Sound Health Association* as an "open membership" organization. However, in this general counsel memorandum, the IRS emphasizes that "truly open" membership is a requisite for considering an HMO to be a "charitable" organization. Gen. Couns. Mem. 38,735, *supra* note 227, at *18.

²³⁰ The IRS weighed the benefits to the community and found them to be substantially greater than any private benefits served by the HMO. The IRS stated that the determination as to whether the private benefits are sufficiently incidental both quantitatively and qualitatively is "measured in the context of the overall benefit conferred by the activity." *Id.* at *16-17 (citing Gen. Couns. Mem. 37,889 (March 20, 1979), available in LEXIS, Fedtax library, GCM file, 1979 IRS GCM LEXIS 309).

²³¹ Gen. Couns. Mem. 38,735, *supra* note 227, at *16-24.

Several years thereafter, the IRS issued General Counsel Memorandum 39,057 ("GCM 39,057").²³² That memorandum involved a not-for-profit HMO which proposed to arrange for health care for pre-paid members through an affiliated individual practice association ("IPA").²³³ The IPA would assure availability, accessibility, and continuity of medical care through agreements with an established network of health care centers. The IRS compared this HMO to SHA and found it lacking numerous qualities present in SHA.²³⁴ Emphasizing that the instant IPA model HMO was not a health care provider but merely an arranger of health care, the IRS found that it did not satisfy the criteria of Revenue Ruling 69-545.²³⁵ It concluded that as a health care arranger, rather than a provider, this HMO's operations and activities served substantial private benefits that were not incidental compared to the community benefits.²³⁶ Therefore, once again, the IRS firmly had stated its position: for an HMO to be considered a "charitable" organization within the meaning of I.R.C. § 501(c)(3), among other things, it must directly provide health care services. The IRS had considered SHA to be such a provider-type HMO even though it had employed merely two physicians who used the HMO facilities to treat enrollee-patients (representative of a staff model HMO²³⁷) and had contracted on a fee-for-service basis with a "courtesy staff" to provide medical services on a referral basis.

In 1990, the IRS issued General Counsel Memorandum 39,828 ("GCM 39,828") as an elaboration on GCM 39,057.²³⁸ The IRS listed numerous important features under the community benefit standard relevant to HMOs seeking I.R.C. § 501(c)(3) status: (1) direct provi-

²³² Gen. Couns. Mem. 39,057 (Nov. 9, 1983), available in LEXIS, Fedtax library, GCM file, 1983 IRS GCM LEXIS 105.

²³³ For a definition of an IPA, see *infra* Glossary.

²³⁴ For example, the IRS found that the HMO would not serve nonmembers and would not maintain any program to assist the nonmember-poor in obtaining emergency medical care. Gen. Couns. Mem. 39,057, *supra* note 232, at *10.

²³⁵ The IRS compared the HMO to Hospital B described in Revenue Ruling 69-545. It indicated that control of the HMO rested exclusively in the members of the IPA rather than in an independent body representing the community at large. *Id.* at *10-*11. The IRS concluded that the HMO was essentially a shell entity that promoted the business interest of the IPA, which, in turn, was controlled by health care providers. *Id.* at *13.

²³⁶ *Id.*

²³⁷ See *infra* Glossary (defining a staff model HMO).

²³⁸ Gen. Couns. Mem. 39,828, *supra* note 205. One commentator has suggested that Plan B, discussed in Gen. Couns. Mem. 39,828 likely was Geisinger Health Plan ("GHP"). See Kenneth L. Levine, *Geisinger Health Plan Likely to Adversely Affect HMOs and Other Health Organizations*, 79 J. TAX'N 90, 91 n.2 (1993). For a discussion of GHP, see *infra* notes 242-56 and accompanying text.

sion of health care services and maintenance of health care facilities and staff; (2) delivery of services on a fee-for-service basis to nonmembers; (3) maintenance of a truly open enrollment without restrictions, as evidenced by such facts as whether individuals and small groups comprise a "substantial portion of membership" and whether the HMO has an "overt program" to attract individuals as potential members;²³⁹ (4) usage of a community rating system and similarity of rates charged to individuals and groups;²⁴⁰ (5) operation of a "meaningful" subsidized membership program; (6) provision of health education and research programs; (7) operation of an open emergency room and communication to the community of its availability; (8) treatment of patients covered by Medicare, Medicaid, and similar programs; (9) payment of health care providers, such as physicians, on a fixed fee basis; and (10) utilization of surplus funds to improve facilities, equipment, patient care, and educational programs for the public. The IRS seemed to take the position that certain characteristics, including the direct provision of health care services, truly open enrollment, and the delivery of care through reduced rates to the medically indigent, are mandatory for an HMO to achieve I.R.C. § 501(c)(3) tax-exempt status.²⁴¹

More recently, in *Geisinger I*,²⁴² Geisinger Health Plan ("GHP"), a non-staff model HMO, which the IRS recognized as an I.R.C. § 501(c)(4) "social welfare" organization, sought I.R.C. § 501(c)(3) tax-exempt status.²⁴³ GHP contracted with more than 400 physicians for their services.²⁴⁴ The Tax Court held in favor of GHP. Using the community benefit standard that it had enunciated in *Sound Health*

²³⁹ Gen. Couns. Mem. 39,828, *supra* note 238, at *16.

²⁴⁰ This factor, along with open membership and the provision of services on a fee-for-service basis to nonmembers is an apparent means of distinguishing an HMO from a provider of "commercial-type" insurance within the meaning of I.R.C. § 501(m) (1994), discussed *infra* notes 257-74 and accompanying text.

²⁴¹ Gen. Couns. Mem. 39,828, *supra* note 238, at *14-*15.

²⁴² 985 F.2d 1210 (3d Cir. 1993).

²⁴³ See Brief for the Appellee [Commissioner], *Geisinger Health Plan v. Commissioner*, 30 F.3d 494 (3d Cir. 1994) (No. 93-7699), available in LEXIS, Fedtax library, TNT File, 94 TNT 97-43 [hereinafter *Geisinger II Brief*]; *Geisinger HMO Denied 501(c)(3), Not Integral Part of System*, 4 MANAGED CARE WEEK ATLANTIC INFO. SERV., INC., available in Westlaw, MCAREWK database, 1994 WL 2622523. GHP sought I.R.C. § 501(c)(3) status in order to obtain preferential tax treatment accorded those organizations. See *supra* note 19 and accompanying text (describing preferential tax treatment of I.R.C. § 501(c)(3) organizations).

²⁴⁴ The courts described GHP as an entity that arranged for health care to be provided to its subscribers by contracts with hospitals, radiologists, laboratories, clinics, and pharmacies. See *Geisinger I*, 985 F.2d at 1213; see also, 62 T.C.M. (CCH) 1656, 1661, 1663 (1991), *rev'd*, 985 F.2d at 1210. It seems likely from the facts that GHP was an IPA model HMO, which was part of a foundation model IDS. For discussion of the HMO models, and IDS models, see *infra* Glossary.

Ass'n²⁴⁵ and comparing GHP to SHA, the Tax Court ruled that the class of possible members in GHP is "practically unlimited."²⁴⁶ The Tax Court found that GHP had no substantial limitation on the class of individuals eligible for membership nor on persons eligible for membership in GHP's planned, but unimplemented, dues program.²⁴⁷ The court supported this decision by reciting the following factors: (1) individuals alone and through groups could enroll for the same pre-paid premium based on a community rating system;²⁴⁸ (2) groups with at least 100 eligible enrollees within GHP's service area could enroll without completing a medical history questionnaire, but questionnaires were required of enrollees through smaller groups;²⁴⁹ (3) Medicare recipients were offered medical services at a reduced rate on a wraparound basis; and (4) the HMO would cover Medicaid patients when it reached an agreement with the State for coverage. The Tax Court concluded that the community benefited and the prohibition against excessive private benefit was not violated.²⁵⁰ Focusing on the IRS's argument that qualification as a charitable health care organization under I.R.C. § 501(c)(3) requires the entity to be a "provider" of medical services—which GHP was not, but rather was merely an arranger of health care services—the Tax Court responded, "[t]he furnishing of medical care or the operation of a hospital or an HMO is not specifically listed as a qualifying exempt activity under section 501(c)(3). The provision of medical services must therefore fall within the words 'charitable purpose' to be exempt."²⁵¹ The court concluded that actual provision of medical services by the HMO is not required to qualify, but "it is the purpose toward which an organization's activities are directed that is ultimately dispositive."²⁵² The Tax Court then held that "it is the organization's ability to ensure that adequate health care services are actually delivered to a sufficiently large class in the community that it serves that is critical."²⁵³

The Third Circuit disagreed with the Tax Court's holding, but, while insisting on a facts and circumstances analysis, agreed that *Sound*

²⁴⁵ See *supra* notes 216–26 and accompanying text.

²⁴⁶ *Geisinger I*, 62 T.C.M. (CCH) at 1663.

²⁴⁷ *Id.*

²⁴⁸ *Id.* at 1657.

²⁴⁹ *Id.* at 1659.

²⁵⁰ The Tax Court focused on the prohibition of excessive private benefit to "insiders," but found none. *Id.* at 1663. For a discussion of the prohibition of private inurement, see *infra* part IV.C.

²⁵¹ *Geisinger I*, 62 T.C.M. (CCH) at 1661.

²⁵² *Id.*

²⁵³ *Id.* at 1663.

Health Ass'n, Revenue Ruling 69-545, and the revenue ruling's progeny provided appropriate precedents as an analytical starting point.²⁵⁴ The appellate court asserted a narrower approach than the Tax Court in analyzing GHP's purpose and activities. It concluded that GHP, on its own, did not satisfy the community benefit test. The Third Circuit stated:

GHP cannot say that it provides any health care services itself. Nor does it ensure that people who are not GHP subscribers have access to health care or information about health care. According to the record, it neither conducts research nor offers educational programs, much less educational programs open to the public. It benefits no one but its subscribers.

....

... The community benefited is, in fact, limited to those who belong to GHP since the requirement of subscribership remains a condition precedent to any service. Absent any additional indicia of a charitable purpose, this self-imposed precondition suggests that GHP is primarily benefiting itself (and, perhaps, secondarily benefiting the community) by promoting subscribership throughout the areas it serves.

....

In sum, GHP does not qualify for tax-exempt status under section 501(c)(3) since it does no more than arrange for its subscribers, many of whom are medically underserved, to receive health care services from health care providers. . . . Arranging for the provision of medical services only to those who "belong" is not necessarily charitable, particularly where, as here, the HMO has arranged to subsidize only a small number of such persons. GHP, standing alone, is not entitled to tax-exempt status under section 501(c)(3).²⁵⁵

As interpreted by the Third Circuit, the community benefit standard requires that an I.R.C. § 501(c)(3) stand alone HMO be an actual provider of health care rather than merely an arranger or deliverer of health care. The Third Circuit did not articulate a means for differentiating a health care provider from a health care arranger. Reading between the lines of the Third Circuit opinion, it appears that the court may have distinguished the two classifications based on whether the

²⁵⁴ *Geisinger I*, 985 F.2d at 1216 (discussing the weight to be given to revenue rulings generally and the appropriateness of using a ruling involving a hospital).

²⁵⁵ *Id.* at 1219-20.

organization employs the physicians actually delivering the medical care. Assuming this distinction, network model HMOs, IPA model HMOs, and dedicated and ordinary group model HMOs would be precluded from qualifying for tax-exempt status under I.R.C. § 501(c)(3) on a stand alone basis.²⁵⁶ In that event, only staff model HMOs would remain capable of obtaining and retaining "charitable" organization status.

Although the Third Circuit ruled that GHP was ineligible for I.R.C. § 501(c)(3) status, GHP was left with its previously conferred status as a "social welfare" organization. Neither GHP nor the Commissioner had questioned on brief or during argument GHP's entitlement to I.R.C. § 501(c)(4), and consequently the Tax Court and the Third Circuit did not address the issue.

(2) Stand Alone HMOs and I.R.C. § 501(m)

It appears that as a first step for qualification as a tax-exempt "charitable" organization under I.R.C. § 501(c)(3), an HMO must be an actual provider of health care services—that is, a staff model HMO. Additionally, its membership must be *truly* open to the entire community, as evidenced by all facts and circumstances. An HMO that satisfies these conditions then must overcome another hurdle. Pursuant to I.R.C. § 501(m)(1), "no substantial part" of the activities of an otherwise qualifying I.R.C. § 501(c)(3) or (c)(4) organization may consist of "providing commercial-type insurance."²⁵⁷

²⁵⁶ For a discussion of the HMO models, see *infra* Glossary. Two commentators forcefully argue that the only type of HMO that is a "provider" of health services is the staff model. Neal & Papiewski, *supra* note 206, at 640. They suggest that to be a provider of health care, an HMO must employ physicians and not merely contract with physicians to provide medical services. Merely contracting for others to directly provide health care services is the equivalent of arranging services, not directly providing them. The commentators suggest that even a dedicated group model HMO is not a "provider" because, like an ordinary group model HMO, the physician-providers are employed by a taxable entity other than the HMO that contracts for their services. *Id.*

²⁵⁷ This provision was added by § 1012(a) of the Tax Reform Act of 1986, Pub. L. No. 99-514, 100 Stat. 2085, 2390-91 (1986) (codified as amended at I.R.C. § 501 (1994)). The I.R.C. does not define the term "substantial." The Explanation of Provisions section of the House Report and the Joint Committee on Taxation General Explanation refers to *Haswell v. United States*, 500 F.2d 1133 (Ct. Cl. 1974), and *Seasongood v. Commissioner*, 227 F.2d 907 (6th Cir. 1955). See H.R. REP. NO. 426, 99th Cong., 1st Sess. 1, 664 (1985); STAFF OF THE JOINT COMM. ON TAXATION, 99TH CONG., 2D SESS., GENERAL EXPLANATION OF THE TAX REFORM ACT OF 1986, at 585 (Comm. Print 1987) [hereinafter 1986 ACT BLUE BOOK]. The I.R.C. defines "commercial-type insurance" only by reference to cost. The House Report defines the term as "any insurance of a type provided by commercial insurance companies." H.R. REP. NO. 426, *supra*, at 465.

I.R.C. § 501(m)(3)(B) provides that "commercial-type insurance" shall not include "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organization." I.R.C. § 501(m) was enacted primarily to subject Blue Cross and Blue Shield, previously tax-exempt as I.R.C. § 501(c)(4) "social welfare organizations," to taxation as insurance companies.²⁵⁸ The conference committee report to the Tax Reform Act of 1986 indicates that I.R.C. § 501(m) is not intended to affect the exemption of any HMO.²⁵⁹ This sentiment is reiterated in the conference committee report to the Technical and Miscellaneous Revenue Act of 1988.²⁶⁰ However, as commentators have pointed out, the statutory language is ambiguous because I.R.C. § 501(m)(3)(B) appears superfluous to I.R.C. § 501(m)(1).²⁶¹

The IRS's own pronouncements have indicated confusion as to the effect of I.R.C. §§ 501(m)(1) and (m)(3) on the tax-exempt status

²⁵⁸ 1986 ACT BLUE BOOK, *supra* note 257, at 584-88; H.R. REP. NO. 426, *supra* note 257, at 664-65. Congress repealed the tax exemption of Blue Cross and Blue Shield because they were viewed as direct competitors to commercial health insurance companies which did not have the same preferred tax-exempt treatment. 1986 ACT BLUE BOOK, *supra* note 257, at 584-88; H.R. REP. NO. 426, *supra* note 257, at 664-65. However, Congress recognized that although health insurance was available through commercial insurers, the competitive environment might result in coverage becoming too expensive or unavailable to small and high risk groups. 1986 ACT BLUE BOOK, *supra* note 257, at 584-88; H.R. REP. NO. 426, *supra* note 257, at 664-65. Therefore, wishing to distinguish between typical commercial insurance companies and Blue Cross and Blue Shield organizations, as well as to provide some tax equity, as part of the Tax Reform Act of 1986, Congress enacted I.R.C. § 833. Tax Reform Act of 1986, Pub. L. No. 99-514, § 1012(b)-(c), 100 Stat. 2085, 2391 (1986) (codified at 26 U.S.C. § 833 (1988)). That statute provides certain tax-favored treatment to existing Blue Cross and Blue Shield organizations, as well as other organizations that meet strict requirements. See I.R.C. § 833(c) for a definition of the qualifying organizations to which the statute applies.

In general, I.R.C. § 833(a) provides that a qualifying organization will be treated as a stock property-casualty insurance company, but it exempts the qualifying organizations from the requirement of including in income 20% of additions to their unearned premium reserves. I.R.C. § 833(b) permits qualifying organizations to take a special deduction for regular tax purposes, but not for alternative minimum tax purposes. This special deduction is equal to the excess, if any, of 25% of the sum of claims incurred during the taxable year, and expenses incurred during the taxable year in connection with the administration, adjustment or settlement of claims, over adjusted surplus as of the beginning of the year. I.R.C. § 833(b). However, this deduction is limited to the organization's regular health-related taxable income, determined according to specified rules. *Id.*

²⁵⁹ H.R. CONF. REP. NO. 841, 99th Cong., 2d Sess., II-345-46 (1986), *reprinted in* 1986 U.S.C.C.A.N. 4075, 4433-34.

²⁶⁰ H.R. CONF. REP. NO. 1104, 100th Cong., 2d Sess., II-9 (1988), *reprinted in* 1988 U.S.C.C.A.N. 5048, 5269; S. REP. NO. 445, 100th Cong., 2d Sess., 120-21, *reprinted in* 1988 U.S.C.C.A.N. 4515, 4637-38.

²⁶¹ See Neal & Papiewski, *supra* note 206, at 644 (suggesting that Congress must have intended the HMO exception to have a broader meaning as a result of the repeated language of I.R.C. §§ 501(m)(1) and (m)(3)).

of HMOs. In 1968, the IRS issued Revenue Ruling 68-27, which indicated that a staff model HMO would not be considered an "insurance company" because it provided preventive health care, which did not involve insurance risk but merely business risk.²⁶² Thereafter, in a release purportedly involving Geisinger Health Plan, the IRS took the position that a non-staff model HMO was not entitled to I.R.C. § 501(c)(3) status because it engaged in substantial activities as a commercial-type insurance company in violation of I.R.C. § 501(m).²⁶³

More recently, the IRS issued General Counsel Memorandum 39,829 ("GCM 39,829"),²⁶⁴ to amplify and clarify GCM 39,828. GCM 39,828 presented the IRS's legal approach for determining under I.R.C. § 501(m) whether an I.R.C. § 501(c)(4) HMO engages in "commercial-type insurance" and whether the HMO at issue provided more than incidental health insurance of the kind customarily provided by HMOs. The HMO in GCM 39,829 was a not-for-profit IPA model HMO that was considered tax-exempt under I.R.C. § 501(c)(4). It was not a point-of-service plan nor an open-ended HMO, and members were locked into care through the HMO's affiliated providers so that non-emergency treatment could not be obtained outside the HMO's providers. The IRS did not wholly rely on Revenue Ruling 68-27.²⁶⁵ Instead, it also reviewed general counsel memoranda,²⁶⁶ cases,²⁶⁷ and legislative history²⁶⁸ in its attempt to determine whether the principal activity of modern HMOs is the provision of health care or the provision of commercial-type insurance.

²⁶² Rev. Rul. 68-27, 1968-1 C.B. 315. In the revenue ruling, the IRS emphasized that a staff model HMO was not an insurance company because it directly provided medical services to members through salaried physician-employees in the HMO's clinic. The HMO provided preventive medical care which the IRS considered to be not equivalent to an insurance risk but to be merely a business risk. The IRS reasoned that when illness occurs in member patients, generally no extra expenses must be incurred by the HMO. The HMO is required to pay the salaries of its employed physicians, nurses, and technicians regardless of the illness status of the HMO members.

²⁶³ Gen. Couns. Mem. 39,828, *supra* note 238. On brief before the Tax Court in *Geisinger II*, IRS abandoned its earlier position that the HMO was a commercial-type insurance provider in violation of I.R.C. § 501(m). *Geisinger II Brief*, 30 F.3d 494 (3d Cir. 1994) (No. 93-7699), available in LEXIS, Fedtax library, TNT File, 94 TNT 97-43.

²⁶⁴ Gen. Couns. Mem. 39,829 (Aug. 30, 1990), available in LEXIS, Fedtax library, GCM file, 1990 IRS GCM LEXIS 25.

²⁶⁵ *Supra* note 262.

²⁶⁶ Gen. Couns. Mem. 39,703 (Feb. 26, 1988), available in LEXIS, Fedtax library, GCM file, 1988 IRS GCM LEXIS 15; Gen. Couns. Mem. 39,828, *supra* note 205.

²⁶⁷ *E.g.*, *Helvering v. LeGierse*, 312 U.S. 531 (1941); *Jordan v. Group Health Ass'n*, 107 F.2d 239 (D.C. Cir. 1939); *Allied Fidelity Corp. v. Commissioner*, 66 T.C. 1068, 1073 (1976), *aff'd*, 572 F.2d 1190 (7th Cir. 1978).

²⁶⁸ S. REP. NO. 313, 99th Cong., 1st Sess. (1986); H.R. CONF. REP. NO. 841, *supra* note 259, at II-346, reprinted in 1986 U.S.C.A.N. at 4434; H.R. REP. NO. 426, *supra* note 257.

The IRS took a facts and circumstances approach in GCM 39,829. It reviewed the following factors with respect to the HMO at issue: (1) whether the HMO transferred and distributed an insurance risk; (2) whether the HMO operated in a manner similar to for-profit insurers or Blue Cross and Blue Shield; (3) whether the HMO marketed a product similar to for-profit insurers or Blue Cross and Blue Shield; (4) whether the HMO provided health care services directly to patients; and (5) whether the HMO shifted any risk of loss to service providers through salary or fixed-fee arrangements. The IRS concluded that regardless of the model-type label attached to an I.R.C. § 501(c)(4) HMO, if the HMO compensates some primary care physicians exclusively on a salary, capitation, or other fixed fee basis, it is considered to be principally a health care provider and to provide insurance only incidentally. This last attribute brings the HMO within the exception of I.R.C. § 501(m)(3)(B). Hence, even if the HMO pays additional health care providers on a fee-for-service basis, under GCM 39,829, it is deemed not disqualified from tax-exempt treatment by virtue of I.R.C. § 501(m)(1).²⁶⁹ In the instant case, the IPA model HMO qualified under the stated criteria for I.R.C. § 501(c)(4) treatment and was not disqualified by I.R.C. § 501(m).

(3) HMO Summary

In summary, there is considerable confusion and variation in the treatment of stand alone not-for-profit HMOs. The clear message of GCM 39,829 is that I.R.C. § 501(c)(4) staff and non-staff model HMOs that compensate a number of primary care physicians on a salary, capitation, or other fixed fee basis are considered medical service providers and not commercial-type insurers for purposes of I.R.C. § 501(m). Consequently, such I.R.C. § 501(c)(4) HMOs can qualify for tax-exempt treatment under I.R.C. § 501(a).²⁷⁰

By contrast, in *Geisinger I*, the Third Circuit held that GHP, as a stand alone IPA model HMO, did not qualify for I.R.C. § 501(c)(3) treatment because it did not directly provide health care services.²⁷¹ Therefore, as a first step, to qualify as a "charitable" health care organization within the meaning of I.R.C. § 501(c)(3), the community benefit standard requires an HMO to satisfy health care

²⁶⁹ Cf. Tech. Adv. Mem. 94-12-002 (Dec. 17, 1993) (for-profit IPA model HMOs treated as insurance companies).

²⁷⁰ See Neal & Papiewski, *supra* note 206, at 644.

²⁷¹ See *supra* notes 242-56 and accompanying text.

provider status.²⁷² It appears that only staff model nonprofit HMOs will so qualify.²⁷³

As a second step for tax exemption under I.R.C. § 501(a), pursuant to I.R.C. § 501(m), an I.R.C. § 501(c)(3) HMO must prove that "no substantial part" of its activities consists of "commercial-type insurance." The question arises as to whether this determination is superfluous because under the community benefit standard, an I.R.C. § 501(c)(3) HMO must have already proved that it was a health care provider.²⁷⁴ Although untested to date, it seems unlikely that such an HMO would again need to demonstrate that it is a health care provider in the context of I.R.C. § 501(m). However, if the HMO were required to do so, it is unclear whether the standard would be the same as that for demonstrating compliance under the community benefit test for "charitable" organization status. What does appear clear is that under I.R.C. § 501(m) such an I.R.C. § 501(c)(3) HMO would need to prove that no more than an incidental portion of its activities are insurance related and that any insurance activities are of the kind common to all HMOs.

In conclusion, not-for-profit stand alone staff model and non-staff model HMOs might still enjoy the potential of qualifying for tax-exempt status under I.R.C. § 501(c)(4). By contrast, assuming incidental health insurance activities of a type common to HMOs, not-for-profit staff model HMOs are the only type of stand alone HMO with the opportunity to qualify under I.R.C. § 501(c)(3). Of course, even these staff model stand alone HMOs must satisfy the I.R.C. § 501(c)(3) public policy doctrine and the prohibitions against private inurement and excessive private benefit.

C. *Prohibition Against Private Inurement*

I.R.C. §§ 501(c)(3) and (c)(4) contain a prohibition against private inurement.²⁷⁵ This proscription is intended to ensure that an organization's funds are dedicated to its exempt activities by forbidding individuals "in a position to do so from siphoning off any . . . income or assets for personal use" or benefit.²⁷⁶ The aim is to prevent

²⁷² See *supra* notes 255-56 and accompanying text.

²⁷³ See *supra* note 256 and accompanying text.

²⁷⁴ See *supra* notes 255-56 and accompanying text.

²⁷⁵ I.R.C. § 501(c)(3) provides that "no part of the net earnings . . . inures to the benefit of any private shareholder or individual." I.R.C. § 501(c)(4) has a similar prohibition: "[t]he net earnings of which are devoted exclusively to charitable, educational, or recreational purposes."

²⁷⁶ Gen. Couns. Mem. 39,862 *supra* note 201, at *17. At an earlier time, the Office of Chief Counsel of the IRS explained that "inurement is likely to arise where the financial benefit

distributions of charitable assets in any form by terms that would not be considered arms length and would not be identical to ordinary business practices—such as payment in excess of fair market value of assets purchased or payment of more than reasonable compensation—with respect to persons having an opportunity to control or influence the organization's activities.²⁷⁷ Therefore, the prohibition applies to "insiders" having a personal or private interest in the organization.²⁷⁸ It is clear from the intent of the private inurement prohibition that directors and officers of a not-for-profit organization will be considered insiders.²⁷⁹ The Office of General Counsel of the IRS has taken a broad view, and in the context of not-for-profit hospitals, it consistently has regarded all physicians on a hospital's medical staff as "insiders,"²⁸⁰ even if they are not employed by the hospital but have a close professional working relationship with the hospital.²⁸¹

Because the proscription is an absolute prohibition with no existing *de minimis* exception and the exclusive sanction for its violation is revocation of tax-exempt status, this statutory prohibition is formi-

represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to accomplishing exempt purposes." Gen. Couns. Mem. 38,459 (July 31, 1980), available in LEXIS, Fedtax library, GCM File, 1980 IRS GCM LEXIS 71, at *18; see Treas. Reg. §§ 1.501(c)(3)-1(c)(2), 1(d)(1) (as amended in 1990); *American Campaign Acad. v. Commissioner*, 92 T.C. 1053, 1065-66 (1989). For a detailed discussion of the private inurement concept, see HOPKINS, *supra* note 19, at 264-99.

²⁷⁷ See Priv. Ltr. Rul. 91-12-006 (Dec. 20, 1990); Gen. Couns. Mem. 39,598 (Dec. 8, 1986), available in Westlaw, FTX-GCM file, GCM 39598; HOPKINS, *supra* note 19 at 264-66; Bernadette M. Broccolo & Michael W. Peregrine, *Bad Doctor Deals Place Hospitals at New Risk, Part II—The Lac Facilities, Inc. Revocation*, 11 EXEMPT ORG. TAX REV. 267, 268-69 (1995). But see Kenneth L. Levine, *Guidelines on Donations of Medical Practices to Tax-Exempt Hospitals*, 57 TAX NOTES 1059 (1992) (discussing possible means of outright and deferred gifts of medical practices to tax-exempt hospitals by retiring physician not considered an "insider" and without violation of Medicare/Medicaid fraud and anti-abuse laws).

²⁷⁸ See Gen. Couns. Mem. 39,598, *supra* note 277, at *18-*19; HOPKINS, *supra* note 19, at 266-74; see also *American Campaign Acad.*, 92 T.C. at 1066.

²⁷⁹ See Treas. Reg. §§ 1.503(c)(3)-1(c)(1), -1(d)(1).

²⁸⁰ Gen. Couns. Mem. 39,498 (Jan. 28, 1986), available in LEXIS, Fedtax library, GCM file, 1986 IRS GCM LEXIS 35, at *7; Gen. Couns. Mem. 39,862, *supra* note 201, at *18.

²⁸¹ Gen. Couns. Mem. 39,862, *supra* note 201, at *19. This position has roots in a prior general counsel memorandum in which the IRS broadened the concept of an "insider" to the point of including "all persons performing services for an organization [because, in the opinion of the IRS, those individuals] have a personal and private interest and therefore possess the requisite relationship necessary to find private benefit or inurement." Gen. Couns. Mem. 39,670 (Oct. 14, 1987) available in LEXIS, Fedtax library, GCM file, 1987 IRS GCM LEXIS 76, at *8. Two commentators have aptly labeled the IRS position that all hospital-affiliated physicians are considered "insiders" as a rebuttable presumption. Broccolo & Peregrine, *supra* note 277, at 269.

dable.²⁸² It may be eluded only by the complete absence of private benefit.²⁸³

As explained by the Tax Court, the prohibition against private inurement shares common and overlapping elements with the prohibition against excessive private benefit.²⁸⁴ Private inurement and private benefit must be evaluated independently. The presence of private inurement violates both the proscription against excessive private benefit and private inurement.²⁸⁵ The absence of private inurement however, does not mean that private benefit can go unevaluated.²⁸⁶ In fact, private benefit can exist without private inurement.²⁸⁷

D. *Prohibition Against Excessive Private Benefit*

The statutory prohibition against excessive private benefit applies to prevent the tax-exempt organization from being organized or operated primarily for the benefit of a small, identifiable group of individuals. The group of individuals is not limited to "insiders," but can include unaffiliated "outsiders" as well. Thus, the intent of the prohibition is to assure that the tax-exempt organization is operated for public, and not private, purposes.

Unlike the absolute prohibition against private inurement, de minimis private benefit is tolerated. If private benefit exists, it must be incidental to public benefit in both a qualitative and a quantitative

²⁸² Few hospitals have lost their tax-exempt status once granted. Those that have lost their tax-favored status have done so on the basis of violating the prohibitions against private inurement or private benefit. For examples of the revocation of the tax-exempt status of hospitals and clinics based on violation of private inurement, see *Harding Hosp. v. United States*, 505 F.2d 1068 (6th Cir. 1974); *Anclote Psychiatric Ctr., Inc. v. Commissioner*, 98 T.C. 374 (1992); *Lowry Hosp. Ass'n v. Commissioner*, 66 T.C. 850 (1976); *Lorain Ave. Clinic v. Commissioner*, 31 T.C. 141 (1958); *Wendy L. Parker Rehabilitation Found., Inc. v. Commissioner*, T.C.M. (CCH) 51 (1986); Internal Revenue Service, *Hospital Challenges Exemption Revocation in U.S. Court of Federal Claims: Technical Advice Memo Underlying Revocation of Hospital's Exempt Status*, 10 EXEMPT ORG. TAX REV. 1314 (1994) (revoking tax-exempt status of LAC facilities); see also Gen. Couns. Mem. 39,862, *supra* note 201; Gen. Couns. Mem. 39,598, *supra* note 277; Gen. Couns. Mem. 39,646 (June 30, 1987), available in LEXIS, Fedtax library, GCM file, 1987 IRS GCM LEXIS 52.

²⁸³ See *infra* notes 284-87 and accompanying text (discussing Tax Court's view of overlapping elements of the two prohibitions).

²⁸⁴ *American Campaign Acad. v. Commissioner*, 92 T.C. 1053, 1068 (1989); *Church of Ethereal Joy v. Commissioner*, 83 T.C. 20, 21 (1984); *Goldsboro Art League, Inc. v. Commissioner*, 75 T.C. 337, 345 n.10 (1980).

²⁸⁵ *American Campaign Acad.* 92 T.C. at 1068-69.

²⁸⁶ *Id.*

²⁸⁷ *Id.* at 1069. Thus, the prohibition against private inurement could be considered a subset of the prohibition against excessive private benefit. Gen. Couns. Mem. 39,862, *supra* note 201, at *32.

sense.²⁸⁸ To be considered qualitatively incidental, a private benefit must occur as a necessary concomitant—that is, natural, indirect, or unintentional—to the activity that benefits the public at large.²⁸⁹ To be classified as quantitatively incidental, the benefit must be insubstantial when compared to the public benefit that arises from the activity.²⁹⁰ Thus, the two-prong test balances the private benefit resulting from a particular activity against the public benefit accruing from that same activity.²⁹¹

Similar to the prohibition against private inurement, the sole sanction for violation of the private benefit standard is revocation of an organization's tax-exempt status. In recent years, the issues of private inurement and private benefit in the health care setting have arisen primarily in the context of hospital-physician joint ventures, physician retention and recruitment, and health care provider networks, including the formation of IDSs as well as reorganizations of hospital networks.²⁹² The IRS has taken the position that some amount of private benefit is present in "all typical hospital-physician relationships."²⁹³

1. Hospital-Physician Joint Ventures

Joint venture arrangements between tax-exempt hospitals and physicians are highly suspect.²⁹⁴ In determining whether a hospital's

²⁸⁸ Gen. Couns. Mem. 39,862, *supra* note 201 at *35–*37; Gen. Couns. Mem. 37,789 (Dec. 18, 1978), *available in* LEXIS, Fedtax library, GCM file, 1978 IRS GCM LEXIS 42, at *7–*11.

²⁸⁹ Gen. Couns. Mem. 39,862, *supra* note 201, at *35–*37.

²⁹⁰ *Id.*

²⁹¹ The overall public benefit accruing from the tax-exempt organization as a whole does not enter into the balancing process. *See* Gen. Couns. Mem. 37,789, *supra* note 288, at *7–*11; Gen. Couns. Mem. 39,862, *supra* note 201, at *36.

²⁹² For a discussion of the standards applied to IDSs and hospital networks, including their reorganizations, see *infra* part IV.F. In a general counsel memorandum, the IRS stated that it may consider whether not-for-profit hospitals and their parent corporations deserve I.R.C. § 501(c)(3) treatment based on the relationship between the parent corporation and other public charitable organizations controlled by the same persons who control the supporting parent. Gen. Couns. Mem. 39,508 (May 27, 1986), *available in* LEXIS, Fedtax library, GCM file, 1986 IRS GCM LEXIS 45.

²⁹³ *Id.* at *35. The IRS offered the following statement as an explanation of its position: Physicians generally use hospital facilities at no cost to themselves to provide services to private patients for which they earn a fee. The private benefit accruing to the physicians generally can be considered incidental to the overwhelming public benefit resulting from having the combined resources of the hospital and its professional staff available to serve the public. Though the private benefit is compounded in the case of certain specialists, such as heart transplant surgeons, who depend heavily on highly specialized hospital facilities, that fact alone will not make the private benefit more than incidental.

Id. at *36 (citation omitted).

²⁹⁴ The IRS scrutiny focuses on potential violations of the prohibitions against private inure-

participation in a joint venture should jeopardize its exemption, the IRS considers four questions: (1) How are the hospital's tax-exempt purposes furthered by the arrangement?²⁹⁵ (2) Is any private benefit received by the persons involved in the joint venture merely incidental to the tax-exempt purposes of the tax-exempt organization? (3) Do any assets of the tax-exempt organization inure to the private benefit of any insider? and (4) Is any public policy violated as a result of the arrangement?²⁹⁶

Focusing on the prohibitions against private inurement and excessive private benefit, GCM 39,862 is perhaps the most infamous of the IRS releases applicable to physician-hospital joint ventures.²⁹⁷ In that general counsel memorandum, the IRS reconsidered and reversed the position it took in three previously issued private letter rulings.²⁹⁸ Each situation involved the transfer of a hospital department or laboratory, such as an outpatient surgical unit or gastroenterology laboratory, to a joint venture organization formed by the hospital and staff physician-investors. The IRS took the position that the tax-exempt status of the hospital would be jeopardized if the hospital transferred or sold the future net income stream of its department or laboratory to the joint venture organization.²⁹⁹ This stance was based on the prohibitions against private inurement and excessive private benefit.³⁰⁰

ment and excessive private benefit and on the lack of Medicaid patients serviced by most joint venture providers. See U.S. GEN. ACCOUNTING OFFICE, *NONPROFIT HOSPITALS: FOR PROFIT VENTURERS POSE ACCESS AND CAPACITY PROBLEMS* (1993).

²⁹⁵ This question addresses not only the prohibition against private benefit, but also the "operational exclusivity" requirement. See Gen. Couns. Mem. 39,862, *supra* note 201, at *39 (discussing the question). For a brief discussion of the "operational exclusivity" requirement and the community benefit standard as applied by the IRS to physician-hospital joint ventures, see *supra* part IV.B.2.g.

²⁹⁶ For a discussion of the public policy issue, see *infra* part IV.E.

²⁹⁷ See *supra* note 201. One commentator stated that the general counsel memorandum "threw into turmoil a type of relationship that had developed between many physicians and tax-exempt hospitals." Richard M. Lipton, *IRS Attacks Hospital Joint Ventures*, 70 TAXES 59, 59 (1992). Not only did journals directed at tax practitioners perceive GCM 39,862 as tax worthy, but popular news media such as *The Wall Street Journal* had prominent articles with sensationalized headlines or lead lines. See, Paul Streckfus, *Recently Released GCM Serves as Yellow Flag for Exempt Hospitals*, 53 TAX NOTES 1456 (1991); Ron Winslow, *IRS Stance May Force Some Hospitals To End Ventures*, WALL ST. J., Dec. 9, 1991, at B1. For law review articles discussing GCM 39,862, see Patrick H. Lucas, *The Service's Latest Attempt to Regulate Hospital-Physician Relationships: A Critical Analysis*, 9 AKRON TAX J. 13 (1992); Theodore T. Myre, Jr., *Significant Tax Issues in Hospital Related Joint Ventures*, 75 KY. L.J. 559 (1986-87).

²⁹⁸ Gen. Couns. Mem. 39,862, *supra* note 201, at *1 (citing Priv. Ltr. Rul. 88-20-093 (May 31, 1988); Priv. Ltr. Rul. 89-42-099 (Oct. 30, 1989); unpublished Priv. Ltr. Rul. (issued Sept. 13, 1984)).

²⁹⁹ *Id.* at *43-*44.

³⁰⁰ The IRS also discussed the distinct possibility that the arrangements violated public policy. See *infra* part IV.E.2-3 (discussing the Medicare and Medicaid fraud and anti-abuse laws).

The IRS noted that where a hospital retains ownership of property, it operates the property, and it shares its net profits from designated exempt activities with staff physicians, the venture displays attributes of a "shell type arrangement."³⁰¹ The IRS concluded that the arrangements described in GCM 39,862 were shell type arrangements and would confer "direct and substantial" private benefit on the physician-investor "insiders" by the joint venture's receipt of net revenue streams of the hospital's department or laboratory.³⁰² If "for any reason these benefits should be found not to constitute inurement, they nonetheless would exceed the tolerable bounds of prohibited private benefit."³⁰³

After the release of GCM 39,862, the issue arose as to whether a tax-exempt hospital's sale of the future gross revenue stream from an outpatient surgical unit to a joint venture with staff physician-investors would threaten its tax-exempt status under I.R.C. § 501(c)(3).³⁰⁴ Based on GCM 39,862 and its reasoning, the IRS ruled in the affirmative. The IRS was unpersuaded by the joint venturers' assertions that the formation of the arrangement was necessary to stave off competitors and therefore should not jeopardize the exemption.³⁰⁵

Recently, the formation of hospital-physician joint ventures that threaten the tax-exempt status of a hospital have abated to a large degree. On the other hand, issues of private inurement and private benefit have increased in the context of physician retention and recruitment.

2. Physician Retention and Recruitment

For years, hospitals have competed for physicians and have attempted to lure and hire staff physicians by offering incentives. A 1969 revenue ruling provided a framework for contesting subsequent compensation arrangements between hospitals and physicians.³⁰⁶ The rul-

³⁰¹ Gen. Couns. Mem. 39,862, *supra* note 201, at *44.

³⁰² *Id.* at *43-*44.

³⁰³ *Id.* at *36-37. The IRS balanced the public benefit resulting from the transactions—enhanced hospital financial health or efficiencies—and found them merely "tenuous" to the hospital's charitable purpose. Therefore, private benefit far exceeded the permissible "incidental" standard. *Id.*

³⁰⁴ Priv. Ltr. Rul. 92-33-037 (May 20, 1992), *reprinted in* 6 EXEMPT ORG. TAX REV. 838 (1992).

³⁰⁵ *Id.*

³⁰⁶ Rev. Rul. 69-383, 1969-2 C.B. 113. The IRS identified a number of factors to be considered in determining reasonableness of compensation, including: (1) whether the compensation resulted from arms length negotiations; (2) the extent of control by the compensation recipient over the payer organization; (3) the reasonableness of the compensation amount compared to the responsibilities and activities assumed under the contract; (4) whether the compensation would qualify for an ordinary and necessary business deduction under I.R.C. § 162(a);

ing involved a compensation package offered by a hospital to a staff radiologist.³⁰⁷ Pursuant to the arrangement, the radiologist would receive a fixed percentage of gross billings of the radiology division. The IRS found that the radiologist's overall compensation was reasonable in terms of responsibilities and activities assumed by the physician under the contract.³⁰⁸ Moreover, the physician did not control the organization and the contract was negotiated at arms length.³⁰⁹ The IRS found no private inurement.³¹⁰

In 1986, the IRS issued General Counsel Memorandum 39,498, which addressed whether the tax-exempt status of a hospital would be jeopardized by a physician recruitment incentive program that guaranteed a minimum annual income for several years without a co-existing obligation by a recipient physician to repay the subsidies after the contract period.³¹¹ As part of the arrangement, a physician could be required to perform significant services for the hospital, including emergency room duties.³¹² The IRS took the legal position that a recruit who became an employee of the hospital or who merely had a close professional working relationship would be considered an "insider."³¹³ The IRS accorded great significance to the parties' failure to cap the guaranteed annual payments that could be made to a recruit.³¹⁴ It reasoned that the physicians had potential to gain substantial economic benefit in excess of reasonable compensatory amounts.³¹⁵ The total sums possible under the program might not quantitatively be incidental when compared to the hospital's attempt to further the promotion of health care.³¹⁶ Therefore, because such unrestricted income subsidies could violate the I.R.C. § 501(c)(3) prohibitions against pri-

(5) whether the compensation payments serve a real and discernable business purpose of a hospital independent of a purpose to operate the hospital for the recipient's benefit; (6) whether the compensation principally depends on incoming revenue of the hospital or upon accomplishment of the objective of the compensation contract; and (7) the presence of a cap or reasonable maximum compensation to avoid a potential windfall to the recipient. *Id.*; see Thomas K. Hyatt, *Physician Recruitment and Retention for Charitable Hospitals: In the Midst of a Sea Change?*, 6 EXEMPT ORG. TAX REV. 1314, 1318-19 (1992) (citing specifically Gen. Couns. Mem. 38,905 (June 11, 1982), and other IRS releases generally).

³⁰⁷ Rev. Rul. 69-383, *supra* note 306, at *1.

³⁰⁸ *Id.* at *1.

³⁰⁹ *Id.* at *1-*2.

³¹⁰ *Id.* at *3.

³¹¹ Gen. Couns. Mem. 39,498, *supra* note 280, at *2-*3.

³¹² *Id.*

³¹³ *Id.* at *6-*7.

³¹⁴ *Id.* at *9-*10, *13-*14.

³¹⁵ *Id.*

³¹⁶ Gen. Couns. Mem. 39,498, *supra* note 280, at *9-*10, *13-*14.

vate inurement and excessive private benefit, the IRS concluded that such recruitment programs would jeopardize the tax-exempt status of a hospital.³¹⁷

Over the past several years, physician incentive arrangements have proved a "hot bed" of controversy. In December 1994, Hermann Hospital, threatened by a withdrawal of its tax-exempt status, entered into a closing agreement with the IRS.³¹⁸ The closing agreement addressed corrective actions to be initiated by the hospital with respect to transactions conducted over a four-year period.³¹⁹ In a rather unusual step, the IRS disclosed the closing agreement and suggested that pending the issuance of formal guidelines on physician recruitment and incentive packages, the closing agreement demonstrates one practical application of IRS policy on physician recruitment.³²⁰ Although the guidelines of the Hermann Hospital Closing Agreement are fact-specific and the agreement is not all-encompassing,³²¹ it indicates an IRS stance with respect to the recruitment of physicians who maintain private packages.

The closing agreement delineates permissible and impermissible recruitment incentives with respect to attracting a physician from outside the hospital's community. It imposes a requirement that incentives not be conditioned on a physician's admitting or referring patients to the hospital, on restrictions regarding staff privileges at the hospital, or on requisites associated with the physician's treatment or admission of patients to another hospital. The closing agreement enumerates additional duties, at least one of which a physician-recipient must fulfill as part of the contract with the hospital. Finally, the agreement outlines methods for the hospital to demonstrate an existing community need for the physician's recruitment.³²²

More recently, the IRS released Announcement 95-25, which announces the content of a proposed revenue ruling addressing the question of "whether a hospital violates the requirements for exemption from federal income tax as an organization described in § 501(c)(3) . . . when it provides incentives to recruit private practice

³¹⁷ *Id.*

³¹⁸ Bernadette M. Broccolo & Michael W. Peregrine, *Bad Doctor Deals Place Hospitals at New Risk: Part I—Hermann Hospital Closing Agreement*, 10 EXEMPT ORG. TAX REVIEW 1341 (1994).

³¹⁹ *Id.*

³²⁰ See *IRS Closing Agreement*, *supra* note 15, at J-1. Tax attorneys have criticized the closing agreement as "overly restrictive if IRS intends to apply them beyond the facts of this case." *Id.*

³²¹ Broccolo & Peregrine, *supra* note 318, at 1341. The agreement does not address deferred compensation packages, retention packages, or incentive programs directed at physician-employees. *Id.*

³²² *Id.*

physicians to join its non-employee medical staff or to provide services on behalf of the hospital."³²³ The IRS admits that the proposed revenue ruling does not "delineate the boundaries of either permissible or impermissible transactions."³²⁴ However, it has been praised as more lenient than the Hermann Hospital Closing Agreement.³²⁵

The announcement presents incentive packages in five scenarios, four of which involve relocation packages and one of which addresses a retention type package. Much is still unaddressed by the proposed revenue ruling. Yet, two things are clear from the outlined scenarios. First, the IRS is hesitant to rule on guidelines applicable to retention incentive packages. Second, physician recruitment incentive packages may not only include financial assistance in the form of interest-bearing loans, but also may permit: (1) grants of start-up funds if "commercially reasonable"; (2) up to three years of below-market office space rental; (3) moving expenses; (4) up to three years of a guaranteed net income from private practice; (5) one year of malpractice insurance premiums; (6) guarantees of a mortgage on the physician's residence; and (7) reimbursement of "tail" malpractice insurance coverage on a former private practice.³²⁶

In order not to jeopardize the hospital's tax-exempt status, objective evidence must demonstrate that the package furthers the hospital's exempt purpose, that the community benefits from hiring the physician and that having the availability of the physician to treat patients outweighs the private benefit to the physician.³²⁷ Need for the physician can be proved by such objective data as a United States Public Health Service designation of the hospital's community as a Health Professional Shortage Area for primary medical care professionals, including obstetricians and gynecologists.³²⁸ Finally, the announcement distinctly provides that continued qualification for tax-exempt status depends on a hospital's compliance with the Medicare and Medicaid fraud and anti-abuse laws—that is, the hospital's recruitment activities cannot violate public policy.³²⁹

³²³ Ann. 95-25 (April 3, 1995), 1995-14 I.R.B. 11, available in LEXIS, Fedtax library, Relis file, 1995 IRB LEXIS 110, at *1.

³²⁴ *Id.*

³²⁵ Fred Stokeld, *Expect More Closing Agreements, IRS Official Tells Tax-Exempts*, 67 TAX NOTES 1294 (1995) (citing statement by Celia Roady, partner in Washington, D.C. law firm and chairperson of American Bar Association, Tax Section, Exempt Organizations Committee).

³²⁶ Ann. 95-25, *supra* note 323, at *15-*20.

³²⁷ *Id.*

³²⁸ *Id.*

³²⁹ *Id.*

E. *Public Policy Test*

1. *Bob Jones University v. United States*

In 1983, in the context of education, the Supreme Court articulated the community benefit standard in conjunction with a prohibition against the violation of law and public policy.³³⁰ In a sweeping statement, the majority opinion, delivered by Chief Justice Burger, stated in *Bob Jones University v. United States*:

Charitable exemptions are justified on the basis that the exempt entity confers a public benefit—a benefit which the society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues. . . . [A]n institution must fall within a category specified in [I.R.C. § 501(c)(3)] and must demonstrably serve and be in harmony with the public interest. The institution's purpose must not be so at odds with the common community conscience as to undermine any public benefit that might otherwise be conferred.

We are bound to approach these questions with full awareness that determinations of public benefit and public policy are sensitive matters with serious implications for the institutions affected; a declaration that a given institution is not "charitable" should be made only where there can be no doubt that the activity involved is contrary to a fundamental public policy.³³¹

Applying the critical elements of the passage and other language throughout the majority opinion, it is clear that to be considered a tax-exempt charitable organization, the entity's purposes and activities must (1) comport with fundamental public policy and (2) be deemed to confer community benefit, which the Court referred to as "public benefit."³³² However, it is not entirely clear from the

³³⁰ *Bob Jones Univ. v. United States*, 461 U.S. 574, 590–600 (1983).

³³¹ *Id.* at 591–92 (footnotes omitted).

³³² These elements are taken from statements throughout the majority opinion. One such statement provides:

In view of our conclusion that racially discriminatory private schools violate fundamental public policy and cannot be deemed to confer a benefit on the public, we need not decide whether an organization providing a public benefit and other-

opinion whether the public policy doctrine merely is one prong of the operational exclusivity test and thus subsumed within the determination of satisfaction of one of the eight permissible classifications of I.R.C. § 501(c)(3) organizations—that is, charitable, educational, scientific, etc.—or whether it is a wholly separate requirement added by judicial gloss to I.R.C. § 501(c)(3).³³³ In other words, the majority opinion is not clear as to whether the public policy doctrine is an independent test or is a factor that must be satisfied for an organization to be considered “charitable” within the meaning of the statute. Throughout its opinion, the Court ap-

wise meeting the requirements of § 501(c)(3) could nevertheless be denied tax-exempt status if certain of its activities violated a law or public policy.

Id. at 596 n.21.

³³³ In his dissent, Justice Rehnquist points out this confusion by stating:

Another way to read the Court's opinion leads to the conclusion that even though Congress has set forth *some* of the requirements of a § 501(c)(3) organization, it intended that the IRS additionally require that organizations meet a higher standard of public interest, not stated by Congress, but to be determined and defined by the IRS and the courts.

Id. at 617 (Rehnquist, J., dissenting). Likewise, Justice Powell in his concurring opinion suggests some concern about the clarity of the majority's approach. *Id.* at 606–07 (Powell, J., concurring).

In portions of the majority opinion, the Court implied that the public policy requirement is a separate requirement and not subsumed within another requirement. In that event, the public policy requirement would not impact directly a determination of whether an organization falls within one of the eight express categories enumerated in I.R.C. § 501(c)(3), such as charitable, educational, scientific, etc. Illustrations of the separate requirement interpretation can be found in the following examples of the language of the majority opinion:

(1) “[T]o qualify for a tax exemption pursuant to I.R.C. § 501(c)(3), an institution must show, first that it falls within one of the eight categories expressly set forth in that section, and second, that its activity is not contrary to settled public policy.” *Id.* at 585.

(2) “[A]n institution must fall within a category specified in [I.R.C. § 501(c)(3)] and must demonstrably serve and be in harmony with the public interest.” *Id.* at 592 (citation omitted).

(3) “To be entitled to tax-exempt status under § 501(c)(3), an organization must first fall within one of the categories specified by Congress, and in addition must serve a valid charitable purpose.” *Id.* at 592 n.19.

However, in other portions of the opinion, the majority appears to connect the two concepts of public policy and community benefit as necessary to satisfy one of the eight categories of I.R.C. § 501(c)(3). For example, the majority states:

(1) “A corollary to the public benefit principle is the requirement, long recognized in the law of trusts, that the purpose of a charitable trust may not be illegal or violate established public policy.” *Id.* at 591.

(2) “[A] declaration that a given institution is not ‘charitable’ should be made only where there can be no doubt that the activity involved is contrary to a fundamental public policy.” *Id.* at 592.

See Galston, *supra* note 154, at 313–15 (describing legislative history behind public policy constraint); Note, *Bob Jones University v. United States: For Whom Will the Bell Toll?*, 29 ST. LOUIS U. L.J. 561, 574–75 (1985) (indicating the majority opinion is not a paradigm of clarity).

pears to indiscriminately and intermittently mix the various standards and requirements.³³⁴

Regardless of one's reading, the majority opinion in *Bob Jones University*, which upheld the denial of tax exemption to a religious school that practiced racial discrimination, certainly is sufficiently broad to impact not only educational institutions, but also all I.R.C. § 501(c)(3) organizations.³³⁵ Viewed in this way, the Supreme Court decision would broaden the judicially sanctioned standards to include a public policy element when determining a not-for-profit health care organization's qualification for tax-exempt status.

2. Public Policy Doctrine and Medicare/Medicaid Anti-Kickback Rules

In 1972, Congress enacted the first version of the Medicare fraud and abuse rules, known popularly as the Medicare anti-kickback statute.³³⁶ After numerous amendments,³³⁷ the statutes currently prohibit

³³⁴ See *supra* note 333 (presenting select quotations from the majority opinion).

³³⁵ See, e.g., *Church of Scientology v. Commissioner*, 83 T.C. 381, 385, 443-44, 504-05 (1984) (holding that petitioner did not qualify for tax-exempt status because it operated for a substantial commercial purpose, it violated the prohibition against private inurement, it violated well-defined standards of public policy, and it did not provide a public benefit; leaving undecided the issue of "whether an organization providing a public benefit and otherwise meeting the requirements of section 501(c)(3) could nevertheless be denied tax-exempt status if certain of its activities violated a law or public policy"); *Canada v. Commissioner*, 82 T.C. 973, 981 (1984) (citing *Bob Jones University* in determination of whether petitioners were entitled to receive charitable contributions to church); see also Note, *Applying a Public Benefit Requirement to Tax-Exempt Organizations*: *Bob Jones University v. United States*, 49 Mo. L. Rev. 353, 353 (1984).

³³⁶ Social Security Amendments of 1972, Pub. L. No. 92-603, § 242, 86 Stat. 1329, 1419 (1972) (codified as amended at 42 U.S.C. § 1320a-7b(b) (1994)). This original statute was a narrow prohibition against certain fraudulent behavior, and provided for a criminal misdemeanor sanction if violated. For a general discussion of these fraud and anti-abuse rules, see Colombo, *supra* note 82, at 258-63; Glenn A. Reed & Robert E. DeWitt, *Referral Fee Prohibitions*, in *HEALTH CARE CORPORATE LAW: FINANCING AND LIABILITY* 7-1, 7-14 to 7-40 (Mark A. Hall ed., 1994).

³³⁷ In 1977, amendments broadened the prohibited abuses and increased the criminal penalty for violation of the fraud and anti-kickback provision to a felony. Medicare-Medicaid Anti-fraud and Abuse Amendments, Pub. L. No. 95-142, § 4(b), 91 Stat. 1175, 1181 (1977) (codified as amended at 42 U.S.C. § 1320a-7b(b) (1994)). See *supra* note 330 for brief description of penalty under original statute. In 1980, Congress added a scienter requirement; the offender had to "knowingly and willfully" enter into an arrangement considered fraudulent under the anti-kickback rules. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599 (1980) (codified as amended at 42 U.S.C. § 1320a-7b(b) (1994)). The criminal provision provides a felony charge with commensurate sanctions. 42 U.S.C. § 1320a-7b(b) (1994). Under the procedures for a civil action, the Office of Inspector General ("OIG") or Health and Human Services ("HHS") initiates the case. If the OIG finds the health care provider guilty under the statute, the offender can be excluded from further participation in the Medicare and Medicaid programs. However, the health care provider may request a hearing before an HHS administrative law judge. In such a hearing, the OIG has the burden of proving that the health care provider violated the statute by a preponderance of the evidence. An adverse decision by the administrative law judge can be appealed to the HHS Departmental Appeals Board, and court review of this appellate

a health care provider from knowingly and willfully offering, soliciting, paying, or receiving remuneration, whether in cash or in kind, in return for or to induce the referral of a patient for any service for which Medicare or Medicaid might pay.³³⁸ Congress amended the Medicare statutes in 1989 and 1993 in an effort to prohibit physician "self referral."³³⁹ Pursuant to the amended provisions, a physician is now also forbidden from making referrals for certain Medicaid-reimbursed services to entities in which the physician has a prohibited financial relationship³⁴⁰—that is, a financial interest in clinical laboratory services, physical and occupational therapy, radiology and diagnostic services, durable medical equipment, prosthetics, home health services, prescription drugs, and inpatient and outpatient hospital services reimbursed by Medicare or Medicaid.³⁴¹

The enforcing administrative agency, the Office of Inspector General ("OIG") of Health and Human Services ("HHS") has interpreted the fraud and anti-kickback laws broadly, so that a violation occurs if a health care provider intentionally arranges to offer financial incentives for referrals. However, more than ten safe harbors to the anti-kickback rules currently exist under HHS regulations.³⁴² These anti-kickback

level administrative procedure is permitted. However, court review is limited to a determination of whether HHS's decision was "arbitrary and capricious." See Colombo, *supra* note 82, at 224 n.68; Reed & DeWitt, *supra* note 336, at 7-16 to 7-17 & n.9. In 1987, Congress added a civil penalty provision to supplement the existing criminal sanction. Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, § 3, 101 Stat. 680, 686 (1987) (codified as amended at 42 U.S.C. § 1320a-7b(b) (1994)). This amendment enabled the OIG or HHS to expel the guilty health care provider from future participation in Medicare and Medicaid programs. Reed & DeWitt, *supra* note 336, at 7-16 to 7-17 & n.9. These amendments also authorized HHS to issue regulations creating "safe harbors." Pub. L. No. 100-93, § 13, 101 Stat. 680, 697-98 (1987) (codified as amended at 42 U.S.C. § 1320a-7b(b)). See generally Reed & DeWitt, *supra* note 336.

³³⁸ 42 U.S.C. § 1320a-7b(b)(1)-(2) (1988). For further discussion, see *supra* note 8.

³³⁹ Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2236-41 (codified as amended at 42 U.S.C. § 1395nn (1994)); Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312, 596-604 (codified at 42 U.S.C. § 1395nn). Because these self-referral provisions were introduced by Representative Fortney "Pete" Stark, the provisions were referred to as the "Stark Bill."

³⁴⁰ A prohibited "financial relationship" generally includes any ownership, debt or other investment interest in an entity, including any compensation arrangement. 42 U.S.C. § 1395nn(g)(3)-(4) (1994).

With respect to the prohibition against physician self-referral, a guilty provider cannot claim payment for the prohibited self-referred service—and if claimed in violation of the law, it must be reimbursed to the government. 42 U.S.C. § 1395nn(a)(2) (1988 & Supp. V 1993). Additionally, the statute provides for a \$15,000 penalty per violation for presenting a claim for service that the person knows or should know violates the law, and a \$100,000 penalty for entering into a prohibited arrangement that the person knows or should know has a principal purpose of producing illegal referrals. 42 U.S.C. § 1395nn(g)(3)-(4).

³⁴¹ 42 U.S.C. § 1395nn.

³⁴² Other safe harbors have been proposed by HHS involving investment interests in rural

safe harbors involve investment interests and joint venture arrangements,³⁴³ space and equipment rental,³⁴⁴ personal service and management contracts,³⁴⁵ sale of a practice (currently permitted only if the sale is to another practitioner, rather than to a hospital or other entity),³⁴⁶ referral services,³⁴⁷ warranties and discounts,³⁴⁸ payments to employees,³⁴⁹ group purchasing organizations,³⁵⁰ and waivers of co-insurance or deductibles (currently permitted exclusively by hospitals).³⁵¹ Similarly, several exceptions exist to the physician self-referral rules.³⁵²

3. Public Policy Doctrine and Anti-Dumping Standards

As previously mentioned in part II.B.3,³⁵³ during the late 1970s and early 1980s, there were continuous allegations of "patient dump-

area facilities, investment interests in ambulatory surgical centers, investment interests in group practices composed exclusively of active investors, practitioner recruitment in rural areas, obstetrical malpractice insurance subsidies, referral arrangements to specialty services, and cooperative hospital services. 58 Fed. Reg. 49,008 (1993) (to be codified at 42 C.F.R. § 1001.952) (proposed Sept. 21, 1993).

³⁴³ 42 C.F.R. § 1001.952(a)(1), (2)(i) (1994). This safe harbor protects physicians' investment interests in large, publicly held corporations having in excess of \$50 million in net tangible assets, and in certain joint ventures where no more than 40% of the interests are owned by persons capable of referring and no more than 40% of the gross revenues are from referrals.

³⁴⁴ 42 C.F.R. § 1001.952(b)-(c) (1994). A written lease at fair market value must be entered for at least one year, with the fair market value not determined by referrals or value of business reimbursed by Medicare or Medicaid.

³⁴⁵ 42 C.F.R. § 1001.952(d) (1994). The health or management services must be delineated in writing and have a term of at least one year. Compensation must be established in advance, with none of it determined by Medicare or Medicaid referrals or business generated.

³⁴⁶ 42 C.F.R. § 1001.952(e)(1)-(2) (1994). The sale must be completed within one year of execution of the sale agreement; the selling physician must have relocated, retired or not be in a position to make referrals one year after the sale agreement's date.

³⁴⁷ 42 C.F.R. § 1001.952(f) (1994). The referral service must not exclude qualified physicians from participation and must charge fees equally to all participating physicians based only on the cost of the service.

³⁴⁸ 42 C.F.R. § 1001.952(g)-(h) (1994). Warranties and discounts offered in exchange for volume referrals are permitted if both buyer and seller report them on their cost reports or invoices.

³⁴⁹ 42 C.F.R. § 1001.952(i) (1994). Payments to bona fide employees are protected; the term employee is defined by reference to I.R.C. standards that distinguish independent contractors from employees.

³⁵⁰ 42 C.F.R. § 1001.952(j) (1994). Purchasing agents must enter into written agreements with the provider and make certain disclosures in certain circumstances.

³⁵¹ 42 C.F.R. § 1001.952(k) (1994). The waiver or reduction must be universal for all services, but not be offered under a price reduction agreement between a hospital and a third-party payer, and must not later be claimed as a bad debt.

³⁵² 42 U.S.C. § 1395nn(b)-(d) (1988 & Supp. V 1993). The exceptions fall into three categories generally: exceptions to both the ownership and compensation prohibitions; exceptions to the ownership prohibitions only; and exceptions to the compensation prohibitions only. See Colombo, *supra* note 82, at 226-27; Reed & DeWitt, *supra* note 336, at 620-22.

³⁵³ See *supra* note 78 and accompanying text (discussing patient dumping problem).

ing" by hospitals—that is, the transfer of indigent patients, generally the sickest and most costly of patients, to other hospitals, usually public hospitals, before treatment. To contend with the problem, in 1985, Congress enacted anti-dumping laws that require all hospitals participating in Medicare (which includes almost all hospitals) to accept nonpaying patients in their emergency rooms (if they have emergency rooms) to the extent of their capabilities, and all hospitals with Medicaid agreements to admit Medicaid patients without discrimination.³⁵⁴ These laws are designed to extend certain limited protections to persons unable to pay for hospitalization and health care without the assistance of a federal program. The anti-dumping rules require that a hospital provide patients with a medical screening examination and stabilize the patient before transfer by appropriate means to another institution. Sanctions for violation of the statute include, but are not limited to, civil pecuniary penalties and suspension or termination of an offending hospital's Medicare provider status.³⁵⁵

4. Public Policy Doctrine and the IRS

The IRS has clearly signaled that the public policy doctrine dictates that a charitable hospital deserves exemption from tax only if it complies with the Medicare/Medicaid anti-dumping, fraud, and anti-kickback rules.³⁵⁶ Although in the past IRS and HHS interpretations occasionally have differed as to acts and arrangements that may be considered to violate public policy,³⁵⁷ the two agencies' concerns are converging, and the agencies are attempting to coordinate enforcement efforts.³⁵⁸

Evolution of the IRS's attitude is notable with respect to joint ventures and other arrangements between physicians and hospitals.

³⁵⁴ See *supra* note 78 (discussing COBRA, Congress's response).

³⁵⁵ 42 U.S.C. § 1395dd(d)(1)–(2) (1988 & Supp. V 1993).

³⁵⁶ See, e.g., Gen. Couns. Mem. 39,862, *supra* note 201, at *62; IRS Hospital Audit Guidelines, Manual Transmittal 7(10)69–78, ¶ 333.1(5) (Mar. 27, 1992), *reprinted in* 5 EXEMPT ORG. TAX REV. 697 (1992) [hereinafter Audit Guidelines]; IRS-CPE TEXTBOOK, *supra* note 92. Field agents are instructed not only to investigate the denial of treatment to and transfer of patients in an emergency medical condition or women in active labor, but also to examine incidences of "radio triage"—that is, assessing a patient's financial ability by radio contact, usually with an ambulance, and directing the patient be driven to another institution. Audit Guidelines, *supra*; see also IRS-CPE TEXTBOOK, *supra*, note 92.

³⁵⁷ See Charles F. MacKellvie & Mary Lynn McGuire, *Provider-Physician Arrangements: An Uneasy Alliance Under Fraud, Abuse, and Inurement*, in LEGAL MEDICINE 1990, at 189, 190–207 (Cyril H. Wecht ed., 1991); Woodhall, *supra* note 92, at 231–33.

³⁵⁸ See IRS-CPE TEXTBOOK, *supra* note 92; Audit Guidelines, *supra* note 356, at ¶ 333.4; see also IRS and HHS to Coordinate Oversight Operation of Tax-Exempt Health Care Organizations, 2 EXEMPT ORG. TAX REV., Special Supp. 1989.

For example, in the late 1980s, one typical joint venture arrangement between a not-for-profit hospital or its subsidiary and physicians on the hospital staff would be structured as a sale of the hospital department's or service's gross or net revenue stream to a partnership consisting of the hospital and physicians. The department or service, such as an outpatient surgical unit, would continue to be owned and operated by the hospital. However, after the sale, through their partnership interests, the physicians could personally profit from increased referrals and patient utilization of the facilities.³⁵⁹ For a number of years, the IRS ruled that such joint ventures and partnership arrangements would not jeopardize the tax-exempt status of the hospital partner.³⁶⁰ However, in 1991, the IRS changed its position.

In late 1991, in GCM 39,862, the IRS reexamined three previously issued private letter rulings involving a hospital's sale of the net revenue stream from its outpatient surgical unit to a joint venture between the hospital and physicians on its staff.³⁶¹ The IRS reconsidered its position taken in those rulings and, contrary to its earlier position, determined that such arrangements do jeopardize a hospital's tax-exempt status.³⁶² This conclusion was based on the violation by the joint venture arrangements of the three tests of I.R.C. § 501(c)(3): the prohibition against private inurement, the prohibition against excessive private benefit, and the public policy doctrine. Focusing on the public policy test, the IRS concentrated on whether the joint venture arrangements breached the Medicare/Medicaid anti-kickback rules.³⁶³ The IRS first noted that not all physician-hospital joint ventures and hospital arrangements would violate the Medicare/Medicaid statute.³⁶⁴

³⁵⁹ See, e.g., Priv. Ltr. Rul. 92-33-037, *supra* note 304; Priv. Ltr. Rul. 90-29-034 (Apr. 23, 1990); Priv. Ltr. Rul. 89-42-099, *supra* note 298; Priv. Ltr. Rul. 88-20-093, *supra* note 298; see also *supra* notes 294-305 (describing such partnership arrangements).

³⁶⁰ See, e.g., Priv. Ltr. Rul. 90-29-034, *supra* note 359; Priv. Ltr. Rul. 89-42-099, *supra* note 298; Priv. Ltr. Rul. 88-20-093, *supra* note 298.

³⁶¹ See Gen. Couns. Mem. 39,862, *supra* note 201 (addressing Priv. Ltr. Rul. 89-42-099, *supra* note 298; Priv. Ltr. Rul. 88-20-093, *supra* note 298; unpublished Priv. Ltr. Rul., *supra* note 298).

³⁶² Gen. Couns. Mem. 39,862, *supra* note 201.

³⁶³ *Id.* at *62.

³⁶⁴ The IRS stated that it should care about whether these physician hospital arrangements do serve an illegitimate purpose for several reasons:

First, physicians may be tempted to refer patients for unnecessary services or for necessary services provided in an unnecessarily costly setting. This overutilization would drive up the costs of the Medicare and Medicaid Programs without achieving any public benefit. Payments intended to influence the exercise of judgment with respect to referrals may easily become an added cost of doing business in the health care field. Such arrangements may also cause harm to individual patients from their being subjected to unnecessary procedures or having their treatment facilities selected based on pecuniary, rather than quality of care, concerns. . . .

Another important reason to be concerned about these arrangements is that the

After finding that the arrangements questioned in GCM 39,862 did not fall within any of the statutory safe harbors, the IRS determined that these joint venture arrangements contained abusive and illegal features that the OIG had highlighted in its Special Fraud Alert—Joint Venture Arrangements.³⁶⁵ It enunciated a guiding principle: “Where participating in a joint venture does not demonstrably further the hospital’s exempt purposes in some legitimate manner, the Service ought not rule favorably on the arrangement.”³⁶⁶ In the memorandum, the IRS examined the joint ventures to determine whether they furthered the hospital in a legitimate manner and found that they were “no more than a sham” because of the “total absence of any valid business purpose or activity.”³⁶⁷ It concluded: “We believe that engaging in conduct or arrangements that violate the anti-kickback statute is inconsistent with continued exemption as a charitable hospital. . . . No matter how economically rewarding, such activities cannot be viewed as furthering exempt purposes.”³⁶⁸

The IRS has been mindful of the Medicare/Medicaid fraud and anti-kickback rules in the context of hospitals’ purchases of physicians’ practices.³⁶⁹ A potential problem may arise where a not-for-profit hospital purchases a physician’s practice or a group practice and the physician(s) continue practicing medicine. If the form and amount of the payment made to the physicians suggest an intention to induce or reward the referral of business, the disguised payment may violate the anti-kickback rules.³⁷⁰

More recently, the IRS voiced in Announcement 95-25³⁷¹ its concern over the Medicare/Medicaid anti-kickback rules in the context of physician recruitment by hospitals.³⁷² It clearly stated its position: when

hospital’s entire community may be harmed rather than benefitted. Where physicians receive hidden or disguised payments for referrals, honest competition among health care providers based on quality or price is undercut.

Id. at *65-66 (citation omitted).

³⁶⁵ *Id.* at *58-59 (discussing abusive features of OIG Special Fraud Alert-Joint Venture Arrangements, issued in April 1989).

³⁶⁶ *Id.* at *76.

³⁶⁷ Gen. Couns. Mem. 39,862, *supra* note 201, at *77. IRS also cited concern for the “lack of symmetry in upside opportunities and downside risks for the physician-investors.” *Id.* at *78-79. IRS questioned whether the incentives provided to the physician-investors were actually intended to include unstated incentives for referral of Medicare and Medicaid business. *Id.* at *79.

³⁶⁸ *Id.* at *62 (footnote omitted).

³⁶⁹ See IRS-CPE TEXTBOOK, *supra* note 92; see also Levine, *supra* note 277 at 1060.

³⁷⁰ Such disguised payments could take a variety of forms. For example, disguised referral fees could be in the form of above-market rates of compensation paid to the physicians or an option to buy the practice where an actual sale is not contemplated. See IRS-CPE TEXTBOOK, *supra* note 92.

³⁷¹ *Supra* note 323.

³⁷² For further discussion of the physician recruitment issues, see *supra* part IV.D.2.

a hospital is adjudicated guilty of knowingly and willfully violating the Medicare/Medicaid anti-kickback statute by providing recruitment incentives that constitute payments for referrals, the hospital will fail to be recognized as furthering charitable purposes if such activities are substantial.³⁷³

5. Current Relationship Between the IRS and HHS

The IRS has acknowledged that, although the tax and health laws are different, the concerns of the IRS and HHS overlap to some extent, and information on potential violations of the Medicare/Medicaid laws and HHS regulations should be shared.³⁷⁴ The significance of GCM 39,862 and Announcement 95-25 extends well beyond the strict scrutiny of hospital-physician joint ventures and physician recruitment practices. They provide a benchmark for the IRS's position on the prohibitions against private inurement and excessive private benefit.³⁷⁵ Both pronouncements are a formal recognition that all health care organizations, including those forming an IDS or hospital network, must comply with Medicare and Medicaid laws to satisfy the public policy doctrine. Absent compliance, initial qualification or retention of tax-exempt status under I.R.C. § 501(c)(3) would be denied to any component organization of an IDS or hospital network.³⁷⁶

F. *I.R.C. § 501(c)(3) Tax-Exempt Tests and Standards Applied to Health Care Networks*

1. In General

In comparison to the declining number of freestanding hospitals,³⁷⁷ the health care sector continues to experience the formation

³⁷³ Ann. 95-25, *supra* note 323, at 14. Tax-exempt status will be denied or revoked. *Id.*

³⁷⁴ See *supra* notes 357-58 and accompanying text.

³⁷⁵ See *supra* part IV.C-D.

³⁷⁶ To date, no cases or administrative rulings exist involving health care organizations' conformance with the public policy test other than with respect to the Medicare/Medicaid anti-kickback statutes. However, it is conceivable that other public policy concerns might enter the picture at some point. For example, the media has reported that low-income groups in Tennessee allege discriminatory practices against them as Medicaid recipients. Steven A. Holmes, *Drug Makers and Black Groups Fight Prescription Controls*, N.Y. TIMES, Nov. 20, 1994, § 1, at 32. These individuals under TennCare, Tennessee's Medicaid program, suggest that TennCare's use of a restrictive formulary of approved drugs results in denied access to certain drugs that physicians might deem appropriate to prescribe. *Id.* They allege that these practices are discriminatory in that more affluent individuals are not limited in the kind and quality of available prescription drugs. *Id.* Moreover, it is suggested that this practice violates Title VI of the Civil Rights Act of 1964, which bars discrimination in any program receiving federal funds, including Medicaid. *Id.*

³⁷⁷ See *supra* notes 57-58, 80-81, 100-03 and accompanying text.

and growth of horizontal hospital networks and IDSs.³⁷⁸ This expansion has been the result of many factors, including efforts to reduce hospital overcapacity, to increase efficiency, and to furnish comprehensive health care benefits to patients under managed care plans. The degree and type of integration of these assorted networks varies greatly. Regional networks of horizontally affiliated hospitals joined under contractual arrangements or joint ventures to offer medical services are increasingly popular. Vertically integrated IDS models range from partially integrated systems, such as the management services organization ("MSO") model to a total integration model—that is, a single entity IDS composed of merged groups of hospitals, physicians, and possibly HMOs, offering health care services.³⁷⁹ In some states, such as Texas, California, Wisconsin, and Pennsylvania, laws prohibit the corporate practice of medicine, and therefore do not allow hospitals or other corporations to employ physicians or directly provide physician services.³⁸⁰ Yet, even in those states, IDSs have appeared in the form of the foundation model. Under the foundation model IDS, a hospital establishes a not-for-profit corporation (the medical foundation). The medical foundation purchases the medical practice of a group or groups of physicians, including the medical practice's tangible and intangible assets. The medical foundation contracts with the physician group(s) for the delivery of medical services to the foundation's patients.³⁸¹

Regardless of the structure of the network and of whether the structure is achieved by merger or some other form of reorganization,³⁸² it is critical to focus on (1) whether an affiliated entity initially

³⁷⁸ For a definition of "IDS," see *infra* Glossary. One survey reports that of the 1191 free-standing hospitals represented, 81% expect the hospitals not to operate independently by 1999. DELOITTE & TOUCHE, *supra* note 84, at 1, 26. Most anticipate their hospitals to join provider networks, but without ownership changes. *Id.* at 1. Seventy-one percent of the hospitals either currently belong or anticipate developing IDSs, and 66% report that it is "absolutely necessary" for an acute-care hospital to have some form of PHO. *Id.* at 17–18, 21–22; see also Boisture, *supra* note 95, at 272; Richardson, *supra* note 58, at 907.

³⁷⁹ For a description of the various IDS models, see *infra* Glossary. See also Gerald M. Griffith & Brad M. Tomtishen, *Exempt Hospital Affiliations: Bond and UBIT Issues*, 11 EXEMPT ORG. TAX REV. 709 (1995) (discussing regional affiliations of hospitals).

³⁸⁰ See Bromberg, *supra* note 92, at 336; Richardson, *supra* note 58, at 907.

³⁸¹ One practitioner, a former IRS official, has described the foundation model IDS as the "[p]rogeny of superannuated restrictions on the corporate practice of medicine." Bromberg, *supra* note 92, at 336.

³⁸² Mergers, acquisitions, and other forms of legal reorganizations entered into for the purpose of consolidating or streamlining the provision of health care services have become common during the 1990s. Many mergers have occurred in the health industry despite the fact that the expenses of consolidation can be extraordinarily high. For a discussion of the costs associated with mergers of health care providers, see Jay Greene, *The Costs of Hospital Mergers*, MON. HEALTHCARE, Feb. 3, 1992, at 36. It has been reported that between 1983 and 1992, the number

seeking tax-exempt status under I.R.C. § 501(c)(3) qualifies on its own accord or as an "integral part" of the network, and (2) whether a consolidation or otherwise reorganized structure of affiliated entities jeopardizes the existing tax-exempt status of any of the entities. In large part, that determination hinges on satisfaction of the community benefit standard as well as the prohibitions against private inurement and excessive private benefit.³⁸³

2. Tax Exemption of Foundation in Foundation Model IDS

a. *In General*

In the formation and operation of a foundation model IDS,³⁸⁴ a major focus is whether the corporate medical foundation deserves

of hospital systems increased from 249 to 300, with the number of non-federal acute-care hospitals declining from 5788 to 5292. See Richardson, *supra* note 58, at 913 (citing AMERICAN HOSPITAL ASSOCIATION DIRECTORY OF MULTIHOSPITAL SYSTEMS (1980-1987) and editions of the AHA GUIDE for 1988-1993 (implying these changes resulted from horizontal mergers of hospitals)).

The issue that arises as a result of reorganization processes is whether the existing I.R.C. § 501(c)(3) status of a hospital or other affiliated entity is threatened by the reorganization. Numerous private letter rulings and other IRS pronouncements indicate generally that the changed structure will not jeopardize the existing tax-exempt status of a hospital or other entity taking part in the reorganization if the new structure enhances the delivery of health care services and each entity continues to satisfy the requirements of Revenue Ruling 69-545. See, e.g., Priv. Ltr. Rul. 95-19-057 (Feb. 16, 1995); Priv. Ltr. Rul. 95-17-051 (Feb. 2, 1995); Priv. Ltr. Rul. 95-11-038 (Dec. 20, 1994); Priv. Ltr. Rul. 95-11-036 (Dec. 19, 1994); Priv. Ltr. Rul. 95-11-035, *supra* note 205; Priv. Ltr. Rul. 92-28-044 (Apr. 16, 1992); Priv. Ltr. Rul. 92-25-042 (Mar. 25, 1992); Priv. Ltr. Rul. 91-30-002 (Mar. 19, 1991); Gen. Couns. Mem. 39,326 (Jan. 17, 1985), available in LEXIS, Fedtax library, GCM file, 1985 IRS GCM LEXIS 6. If the system can show that due to the reorganization it has a more effective ability or more flexibility to respond to the competitive health care environment and to community health care needs, the IRS has indicated that the new structure will be deemed to enhance health care delivery. See, e.g., Priv. Ltr. Rul. 95-19-057, *supra*; Priv. Ltr. Rul. 92-28-044, *supra*; Priv. Ltr. Rul. 91-30-002, *supra*. If as part of the reorganization a new corporate entity is created, the IRS will undertake an analysis of whether the newly created corporation satisfies all requirements and standards for tax exemption. For example, if a new superparent corporation is created, the organization would be required to satisfy the standards applied by the IRS to such entities. See *infra* notes 446-55 and accompanying text (describing the standards applicable to superparents).

³⁸³The determination depends on satisfaction of all I.R.C. § 501(c)(3) tests enumerated in the text. See *supra* notes 119-25 and accompanying text. The IRS has placed considerable emphasis on scrutinizing these arrangements for purposes of the prohibition against private inurement. See Priv. Ltr. Rul. 94-26-040 (Apr. 4, 1994) (ruling on Rockford Memorial Health Services Corp.); Priv. Ltr. Rul. on Harriman Jones Medical (Feb. 3, 1994), available in LEXIS, Fedtax library, TNT file, 94 TNT 31-103 [hereinafter Harriman Jones Ruling]; Priv. Ltr. Rul. 94-11-043, (Dec. 21, 1993), available in LEXIS, Fedtax library, TNT file, 94 TNT 3-128 [hereinafter Billings Clinic Ruling]; Priv. Ltr. Rul. (Aug. 1, 1993), available in 93 TNT 187-178, 8 EOTR 799-801 (1993) [hereinafter Northwestern Ruling]; Facey Ruling, *supra* note 205; Friendly Hills Ruling, *supra* note 205; IRS-CPE TEXTBOOK, *supra* note 92; see also *supra* part IV.C (discussing the private inurement test).

³⁸⁴The IRS has set forth separate exemption criteria for the formation and operation of a

I.R.C. § 501(c)(3) status. In making this determination, the IRS scrutinizes the foundation and the system as a whole, including the foundation, affiliated hospitals, clinics, or other health care providers.³⁸⁵ Compliance with the community benefit test of Revenue Ruling 69-545, as expanded by IRS rulings and other pronouncements, is essential.³⁸⁶ The IRS recognizes that integration of hospital and physician services will result naturally from formation of the IDS and will be of general benefit to the community.³⁸⁷ For example, integration of patient records and information systems helps to eliminate duplication of tests, procedures, and treatments, which will result in increased efficiencies, enhancement of a health care organization's financial health, and a reduction in health care costs to the community. However, the IRS considers such increased efficiencies and enhancement of an institution's finances alone as insufficient for satisfaction of the community benefit standard.³⁸⁸ Fulfillment of the rules regarding prohibitions against private inurement and excessive private benefit is crucial, with the IRS largely focusing on the physician composition of the foundation's governing boards.³⁸⁹

The IRS has set forth separate exemption criteria for the formation and for the operation of a foundation model IDS.³⁹⁰ As part of its standards, the IRS has not articulated a requirement that each component (e.g., the medical foundation and the hospital) of a foundation

foundation model IDS. See *infra* notes 390, 398-409 and accompanying text. For a description of a foundation model IDS, see *infra* Glossary.

³⁸⁵ See Bromberg, *supra* note 92, at 338; Robert S. Bromberg, *The Tax-Exempt Clinic*, 8 EXEMPT ORG. TAX REV. 557, 557 (1993) [hereinafter Bromberg, *Clinic*]. The criteria for recognizing a clinic as tax-exempt under I.R.C. § 501(c)(3) have not been clearly or fully set forth by the IRS. However, in Gen. Couns. Mem. 38,394 (June 2, 1980), where a clinic was devoted to the provision of health care services to a community but was not involved in medical education, research and related activities, the IRS took the position that the governing boards of the clinic could not be physician controlled. Where a clinic is involved in medical education, research, and related activities, board control by physicians creates a "clear potential for abuse" but not a per se violation of rules. See Bromberg, *Clinic*, *supra*, at 557; Michael W. Peregrine & Bernadette M. Broccolo, *New Limitations on Physician Participation in Corporate Governance*, 65 TAX NOTES 121, 124 (1994).

³⁸⁶ See *supra* note 383 (listing some of the pertinent rulings for foundation model IDSs).

³⁸⁷ See IRS-CPE TEXTBOOK, *supra* note 92.

³⁸⁸ *Id.* at 225; see *Geisinger II*, 30 F.3d 494, 499 (3d Cir. 1994) (where the Third Circuit denied the HMO, GHP, status as a "charitable" organization under I.R.C. § 501(c)(3) pursuant to the integral part doctrine of I.R.C. § 502, and clearly stated that efficiency concerns are outweighed by "countervailing policy concerns"); Harriman Jones Ruling, *supra* note 383.

This IRS position is consistent with its stance in Gen. Couns. Mem. 39,862, which involves hospital-physician joint ventures. See *supra* part IV.D.1.

³⁸⁹ See, e.g., IRS-CPE TEXTBOOK, *supra* note 92. For further discussion of the composition of governing boards, see *infra* notes 399, 402 and accompanying text.

³⁹⁰ See IRS-CPE TEXTBOOK, *supra* note 92.

model IDS be considered per se a health care provider.³⁹¹ A former IRS official and current tax practitioner/commentator has expressed the opinion that a medical foundation in a foundation model IDS should be considered a health care provider.³⁹² He acknowledges that the medical foundation does not directly employ, but rather contracts with the physicians that treat its patients.³⁹³ Nonetheless, he argues for provider status based on the underlying reasons for the formation of a medical foundation—that is, under laws of certain states,³⁹⁴ a non-profit corporation such as a hospital cannot directly employ physicians and the medical foundation “is intended to serve as a provider of medical care and not simply as a facilitator or arranger of care.”³⁹⁵ By contrast, in specific reference to the Facey Foundation,³⁹⁶ two other commentators have characterized the role of the medical foundation in functional terms that essentially describe it as a facilitator: “[It] . . . facilitate[s] through assets purchased and contractual arrangements with third parties, the delivery of inpatient, outpatient and other necessary services to patients/enrollees of [its related] hospitals and managed care programs.”³⁹⁷ As these contrasting views demonstrate, the debate remains unresolved.

b. *Formation*

The primary IRS criteria for formation of a foundation model IDS include:³⁹⁸ (1) a demonstration of fair market valuation purchases of physicians’ assets—that is, proof that the hospital pays no more than fair market value for the medical group’s tangible and intangible assets; (2) a governing board representative of the community and

³⁹¹ Although the IRS has not articulated a health care provider requirement, an official IRS publication defines an IDS as a “health care provider (or one component entity of an affiliated network of providers) created to integrate the provision of hospital services with professional medical (e.g., physician) services.” IRS-CPE TEXTBOOK, *supra* note 92. However, the IRS considers non-staff model HMOs and MSOs to be arrangers or facilitators of health care rather than health care providers. See *supra* notes 255–56 and accompanying text (discussing provider versus arranger status with respect to GHP); see *infra* note 432 and accompanying text (discussing arranger status of MSO). Because these organizations can be part of an IDS, this IRS definition may not comport with legal positions that it has taken.

³⁹² Bromberg, *supra* note 92, at 336.

³⁹³ *Id.*

³⁹⁴ See *supra* note 380 and accompanying text (listing several states in which the laws limit nonprofit corporations’ employment of physicians).

³⁹⁵ Bromberg, *supra* note 92, at 336.

³⁹⁶ See Facey Ruling, *supra* note 205.

³⁹⁷ Michael W. Peregrine & Bernadette M. Broccolo, *New “IDS” Determination Letter Offers Promise, Sparks Controversy*, 7 EXEMPT ORG. TAX REV. 757, 759 (1993).

³⁹⁸ *Id.*

composed of no more than twenty percent physicians;³⁹⁹ (3) evidence that the Medicare and Medicaid fraud and anti-abuse rules are not violated; (4) proof that the compensation agreement with the medical group is negotiated at arms-length (preferably by an independent board without physician representation) and does not provide more than incidental private benefit; and (5) evidence that any covenant not to compete is narrow in geographic scope and time duration. Furthermore, the IRS has noted that it is more inclined to recognize a medical foundation as tax-exempt under I.R.C. § 501(c)(3) if it acquires the medical group's assets outright rather than pursuant to a lease or license arrangement.⁴⁰⁰

c. Operation

With respect to the operations of a foundation model IDS, the IRS places primary emphasis on: (1) the maintenance of open medical staffs by affiliated hospitals (open medical staffs are not required of affiliated clinics);⁴⁰¹ (2) the formation of the foundation's governing board, with board membership broadly representing the community and consisting of no more than twenty percent physicians or other interested parties;⁴⁰² (3) the establishment of fee committees to set

³⁹⁹ Attention to community representation on the governing board is consistent with the IRS position in Revenue Ruling 69-545 that the board of trustees of a tax-exempt hospital must reflect the community in which the hospital is located. See *supra* part IV.B.2.c (discussing Revenue Ruling 69-545). The 20% figure has been explained as having its genesis in the IRS's perception of the normal composition of a community's population.

[T]he [IRS] has taken the initial position that physicians generally do not make up more than 20 percent of the population of any community, and therefore, while they are willing to concede that the physicians can have a 20 percent representation on the board, they are insistent that other parts of the community be represented through the 80 percent non-physician portion of the board.

Bromberg, *supra* note 92, at 337-38.

⁴⁰⁰ IRS-CPE TEXTBOOK, *supra* note 92.

⁴⁰¹ See IRS-CPE TEXTBOOK, *supra* note 92; Friendly Hills Ruling, *supra* note 205.

⁴⁰² See IRS-CPE TEXTBOOK, *supra* note 92; see also Facey Ruling, *supra* note 205; Friendly Hills Ruling, *supra* note 205. IRS representatives sometimes have referred to the 20% figure as merely a "safe harbor" and "not an absolute requirement or limitation" on the percentage of physicians and interested parties that may comprise the governing board. *Exempt Organizations: IRS Focuses on Community Benefit in Integrated Delivery System Rulings*, Daily Tax Rep. (BNA), at D-12 (Aug. 16, 1993), available in Westlaw, BNA-DTR file (statement of T.J. Sullivan, Special Assistant for Health Care, Office of the Assistant Commissioner for Employee Plans and Exempt Organizations, IRS). At other times, IRS representatives have indicated a more aggressive approach touching on a 20% restriction. For example, it has been expressed that "[w]e want to make sure no more than 20% of control goes to physicians or employees of the network." *Factors Determining If Health Systems Are Tax-Exempt Outlined By IRS Official*, Daily Tax Rep. (BNA), at G-2 (Oct. 24, 1994), available in Westlaw, BNA-DTR file (statement of T.J. Sullivan, Special Assistant for Health Care, Office of the Assistant Commissioner for Employee Plans and Exempt Organizations, IRS).

payment amounts for medical services, with independent membership subordinate to the authority of the foundation's governing board;⁴⁰³ (4) the organization of a separate committee to negotiate physician compensation, with membership void of physician representation;⁴⁰⁴ (5) the provision of medical education and research;⁴⁰⁵ (6) a demonstration that the system increases accessibility to treatment by Medicare and Medicaid patients and treats such patients on a nondiscriminatory basis;⁴⁰⁶ and (7) evidence that hospitals or clinics maintain an open emergency room policy and treat patients regardless of their ability to pay.⁴⁰⁷

In several private letter rulings, the IRS has taken a clear position that charity care is an essential component of the community benefit standard to be applied to foundation model IDSs.⁴⁰⁸ In comparing

This 20% limit is permissive if viewed in light of the absolute prohibition against private inurement rather than the limitation on private benefit. See *supra* part IV.C-D. In other words, the issue arises as to whether *any* physician representation violates the private inurement prohibition. See Gen. Couns. Mem. 39,862, *supra* note 201; Gen. Couns. Mem. 39,498, *supra* note 280.

For an explanation of the basis for the 20% figure, see *supra* note 399 (discussing IRS's perception of physician composition of a community).

⁴⁰³ See IRS-CPE TEXTBOOK, *supra* note 92. Like the governing board, the IRS takes the position that physicians should be limited to a "minority position" on price setting committees. *Makeup of Fee Board Factor in Exempting Health Care Providers, IRS Official Says*, Daily Tax Rep. (BNA), at G-4 (Apr. 25, 1995), available in Westlaw, BNA-DTR file [hereinafter *Makeup of Fee Board*] (statement of Phyllis Haney, senior attorney, Office of Associate Chief Counsel, Employee Plans and Exempt Organizations, IRS). However, if half of the committee were physicians, there would be little likelihood of a grant of tax-exempt status. *Id.*

⁴⁰⁴ See *Makeup of Fee Board*, *supra* note 403.

⁴⁰⁵ See IRS-CPE TEXTBOOK, *supra* note 92 (describing the provision of medical education and research as a "favorable factor").

⁴⁰⁶ See IRS-CPE TEXTBOOK, *supra* note 92; see also *Facey Ruling*, *supra* note 205; *Friendly Hills Ruling*, *supra* note 205.

⁴⁰⁷ See IRS-CPE TEXTBOOK, *supra* note 92; see also *Facey Ruling*, *supra* note 205; *Friendly Hills Ruling*, *supra* note 205.

⁴⁰⁸ In the *Friendly Hills Ruling*, the foundation was described as operating a general acute-care hospital and ten clinic facilities. *Friendly Hills Ruling*, *supra* note 205, at 490. The foundation agreed that the hospital would continue to operate an emergency room open to the public and to provide emergency care to anyone regardless of ability to pay. *Id.* at 491. Additionally, the foundation agreed to treat any person without regard to ability to pay if present at any clinic location and in need of immediate care. *Id.* Moreover, indigents receiving emergency room care and requiring hospitalization would be admitted to the hospital for inpatient care and would receive at the hospital or clinics all necessary follow-up care free or at discounted rates, depending on the patient's financial means. *Id.* Finally, the foundation agreed that the hospital and clinics would participate in Medicare and Medicaid on a nondiscriminatory basis. *Id.*

In the *Facey Ruling*, the foundation agreed to provide \$400,000 of charity care annually during its first two years of operation and at least \$400,000 of charity care thereafter. *Facey Ruling*, *supra* note 205, at 830. The foundation also agreed that the medical group with which it had contracted for medical services would provide a "substantial number" of physicians to serve in the hospital emergency room as "backup." *Id.* at 829. Moreover, the foundation agreed to provide

freestanding hospitals, the IRS has enunciated the rule that in "most cases, an IDS will have to go well beyond meeting the hospital [open emergency room and Medicare nondiscrimination factors] standard to demonstrate sufficient community benefit, especially in its outpatient or clinic settings."⁴⁰⁹

3. Tax Exemption of an Affiliated Health Care Provider in a Foundation Model IDS: The Role of the Integral Part Doctrine

An affiliated not-for-profit health care provider organization, such as a hospital, clinic, or HMO may seek I.R.C. § 501(c)(3) status on a stand alone basis.⁴¹⁰ Absent the ability of such an organization to so qualify, it may pursue tax-exempt status as an integral part of the IDS or network.⁴¹¹ This double attempt for I.R.C. § 501(c)(3) status is the route recently ventured by GHP, a not-for-profit corporation owning and operating an HMO.⁴¹²

After the Third Circuit reversed the Tax Court and denied I.R.C. § 501(c)(3) tax-exempt status to GHP on a stand alone basis in *Geisinger I*,⁴¹³ GHP sought I.R.C. § 501(c)(3) status as an "integral part" of the Geisinger System of Pennsylvania health care organizations.⁴¹⁴ Ruling against GHP in *Geisinger Health Plan v. Commissioner*, ("Geisinger II"),⁴¹⁵ the Tax Court reviewed its perception of the integral part doctrine. Stating that the integral part doctrine is not codified, the court relied on Treasury Regulation section 1.502-1(b), cases, and revenue rulings to define and apply the integral part doctrine to GHP. Essen-

emergency room care without regard to a patient's ability to pay, and the clinic or affiliated hospital would treat patients without regard to ability to pay. *Id.* The foundation also agreed to participate in Medicare and Medicaid on a nondiscriminatory basis. *Id.* at 830.

Similar agreements were entered in the Billings Clinic Ruling, *supra* note 383, and in the Harriman Jones Ruling, *supra* note 383. In each of those rulings, the IRS permitted I.R.C. § 501(c)(3) treatment.

⁴⁰⁹ IRS-CPE TEXTBOOK, *supra* note 92.

⁴¹⁰ See, e.g., part IV.B.h.2.(1).

⁴¹¹ The Third Circuit has described the integral part doctrine as "an exception to the general rule that entitlement to exemption is derived solely from an entity's own characteristics." *Geisinger II*, 30 F.3d 494, 498 (3d Cir. 1994).

⁴¹² See *Geisinger I*, 62 T.C.M. (CCH) 1656 (1991), *rev'd*, 985 F.2d 1210 (3d Cir.), *on remand*, *Geisinger II*, 100 T.C. 394 (1993), *aff'd*, 30 F.3d 494 (3d Cir. 1994). For a discussion of *Geisinger I*, see *supra* notes 242-56 and accompanying text.

⁴¹³ *Geisinger I*, 985 F.2d at 1210.

⁴¹⁴ *Geisinger II*, 30 F.3d at 494. The Geisinger System consists of GHP and eight other not-for-profit entities that promote health care in 27 counties in northeast and north-central Pennsylvania. *Id.* at 496. The system, which is controlled by a parent foundation corporation, includes two medical centers, a clinic, a detoxification center, two professional liability trusts, and management personnel who provide administrative services to the system. *Id.*

⁴¹⁵ See *Geisinger II*, 100 T.C. at 394.

tially, the Tax Court applied a two-prong test to determine whether an organization qualifies for exemption under the integral part doctrine. The Tax Court test asked: (1) whether the organization's activities are carried on under the supervision or control of an exempt affiliated organization,⁴¹⁶ and (2) whether the activities could be regularly carried on by the affiliate without constituting an unrelated trade or business.⁴¹⁷

Although the Third Circuit affirmed the Tax Court's holding against GHP in *Geisinger II*, it took a somewhat different approach to the integral part doctrine.⁴¹⁸ The court acknowledged that structural efficiencies of the health care system might be hampered by its interpretation of the doctrine.⁴¹⁹ Nonetheless, it indicated that a subsidiary may qualify for tax-exempt status as an integral part of its I.R.C. § 501(c)(3) parent only if:

⁴¹⁶The Tax Court specifically stated: "The parties agree that an organization is entitled to exemption as an integral part of a tax-exempt affiliate if its activities are carried out under the supervision or control of an exempt organization and could be carried out by the exempt organization without constituting an unrelated trade or business." *Id.* at 402.

⁴¹⁷*Id.* at 404. Elaborating, the Tax Court expressed the following:

Given the existence of sales to and services performed for persons who are not patients of the exempt entities within the Geisinger system, we must determine whether petitioner's overall operations are "substantially related to the exempt function" of its exempt affiliates. If petitioner's activities are "conducted on a scale larger than is 'reasonably necessary'" to accomplish the purposes of the exempt entities, there is no substantial relationship within the meaning of the regulations.

Id. at 405-06.

⁴¹⁸Contrary to GHP's prodding, the Third Circuit flatly refused to accept GHP's position that pursuant to the integral part doctrine, tax-exempt status should automatically be granted if GHP were merged with its tax-exempt affiliates, which would continue to retain their exemption. The Third Circuit stated:

[T]he integral part doctrine does not mean that GHP [the entity seeking tax-exempt status] would be exempt solely because either GMC or the Clinic [affiliated exempt organizations] could absorb it while retaining its tax-exempt status. While this is a necessary condition to applying the doctrine, it is not the only condition.

Geisinger II, 30 F.3d at 499.

⁴¹⁹To this end the Third Circuit expressed:

We acknowledge that interpreting the integral part doctrine in the manner GHP urges might enable entities to choose their organizational structures based on efficiency concerns rather than perverting those concerns by making tax considerations relevant. In our view, however, there are countervailing policy concerns which justify determining each entity's tax status based upon its own organizational structure. It is less complex and more certain for courts and administrators to assess an entity's tax status in light of its unique organizational composition and its association with another entity, and only to have to take into account some hypothetical combination of organizations as a second step in those relatively rare instances when an organization meets the other precondition of integral part status we set forth below.

Id. at 499.

(i) it is not carrying on a trade or business which would be an unrelated trade or business (that is, unrelated to exempt activities) if regularly carried on by the parent, and (ii) its relationship to its parent somehow enhances the subsidiary's own exempt character to the point that, when the boost provided by the parent is added to the contributions made by the subsidiary itself, the subsidiary would be entitled to Section 501(c)(3) status.⁴²⁰

Focusing on whether GHP's affiliation with the Geisinger System enhanced GHP's exempt nature, the Third Circuit found that by virtue of the association, GHP did not serve a broader patient base in the community than if unaffiliated.⁴²¹ The court concluded that GHP failed to receive the requisite boost needed to satisfy the integral part doctrine.⁴²²

Under the available alternatives, a non-staff model HMO either may seek I.R.C. § 501(c)(3) status on a stand alone basis or pursuant to the integral part doctrine. If tax-exempt status is sought on the former basis, the HMO must satisfy the community benefit standard on its own accord. However, under current case precedent and IRS interpretations that have not treated non-staff model HMOs as health care providers,⁴²³ attainment of that goal appears unlikely. Absent satisfaction of the community benefit test on a stand alone basis, an HMO affiliated with health care providers would have an opportunity to

⁴²⁰ *Geisinger II*, 30 F.3d at 501. The first prong of the Third Circuit test is essentially the second segment under the Tax Court's test.

⁴²¹ Prior to the Third Circuit decision in *Geisinger II*, the tax bar, the Tax Court, and the IRS had focused on whether the subsidiary furthers the parent's tax-exempt purpose. The Third Circuit's approach appears to approach the question from the opposite direction—that is, does the subsidiary's affiliation with the parent enhance the subsidiary's tax-exempt purpose? However, one commentator has pointed out that the Third Circuit's ruling may "simply be another way of saying that the subsidiary must further the parent's exempt purposes." LaVerne Woods, *The Third Circuit's Integral Part Test in Geisinger Health Plan: Implications for Integrated Delivery Systems*, 10 EXEMPT ORG. TAX REV. 1351, 1354 (1994). The commentator elaborated:

Viewed in this light, the second prong of the Third Circuit's test is not novel at all, but rather a restatement of the first prong, i.e., that the subsidiary's activity must not be an unrelated trade or business if conducted by the parent. Any activity of the subsidiary that would not constitute an unrelated business if conducted by the parent must by definition further the parent's exempt purposes. Under this interpretation, while the Third Circuit formally declined to address the issue of whether GHP's activities would be an unrelated business if carried on by its exempt affiliates, it effectively decided that the activities were unrelated by finding that GHP received no "boost" from the relationship.

Id. at 1354 (citation omitted).

⁴²² *Geisinger II*, 30 F.3d at 502.

⁴²³ See *supra* notes 238–56 and accompanying text.

qualify vicariously if it could satisfy the two rigorous requirements of the integral part doctrine.

4. Tax Exemption of Management Services Organization ("MSO") in MSO Model IDS

a. *In General*

MSO model IDSs are less integrated than foundation model IDSs. The MSO is organized typically as a separate for-profit or not-for-profit entity.⁴²⁴ The IRS does not view an MSO as a health care provider, but rather as a health care arranger or facilitator.⁴²⁵ Through funding often provided by an affiliated hospital, the MSO purchases the tangible assets of a medical group. The MSO then turns around and under contract with the hospital and physicians furnishes for their use real and personal property—facilities, equipment, etc.—as well as administrative and management services.⁴²⁶ The medical group continues to own the medical practice itself (i.e., the intangible assets), and its physicians directly deliver medical services to patients.⁴²⁷ Thus, an MSO is essentially a joint venture between a hospital and a physician group; as part of its management responsibilities, it may assume an insurance type function by monitoring finances and physician performances in the provision of managed care.⁴²⁸

Although to date, the IRS has not ruled officially on the tax-exempt status of an MSO under I.R.C. § 501(c)(3), it has stated that an MSO is unlikely to qualify for tax exemption.⁴²⁹ The IRS would find

⁴²⁴ See Boisture, *supra* note 95, at 280; Peters, *supra* note 92, at 28–14. Instead of organizing the MSO as a separate entity, it may be formed as a division of the hospital. *Id.*

⁴²⁵ See *infra* Glossary (describing IDS models); Boisture, *supra* note 95, at 280; Richardson *supra* note 58, at 907; Peters, *supra* note 92, at 28–14. *But cf. supra* note 391 and accompanying text (noting the debate as to health care status versus facilitator status of a medical foundation in a foundation model IDS).

⁴²⁶ See Boisture, *supra* note 95, at 280; Richardson, *supra* note 58, at 907; Peters, *supra* note 92, at 28–14.

⁴²⁷ If the medical practice is a professional for-profit corporation, it employs the physicians.

⁴²⁸ Peters, *supra* note 92, at 28–14.

⁴²⁹ See IRS EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM TEXTBOOK FOR FISCAL YEAR 1995 [hereinafter IRS-1995 TEXTBOOK] (basing the position on the prohibition against excessive private benefit by participating physicians and on the lack of charitable purpose); Paul Streckfus, *Report on the 8th Annual ALI-ABA Course of Study on Tax Exempt Charitable Organizations, Held on December 2–3, 1993 in Washington, D.C.: Sullivan Gives Health Care Tax Update*, 9 EXEMPT ORG. TAX REV. 27, 27 (1994) (apparently basing the statement on the IRS position with respect to IPAs); see also *infra* Glossary (defining IPA). In Revenue Ruling 86–98, 1986–2 C.B. 74, the IRS denied tax-exempt status to an IPA on the basis that it is a physician owned vehicle used for marketing their professional services and therefore

support in the Third Circuit decision in *Geisinger I*.⁴³⁰ The court denied I.R.C. § 501(c)(3) treatment to a non-staff model HMO on the ground that the HMO was not a health care provider and hence did not satisfy the community benefit test on a stand alone basis.⁴³¹ Because the IRS does not consider an MSO to be a health care provider, it would refuse I.R.C. § 501(c)(3) status to an MSO on a stand alone basis.⁴³²

its purpose primarily benefits its physician owners in violation of the prohibitions against private inurement and private benefit. See also *Peregrine & Broccolo*, *supra* note 381, at 124.

However, there may be an argument, albeit weak, for tax-exempt treatment of a university hospital affiliated not-for-profit MSO. In a recent private letter ruling, the IRS ruled that a not-for-profit provider based PPO, qualified for I.R.C. § 501(c)(3) treatment. Priv. Ltr. Rul. (Feb. 17, 1995), available in Internal Revenue Service, *University Affiliated Health Care Inc. Qualifies for (c)(3) Exemption*, 11 EXEMPT. ORG. TAX REV. 825, 826 (1995). Participants in the PPO included a university hospital, clinical practices affiliated with the university hospital, and the physicians of the hospital and clinical practices. *Id.* The IRS noted that PPO membership was represented by two groups: the university hospital and the clinical practices, the former of which had effective veto power over PPO actions. *Id.* A similar veto power existed with respect to actions voted on by the board of directors, which is composed of five physicians, two hospital directors, and four clinical practice presidents. *Id.* The PPO would negotiate contracts with third-party payers and providers of medical services, with each such contract negotiated at arms length, and with compensation based on a fixed amount for each service rendered. *Id.* The PPO would provide its own administrative and operations personnel. *Id.* The IRS found that the PPO qualified under the community benefit standard because it would "enhance the ability of the Clinical Practices to attract a continuum of patients with diverse medical problems to the medical school. The operation of these clinics contributes to the ability of the hospital and its faculty to teach their medical students." *Id.*

This liberal approach is unlike the strict stance that the IRS takes with respect to most PHOs—that is, the organization will fail to qualify for tax-exempt treatment because the organization serves the private interests of the participating physicians and lacks a charitable purpose. See IRS-1995 TEXTBOOK, *supra*; *Participation in PHO Will Not Jeopardize Tax-Exempt Status*, 10 EXEMPT ORG. TAX REV. 1323 (1994) [hereinafter *PHO Ruling*] (reprinting a private letter ruling that addresses the tax-exempt status of a hospital on formation of a PHO in which the hospital and physicians each have 50% interests). However, this position is consistent with the rather liberal IRS rulings and court decisions involving medical faculty practice plans affiliated with university teaching hospitals. See, e.g., *University of Md. Physicians, P.A. v. Commissioner*, 41 T.C.M. (CCH) 732 (1981); *University of Mass. Medical Sch. Group Practice v. Commissioner*, 74 T.C. 1299 (1980); *B.H.W. Anesthesia Found. Inc. v. Commissioner*, 72 T.C. 681 (1979); see also *Peregrine & Broccolo*, *supra* note 385, at 124.

An MSO might be able to qualify for I.R.C. § 501(c)(4) status under the less rigorous community benefit standard, which does not appear to require health care provider status. See *supra* notes 242–56 and accompanying text (discussing *Geisinger I* and the community benefit rule with respect to an HMO qualifying for I.R.C. § 501(c)(4) but not (c)(3) tax-exempt status).

⁴³⁰ See *supra* notes 254–56 and accompanying text.

⁴³¹ See *supra* notes 255–56 and accompanying text.

⁴³² Although not addressed officially by the IRS with respect to IDSs, one might raise the question of whether any IDS component must qualify as a health care provider for tax exemption under I.R.C. § 501(c)(3). If it is considered essential by the IRS, as seemingly argued in *Geisinger I*, with respect to an HMO which was part of an IDS, it appears that an MSO would not be entitled to qualify for tax-exempt status under I.R.C. § 501(c)(3). See *supra* notes 255–56 and accompanying text (discussing health care provider status of stand alone HMOs); *infra* notes 433–38 and

b. *Integral Part Doctrine*

It is unclear whether an MSO might qualify for I.R.C. § 501(c)(3) status under the integral part doctrine. As set forth in the Third Circuit's decision in *Geisinger II*, the organization must satisfy a two-prong test under the doctrine. First, the organization seeking tax-exempt status must not carry on an unrelated trade or business if it were conducted regularly by the parent organization. The Third Circuit cited as illustrative of this prong an example in Treasury regulation section 1.502-1(b), which describes "a subsidiary organization which is operated for the sole purpose of furnishing electric power used by its parent organization, a tax-exempt organization, in carrying out its educational activities." It appears that a hospital-controlled MSO is analogous to the electric power subsidiary described in the regulations.⁴³⁵ An MSO functions as a management organization which, under contract, provides management services essential to the contracting hospital and physicians. If a hospital-controlled MSO did not exist as a separate entity, the hospital would provide these essential manage-

accompanying text (discussing possible impact of integral part doctrine and Third Circuit holding in *Geisinger II* on MSOs).

The argument that the IRS considers provider status essential, or at least helpful, for IDS components to qualify for tax-exempt status is bolstered by assertions of a former IRS official and current practitioner and commentator, Robert S. Bromberg. Mr. Bromberg has argued that, at least in California, the foundation in a foundation model IDS is a provider of health care. Bromberg, *supra* note 92, at 336. Mr. Bromberg suggested that provider status is permitted and was always intended for the foundation under the California Health and Safety Code, § 1206(l). *Id.* Mr. Bromberg distinguished the foundation from the MSO on this basis and labeled the MSO as a "facilitator or arranger." *Id.* According to Mr. Bromberg, the IRS may view the foundation as a health care provider. Furthermore, the IRS may have failed to articulate that it actually requires health care provider status for tax-exempt qualification by IDS components. If so, an MSO would be unable to qualify.

The IRS might further support its argument by reliance on the rules prohibiting private inurement and excessive private benefit. An MSO formed by a hospital-physician relationship is akin to a hospital-physician joint venture. If the MSO were governed by the rules applied to hospital-physician joint ventures, the MSO could run afoul of the proscription against excessive private benefit and the prohibition against private inurement. For example, if the MSO were capitalized by the tax-exempt hospital and were to purchase the assets of affiliated physician medical practices at other than arms length, fair market value, private benefit and inurement concerns would be triggered. *See also* Boisture, *supra* note 95, at 280-81.

⁴³⁵ From a recent private letter ruling it appears that, in order not to jeopardize the hospital's own tax-exempt status, physician ownership of the MSO could not exceed 50%. *See PHO Ruling*, *supra* note 429 (a private letter ruling that addresses the tax-exempt status of a hospital on formation of a PHO in which the hospital and physicians each have 50% interests). If an MSO seeks tax-exempt status vicariously through a tax-exempt hospital under the integral part doctrine, the hospital's own tax-favored status must not be jeopardized. Thus, the MSO would need to be hospital controlled. The amount of physician control—whether limited to 20% pursuant to IDS standards—is uncertain. *See supra* notes 399, 402-03 and accompanying text.

ment services for itself either as part of its overall administrative functions or as a separate division. Consequently, such an MSO appears to satisfy the "unrelated trade or business prong" of the integral part doctrine if its activities are conducted on a scale not in excess of that reasonably required by its affiliates.⁴³⁴

The more problematic second prong of the Third Circuit's integral part doctrine requires that the subsidiary's relationship to the parent enhance the subsidiary's exempt charitable character to the point that, when the boost provided by the parent is added, it transforms the subsidiary from an organization undeserving of tax-favored treatment into one deserving tax-exempt status.⁴³⁵ Satisfaction of this prong is uncertain but appears improbable. Although there are major differences,⁴³⁶ an MSO is not totally dissimilar to GHP, the non-staff model HMO in *Geisinger II*. While an HMO is more directly related to the actual delivery of health care services, both organizations provide management support for health care providers. Like an HMO, an MSO can assume some degree and form of insurance-type function if it monitors finances and physician performances in their delivery of managed health care.⁴³⁷ The boost needed, but not received by GHP in *Geisinger II*, according to the Third Circuit, would have been an expansion of GHP's existing patient base—that is, to expand its charitable activities, GHP would have been required to service more patients or a broader and larger community of patients due to its participation in the IDS. An MSO would need a similar increase in its charitable functions or activities through its affiliation. It is rather difficult to conceive of such a boost because an MSO offers largely management and administrative services to support hospitals and physicians; the MSO generally has little relationship to the actual delivery of health care services to the community. Therefore, it supports a charitable purpose but has no independent charitable purpose of its own that can be boosted. Thus, it is unlikely that an MSO would qualify for I.R.C. § 501(c)(3) status under the integral part doctrine.⁴³⁸

⁴³⁴ See Woods, *supra* note 421, at 1353.

⁴³⁵ *Geisinger II*, 30 F.3d 494, 501 (3d Cir. 1994).

⁴³⁶ A major difference between an HMO and an MSO is that the former integrates management and financing functions along with delivering medical care by contracting with physicians, whereas the latter generally is confined to management and financing functions. See *infra* Glossary (describing HMOs and MSOs).

⁴³⁷ See *infra* Glossary (describing MSOs and HMOs).

⁴³⁸ But see Woods, *supra* note 421 (coming to the opposite conclusion but appearing to fail to closely analyze the MSO under the second prong of the Third Circuit's integral part doctrine test).

c. *MSO's Effect on Affiliated Hospital*

An entirely different issue is whether the formation of an MSO would jeopardize the I.R.C. § 501(c)(3) "charitable" organization status of an affiliated hospital. There is little published guidance from the IRS on this topic.⁴³⁹ However, the IRS recently issued a private letter ruling addressing this issue with respect to a PHO.⁴⁴⁰ Because both a PHO and an MSO are generally physician-hospital joint ventures that share similarities,⁴⁴¹ the recent PHO ruling may be indicative of the IRS position with regard to MSOs. In that ruling, the hospital and physicians were each fifty percent members in the PHO, with physician membership established on a per capita basis.⁴⁴² The PHO was formed as a limited liability company. Its major purpose was to act as a vehicle for soliciting and reacting to offers and responses to managed care bids for medical services, to provide a centralized framework for credentialing and educating physicians, and to monitor and improve the delivery of health care.⁴⁴³ The IRS focused primarily on the prohibitions against private inurement and excessive private benefit rather than the community benefit standard and utilized the approach it typically has applied to the foundation model IDSs.⁴⁴⁴ It ruled that

⁴³⁹ On February 17, 1988, the IRS issued an unpublished private letter ruling taking the position that an MSO did not jeopardize the affiliated hospital's tax-exempt status. See Gerald M. Griffith, *Physician "Control" and Section 501(c)(3) Tax-Exempt Status: When a Minority Interest Equals a Majority Interest*, 10 EXEMPT ORG. TAX REV. 121, 123-24 (1994). That ruling emphasized the benefits derived by the hospital from the MSO, including an improvement in the hospital's finances and funds available for tax-exempt purpose activities. *Id.* However, in General Counsel Memorandum 39,862, *supra* note 201, the IRS clearly took the position that financial improvements without a further demonstration of providing benefit to the community is not sufficient for a hospital to qualify for tax exemption. Therefore, it is possible that the February 17, 1988 ruling no longer represents the IRS's position. See Griffith, *supra*, at 124.

⁴⁴⁰ *PHO Ruling*, *supra* note 429. For a definition of a PHO, see *infra* Glossary.

⁴⁴¹ Like an MSO, a PHO typically is a separate entity that serves the affiliated hospital and physicians that created it. Also like an MSO, a PHO may provide management and support services, but is a facilitator rather than a direct health care provider. The PHO is a centralized vehicle through which a hospital and physicians can offer and respond to solicitations from employers, insurers, and other groups for managed health care and can bid to provide managed health care. For further discussion of PHOs and MSOs, see *infra* Glossary.

⁴⁴² *PHO Ruling*, *supra* note 429, at 1323.

⁴⁴³ *Id.*

⁴⁴⁴ See *supra* part IV.F.2. The IRS cited the following factors as influencing its decision: (1) the daily responsibility for management, operations, and decision-making functions were vested in a board of directors and not more than 20% of the board would be composed of medical staff members, former employees, retired medical staff members or their relatives, eligible parties or their affiliates; (2) a separate price negotiation committee had exclusive authority to manage fee schedules and all financial and personnel aspects of managed care contracts; (3) the hospital's interest in the PHO was proportionate to its share of capital contributed to the PHO; and (4) physicians received benefits (profits and cash distributions) in proportion to their capital contri-

the PHO would not adversely affect the hospital's I.R.C. § 501(c)(3) status.⁴⁴⁵

5. Tax Exemption of Superparent in Hospital Network

Consolidations of hospitals into regional networks of affiliated hospitals have become increasingly common as a means of providing a full range of health care services demanded by the public and of creating hospital efficiencies not available on a local level.⁴⁴⁶ As part of these arrangements, a "superparent" or "grandparent," a not-for-profit parent corporation to all of the affiliated hospitals, might be formed. The IRS has clearly expressed its position that, with respect to these "provider networks," each not-for-profit entity, whether hospital or superparent, must qualify for tax-exempt status by its own right.⁴⁴⁷ To so qualify, a community benefit analysis will be undertaken, and the superparent supporting organization must demonstrate that it satisfies the "structural relatedness test"—that is, the particular not-for-profit entity is an integral part of an organizational structure providing community benefit.⁴⁴⁸

One such affiliated network of hospitals with a superparent, which sought tax-exempt status under I.R.C. § 501(c)(3), was Northwestern Healthcare Network.⁴⁴⁹ The network involved multiple hospitals and, in some cases, the hospitals' parent corporations. These entities agreed to affiliate to form a regional academic and research oriented health care network.⁴⁵⁰ A superparent was formed generally to support or benefit and carry out the purposes of the hospitals in the network, to enhance and improve the delivery of high-quality, cost effective health care services on a regional basis, to promote the education of health

bution so that private benefit served by the PHO was incidental. *PHO Ruling*, *supra* note 429. Interestingly, although not mentioned in the ruling, T.J. Sullivan, Special Assistant for Health Care, Office of the Assistant Commissioner for Employee Plans and Exempt Organizations, IRS, has stated that this ruling is based on the integral part theory. Fred Stokeld & Paul Streckfus, *Tax-Exempt PHO Not Your Typical PHO*, *Says IRS*, 67 TAX NOTES 607, 608 (1995).

⁴⁴⁵ *PHO Ruling*, *supra* note 429, at 1325.

⁴⁴⁶ See Griffith & Tomtishen, *supra* note 374, at 709.

⁴⁴⁷ See *Exempt Organizations: 501(c)(3) Hospitals Must Guard Exemption in Acquisitions and Mergers*, *Official Says*, Daily Tax Rep. (BNA), at D-13 (Mar. 6, 1995), available in Westlaw, BNA-DTR file (comments of T.J. Sullivan, Special Assistant for Health Care, Office of the Assistant Commissioner for Employee Plans and Exempt Organizations, IRS).

⁴⁴⁸ *Id.* The organization must be a "supporting" organization within the meaning of I.R.C. § 509(a)(3) (1994), which the IRS has viewed as an integral part of the system within the meaning of Revenue Ruling 78-41, 1978-1 C.B. 148. See, e.g., Priv. Ltr. Rul. 94-260-40 (Apr. 4, 1994); Priv. Ltr. Rul. 92-25-042 (Mar. 25, 1992); Priv. Ltr. Rul. 91-30-002 (Mar. 19, 1991).

⁴⁴⁹ Northwestern Ruling, *supra* note 383.

⁴⁵⁰ *Id.*

care professionals, and to advance scientific research through the collaboration of the affiliated hospitals with Northwestern University and its medical school.⁴⁵¹ Specifically, the affiliation was designed to: (1) coordinate patient care, the result of which would reduce duplication of services and allow more cost effective delivery; (2) offer more specialized services to a larger patient base; (3) enhance clinical, research, marketing, planning, financial and managerial services, and pecuniary and organizational expertise; (4) enhance and improve strategic planning on a regional basis; (5) enhance access to capital markets; (6) access technological and medical advances; (7) promote education of physicians and other health care professionals; and (8) advance science through research.⁴⁵² Focusing on these factors, the IRS essentially weighed whether the superparent, in its own right and as a supporting organization through its affiliation with the entities in the network, would supply an essential service to the network, would be an integral part of the missions of the system, and thereby would enhance the network and benefit the regional community sufficiently to warrant I.R.C. § 501(c)(3) status.⁴⁵³ The IRS reviewed the composition of the governing boards, the Council of Governors and the Board of Directors, and found critical that no more than twenty percent of their representation would be physicians affiliated with the hospitals, their parent corporations or the network.⁴⁵⁴ Based on these features, the IRS granted tax-exempt status to the superparent.⁴⁵⁵

6. Summary

On one level, the criteria for entitlement to tax-exempt status of component institutions of the new and changed health care structures have evolved little during the past twenty-five years. The community benefit standard, the prohibitions against private inurement and excessive private benefit, and the public policy doctrine continue to demand that, on balance, without violating federal laws and policies, a tax-exempt health care organization enhance health care provided to a broad group rather than benefit a private group of individuals. Yet, on a more micro-level, the IRS has tightened certain criteria for determining whether a health care organization in the contemporary health care environment deserves tax-exempt treatment. The IRS has

⁴⁵¹ *Id.*

⁴⁵² *Id.*

⁴⁵³ *Id.*

⁴⁵⁴ Northwestern Ruling, *supra* note 383.

⁴⁵⁵ *Id.*

revived or regenerated its 1956 emphasis on the provision of health care to the medically indigent;⁴⁵⁶ it now views the provision of charity care as an essential component of the community benefit standard as applied to IDSs.⁴⁵⁷ To reflect the perceived composition of the community, the governing board of a newly structured not-for-profit "charitable" health care organization—a PHO, a medical foundation of an IDS, etc.—should not include more than twenty percent physicians.⁴⁵⁸ To demonstrate compliance with the prohibitions against private inurement and excessive private benefit, separate independent committees should be formed to negotiate fee structures and compensation arrangements with medical groups affiliated with an IDS.⁴⁵⁹

Since the mid-1960s, health care relationships and structures have undergone revolutionary transformations. In the same time frame, the tax exemption standards have evolved little and have been marked by a conservative, narrow, and slow approach to rethinking those standards. While this strategy has assured a degree of consistency, the lack of more radical alterations in the criteria for tax-exempt status may have hindered the outreach, effectiveness, and efficiency of our health care system. It is in this light that the following proposal is suggested.

V. PROPOSAL

A. *Background*

Looking at the dramatic changes in our nation's health care delivery system and at the current federal income tax scheme impacting the health care sector, scholars and commentators have suggested several core problems: (1) the need to provide quality health care to the nation's population;⁴⁶⁰ (2) the failure of our health care system to provide those medical services to the medically indigent;⁴⁶¹ (3) the

⁴⁵⁶ See *supra* part IV.B.2.b.

⁴⁵⁷ See *supra* notes 408–11 and accompanying text.

⁴⁵⁸ See *supra* notes 399, 402, 444 and accompanying text.

⁴⁵⁹ See *supra* note 404 and accompanying text.

⁴⁶⁰ See Noble, *supra* note 8.

⁴⁶¹ Public hospitals have the primary burden for caring for the medically indigent. Voluntary not-for-profit hospitals provide a relatively small share of the health care required for persons unable to pay, although there is evidence that urban not-for-profit hospitals, and especially teaching hospitals, provide a significant amount of care to indigents, especially through emergency room care. *IRS Issues Health Care ISP Digest*, *supra* note 87; Richardson, *supra* note 58, at 912; David S. Salkever & Richard G. Frank, *Health Services, in WHO BENEFITS FROM THE NON-PROFIT SECTOR?* 38, 38–54 (Charles T. Clotfelter ed., 1992); Sloan et al., *supra* note 195, at 20–36. For discussion of the provision of uncompensated care by not-for-profit and for-profit hospitals, including controversy over the definition of uncompensated care, see generally GRAY, *supra* note

perception that not-for-profit hospitals have the responsibility to provide uncompensated medical care to persons regardless of ability to pay;⁴⁶² and (4) the failure of the IRS to base deservedness for tax-exempt treatment of hospitals on the provision of health care services to the indigent.⁴⁶³ This list reflects many rather obvious, but questionable, assumptions.

A central supposition is that hospitals' provision of free and below-cost health care to the poor is truly eleemosynary. However, such free and below-cost health care is supported in large part by private payers, generally private insurers. Under hospitals' differentiated systems of charging patients for health care, these private payers, perceived as having the ability to pay higher fees, pay sums in excess of actual health care costs incurred with respect to covered patients. It is the contention of the author that neither the hospitals nor the private payers involved in this cross-subsidization system are acting out of charity in the donative generosity sense of the word. Rather, the behavior of the hospitals and private payers in undertaking these financial arrangements may be driven to some extent by market forces, and, as a result is reminiscent of charity only in its broadest legal sense—that is, the provision of otherwise unavailable medical services to a medically underserved population. Second, it is assumed that not-for-profit hospitals have primary responsibility to furnish medical services to the needy.⁴⁶⁴ Perhaps so, but perhaps not. Instead, under an even more traditional view of social responsibility and of institutions that are in positions of meeting the needs of medically indigent,⁴⁶⁵ maybe it is the responsibility of every health care provider to provide health care to the poor and medically underserved population.⁴⁶⁶ Another underlying assumption is that even in this competitive health care environment, not-for-profit institutions should not be operated in a business-

58; Lewin et al., *supra* note 195; Sanders, *Does Mission Really Matter?*, *supra* note 195; Sanders, *Measuring Charitable Contributions*, *supra* note 195; Steinwald & Neuhauser, *supra* note 34; Arrington & Haddock, *supra* note 195; Herzlinger & Krasker, *supra* note 195; Thorpe & Phelps, *supra* note 195.

⁴⁶² See *supra* note 196 (discussing the perception of persons regarding the provision of charity care by hospitals).

⁴⁶³ See *supra* note 193–94 (citing sources proposing alternative means of defining community benefit).

⁴⁶⁴ It appears that the perception extends not only to public hospitals but also to private not-for-profit hospitals.

⁴⁶⁵ See *supra* notes 21–22, 31–34 and accompanying text (discussing the early role of proprietary and voluntary hospitals).

⁴⁶⁶ This view may apply especially at a time when market forces have placed health costs beyond the means of a substantial proportion of the nation's residents. See *supra* notes 11–13 and accompanying text (describing the percentage of the nation's population without health insurance coverage).

like manner for the purpose of earning a profit.⁴⁶⁷ It is the author's belief that such organizations should be encouraged to use business-like approaches to attain surplus income as long as the surplusage is dedicated to the achievement of the organizations' "charitable" missions.⁴⁶⁸ Additionally, it is assumed that only not-for-profit health care organizations deserve the tax preferred treatment associated with the performance of perceived "charitable" activities. This should not be the case. For-profits should also be entitled to tax benefits if they truly contribute to "charitable-type" activities.

B. Proposed Tax Regime

The author suggests that we set aside these assumptions and conceive an entirely different federal tax regime. This new tax scheme would grant some form of tax-favored treatment to for-profit and not-for-profit health care organizations that engage in the types of charitable activities and programs that society views as valuable and worthy of governmental subsidy through tax relief.⁴⁶⁹ In other words, for purposes of federal taxes (as opposed to state purposes) health care organizations would be "neutered"; they would not be viewed through the for-profit/not-for-profit dichotomy.⁴⁷⁰ The system would be de-

⁴⁶⁷ See *supra* note 196 and accompanying text.

⁴⁶⁸ See generally, Bittker & Rahdert, *supra* note 120, at 307-15.

⁴⁶⁹ A major underpinning of traditional tax theory is the existence of numerous general and specific objectives that the tax system can serve. See Joseph T. Sneed, *The Criteria of Federal Income Tax Policy*, 17 STAN. L. REV. 567, 568-69 (1965). In simple terms, the basic general social, equity, administrative, and economic objectives and criteria of our tax system can be categorized as follows: (1) raising revenues; (2) assuring fair and simple administrability of taxes; (3) promoting stability and economic growth while minimizing interference in an efficient economy; (4) assuring neutrality—equal taxation of persons with equal incomes; and (5) developing a tax system consistent with and for the promotion of the political system and the United States Constitution, including the creation of special incentives. See Daniel Shaviro, *Beyond Public Choice and Public Interest: A Study of the Legislative Process as Illustrated by Tax Legislation in the 1980s*, 139 U. PA. L. REV. 1, 31-108 (1990) (discussing various theories concerning congressional tax legislation); Nancy E. Shurtz, *A Critical View of Traditional Tax Policy Theory: A Pragmatic Alternative*, 31 VILL. L. REV. 1665, 1666 (1986) (suggesting the general purposes that should be served by the tax system); Edward A. Zelinsky, *Efficiency and Income Taxes: The Rehabilitation of Tax Incentives*, 64 TEX. L. REV. 973, 973-74 (1986) (discussing that the inefficiency of tax incentives is widely treated as obvious and well established); see also Boris I. Bittker, *The Property and Vitality of a Federal Income Tax Deduction for Private Philanthropy*, in TAX IMPACTS ON PHILANTHROPY 145, 153-62 (1972) (justifying tax deduction for philanthropy on grounds that it does not violate tax policy precept of equity and efficiency); Susan Fergenbaum & Thomas Jenkinson, *Government Incentives for Historic Preservation*, 37 NAT'L TAX J. 113 (1984). Within certain parameters this approach would attempt horizontal equity—that is, neutrality—between not-for-profit and for-profit health care institutions earning equal incomes.

⁴⁷⁰ Although the author is aware that this stance would result in the abolishment of the charitable deduction for income, gift, and estate tax purposes, contemporary health care organizations receive relatively little support from donations. See Hall & Colombo, *Charitable Status*,

signed to foster the underlying missions of current not-for-profit health care organizations, which are often stated in terms of charity, quality of care, and community service. This approach should result not only in encouraging all health care organizations to conduct charitable activities and programs, but also in reducing criticisms that the tax system places not-for-profit health care organizations in a preferred competitive position as compared with for-profit organizations.⁴⁷¹

1. Tax-Favored "Charitable Activity Expenses"

There are a couple of tax-favored approaches that could be applied to accomplish these purposes. The new tax system might entitle health care organizations to either a federal tax deduction or, preferably,⁴⁷² a refundable and recapturable tax credit⁴⁷³ for "charitable activity expenses." The value of the deduction or tax credit would be determined on a weighted basis.⁴⁷⁴ Similar to the business expense deduction, or perhaps as a subset of I.R.C. § 162(a), the term "chari-

supra note 146, at 406 n.350 (citing National Association of Hospital Development, fiscal year 1987-88 figures indicating 1.6% of member hospitals' "total budgets" from cash donations); *see also* NONPROFIT ALMANAC 1992-93, at 260, 272-73 (Virginia A. Hodgkinson et al. eds., 4th ed. 1993); Foster, *supra* note 57, at 351-52 (citing data from American Association of Fundraising Counsel). It has been said that the primary tax benefits obtained by not-for-profit organizations are those at the state level. *See* Hyman, *supra* note 18, at 330.

This "neutered" approach would have the side effect of making irrelevant issues of private inurement and private benefit, which the IRS seems to spend considerable time monitoring.

⁴⁷¹ *See, e.g.*, OFFICE OF ADVOC., U.S. SMALL BUSINESS ADMIN., ISSUE ALERT: UNFAIR COMPETITION WITH SMALL BUSINESS (1986); OFFICE OF THE CHIEF COUNSEL FOR ADVOC., U.S. SMALL BUSINESS ADMIN., UNFAIR COMPETITION BY NONPROFIT ORGANIZATIONS WITH SMALL BUSINESS: AN ISSUE FOR THE 1980's (3d ed. 1984); Hansmann, *Unfair Competition*, *supra* note 130, at 605; Mancino, *supra* note 34, at 1018.

⁴⁷² The refundable and recapturable tax credit approach is preferable because, by its very nature as an offset against tax liability, it would provide a larger financial incentive for a health care organization than a deduction that serves only to reduce taxable income.

⁴⁷³ A refundable tax credit is one where the credit in excess of the taxpayer's tax liability is refunded by the Treasury and a recapturable tax credit can be carried back and carried forward if unused. *See, e.g.*, 26 U.S.C. §§ 38(c), 39, 55 (1994); *see also* Nina J. Crimm, *A Tax Proposal to Promote Pharmacologic Research, to Encourage Conventional Prescription Drug Innovation and Improvement, and to Reduce Product Liability Claims*, 29 WAKE FOREST L. REV. 1007, 1058 n.268 (1994).

⁴⁷⁴ Because the health care organization would not be considered tax-exempt under I.R.C. § 501(c)(3), previous criticisms of the idea of granting business expense deductions to tax-exempt organizations on the ground that they are not profit-seeking institutions would be unfounded with respect to the proposal. *See, e.g.*, Bittker & Rahdert, *supra* note 120, at 310-13 (proposing income measurement theory to explain income tax exemption based on the absence of a practical and traditional accounting method to measure the net income of not-for-profit organizations and therefore difficult to categorize charitable activity expenses as business expense type deduction). *But see* Atkinson, *supra* note 146, at 611-16 (criticizing the income measurement theory); Hall & Colombo, *Charitable Status*, *supra* note 146, at 385-86 (same); Hansmann, *Rationale*, *supra* note 146, at 59-91 (same).

table activity expenses" would be defined broadly. The definition might include "expenses incurred by a health care provider, arranger, or facilitator organization at cost in the direct or cooperative development, production, and carrying on of 'charitable activities.'" This definition would permit tax-favored treatment to a health care organization, whether or not deemed to be a direct provider of health care.⁴⁷⁵ By opening entitlement to non-providers of health care, greater participation is encouraged by PHOs, MSOs, non-staff HMOs, and other health care organizations currently deemed by the IRS to be health care facilitators or arrangers. Through cooperative efforts, health care provider organizations, facilitators, and arrangers could contribute vitally to the enhancement of health care.⁴⁷⁶

2. "Charitable Activity"

As recognized by the Supreme Court in *Eastern Kentucky Welfare Rights Organization v. Simon*, societal needs and concepts of charity change over time, and thus the definition of the term "charitable activity" must be fluid and sufficiently flexible to account for these forces.⁴⁷⁷ Like proposals previously set forth by organizations and aca-

⁴⁷⁵ See *supra* notes 255-56, 391, 424-32 and accompanying text (regarding health care provider versus arranger or facilitator status).

⁴⁷⁶ Application of the tax-favored treatment to a non-staff HMO would provide impetus for the HMO to pay for medical personnel training or medical research that does not directly benefit their enrollees. HMOs, as cost cutters, have been accused of failing to contribute to the public good. See *Trouble for Teaching Hospitals*, N.Y. TIMES, May 15, 1995, at A16.

⁴⁷⁷ 506 F.2d 1278, 1286-89 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976). The term might be defined to encompass the considerations and approaches proposed by organizations, academicians and state governments in efforts to upgrade and broaden the IRS's community benefit standard. For a rendition of these proposals, see *supra* notes 193-94 and references cited therein.

For example, the term might be defined as follows:

"Charitable activities" by a health care organization shall include the provision of: (1) inpatient or outpatient emergency or non-emergency health care services (including medical laboratory services), prescription medications, and medical devices (as defined by the federal Food and Drug Administration) at or below cost which are directly related to the diagnosis, testing, or treatment of a medical illness or medical condition to persons determined to be at or below the federal poverty line (as redetermined annually by the federal government pursuant to guidelines developed in conjunction with Health and Human Services) and to persons unable to obtain health or hospitalization insurance having a \$500 deductible, having a co-payment requirement in excess of 20% by the insured, and having no waiting period nor pre-existing condition impediment, through group insurance provided by his/her employment or the employment of a relative, or through individual insurance after demonstrating that the individual was rejected for coverage in writing by three state chartered health insurance companies; (2) planned educational programs involving aspects of health care advertised and made available to the urban or rural community or region serviced by the health care organization, as defined in its state articles of incorporation or other state licensing document; (3) educational training to medical staff physicians, nurses and paramedical per-

demicians for redefining the community benefit standard under the current tax regime,⁴⁷⁸ the statutory definition should include—perhaps through a catch-all provision⁴⁷⁹—community- or regional-specific medical activities and programs that are considered worthy of federal tax subsidization. The community/regional specificity would account for location-dependent medical needs and problems. A large urban area in which reside many medically indigent who do not have their own primary care physicians but use emergency rooms for most, if not all, medical care, might require different types of health care programs to provide its population better access to quality health care than a wealthy, well-insured suburban area in which, for the most part, residents have their own physicians. For example, Columbia-Presbyterian Medical Center in New York City recently started a free shuttle service to its newly established nearby clinic.⁴⁸⁰ A person presenting with a medical problem determined not to be an emergency through a nurse-conducted preliminary examination is given an option: either continue to wait for hours until seen by an emergency room physician, or be shuttled by direct van service to the clinic for faster (and cheaper) medical care.⁴⁸¹ This program in the New York City setting is valued. By comparison, the same program in a wealthy suburban area in which ninety-eight percent of the population have health insurance and personal physicians might not be valued.

3. Certification Panel

Similar to provisions recently proposed under the Health Security Act of 1993,⁴⁸² the new tax scheme should incorporate a community-

sonnel; (4) basic science and medical clinical research performed by qualified employees of the organization (alone or by contract with another health care organization), health or medical sciences division in the federal, state or local government, a college, a university, a certified medical school, pharmaceutical company or biotechnology company; and (5) such other medically related services or programs determined as furthering a community's or region's medical needs, access to medical care, and medical goals (with a focus on medical problems of minorities, the poor, and other medically underserved populations) as established through inclusion on the calendar year's annually updated community medical plan by a certification panel, composed of a broad representation of the community formed in accordance with guidelines compiled by the Internal Revenue Service and Health and Human Services.

⁴⁷⁸ See *supra* note 193.

⁴⁷⁹ See *supra* note 477 (providing a catch-all provision in the sample definition).

⁴⁸⁰ See David Gonzalez, *Emergency Room Option: Free Ride to Hospital Clinic*, N.Y. TIMES, July 16, 1995, § 1, at 1.

⁴⁸¹ *Id.*

⁴⁸² See S. 1757, 103d Cong., 1st Sess. (1993) (proposed Health Security Act attempting to

or region-based certification panel.⁴⁸³ This panel would be responsible for developing and disseminating to health care organizations community/regional medical plans—perhaps a five-year and a ten-year plan reviewed and updated biannually—to outline the medical needs, availability of medical care and resources, medical goals of the particular locale, and determinations of the best means of allocating existing and potential medical resources to achieve a level of health care considered sufficient.⁴⁸⁴ The panel would judge the worthiness of a health care organization's particular activities and programs in light of the medical plans. Activities deemed worthy of "charitable activity" status, and therefore entitled to some tax-favored treatment, would then be subject to further scrutiny.

a. *Weight Ranges and Allocations*

Based on the particular community's or region's medical needs and plans, the panel would be responsible for determining the weight to allocate to a particular "charitable activity." The specific weight would be based on a federally approved and regulated scale assigned to broad classes of "charitable activities." Each classification would be assigned a permissible broad range of weights based on general societal priorities (e.g., eighty to one hundred), with overlapping weights allowed among the categories. Some of the categories might include: (1) the enhancement of access for minorities and medically underserved populations to preventive health care services;⁴⁸⁵ (2) the strengthening of the quality of health care treatment; (3) the improvement of access

establish at least annually, a requirement that the health care organization, along with community leaders, assess the health needs of its community and develop a plan to meet those needs).

⁴⁸³ The guidelines for establishing the certification panel would set forth rules for assuring that the panel is composed of a broad group of persons representing the community. If the guidelines limit the physician composition of the panel, they might provide for an advisory group of physicians and nurses that could provide technical assistance and inform the panel of community medical issues observed and requiring attention.

The program might be arranged in a manner similar to the federally mandated certificate-of-need programs that review and approve substantial capital expenditures and new services undertaken by health care providers. See generally 42 U.S.C. § 300m-6 (1982 & Supp. IV 1986), repealed by Act of Nov. 14, 1986, Pub. L. No. 99-660, Title VII, § 701(a), 100 Stat. 3799, 3799 (1986); Robin Dimieri & Stephen Weiner, *The Public Interest and Governing Boards of Nonprofit Health Care Institutions*, 34 VAND. L. REV. 1029 (1981).

⁴⁸⁴ To a large extent, the determination of what constitutes a sufficient level of health care must be made on a political level, after input by the medical establishment and representatives of society, such as educators, social workers, etc.

⁴⁸⁵ This category might include not only meeting the needs of certain socio-economic groups (e.g., prenatal care for poor pregnant women, care for homeless, etc.) but also those of special age groups (e.g., the elderly, children, etc.).

for minorities and medically underserved populations to emergency care services; (4) the encouragement of cooperative clinical research; (5) the stimulation of cooperative basic science research and medical technological advancements;⁴⁸⁶ (6) the development or improvement of training programs for physicians, nurses, and other medical personnel; (7) the development and production of innovative community educational programs; and (8) the enhancement of access to community educational programs for minorities and medically underserved populations.

For argument's sake, the federally approved weight range for the first five categories might be seventy-five to one hundred; the last three classifications might be assigned a scale of sixty to eighty-five. After assigning locally adjusted weight ranges to each broad federal category and disseminating this information, a certification panel would use these ranges as initial guidelines to evaluate an institution's particular charitable activities and programs. Annually, each panel would disseminate the weights that it has assigned to specific charitable activities and programs to the health care organizations within its jurisdiction. This distribution process would permit all health care organizations to make more informed choices when considering programs and activities to undertake.

To illustrate, let's return to the previously described Columbia-Presbyterian clinic and shuttle van program. Let's assume that Columbia-Presbyterian is in the process of considering such a program. The hospital administrators believe that the plan might fall into the first broad category of "charitable activity"—the enhancement of access for minorities and medically underserved populations to preventive health care services. Based on current national societal values and sentiment, the federally approved weight range for the classification is known to be seventy-five to one hundred. The administrators determine from information disseminated by the New York City certification panel that the category into which the shuttle program fits is valued most highly, and because there are no comparable programs in the area, the likelihood of a high rating is increased. Columbia-Presbyterian also discovers through data shared by the New York City panel that other "out-reach" programs have been allocated weights of ninety to ninety-seven.

⁴⁸⁶ Scientific and medical research have long been regarded in this country as fundamental to the health care system. Research has been perceived as integral to new innovations that might conceivably lead to better and/or less expensive treatments, technology, and medications, as well as advances in preventive medicine. See Crimm, *supra* note 473, at 1017, 1039, 1078-81; see also DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS, 162-75 (1990).

The hospital administrators submit a detailed proposal for the shuttle program, and on review the certification panel indicates that it ultimately will assign a rate of ninety-eight if certain modifications are made. Columbia-Presbyterian agrees to make the changes and earns the ninety-eight weight.

Comparatively, a panel in another location might assign a weight range of between eighty and ninety to the same broad federal category and ultimately allocate a weight of eighty-four to the same type of shuttle program. In both cases, the determinations are based on the federally approved weight range, the medical plans of the community or region, and the program's uniqueness in the community. Additionally, certification panels would be able to share information on their weight ranges, which inevitably would be factored into decisions and weight allocations.

The next step in the process would convert the assigned weight into a percentage (e.g., ninety or one hundred percent). The health care organization would utilize the percentage to calculate the deduction or tax credit available for expenses incurred and directly related to the "charitable activity." In other words, the percentage would be multiplied by the "charitable activity expenses." That figure would be the deductible expense or amount of tax credit.

b. *Report Cards*

As another incentive for a health care organization to participate in the development, production, and carrying on of "charitable activities," the certification panel would issue "report cards" at the end of every year or two. Each report card would be organization-specific but would supply data to enable the health care organization to compare itself with others. This would be accomplished by tallying and specifying the allocated weights for charitable activities and programs undertaken by each health care organization within the panel's jurisdiction. Thereafter, report card results would be compiled and distributed to the consumers of the community's/region's health care organizations. Health care organizations earning high marks could utilize the results as a marketing tool; consumers would be able to use the data to assist with such medical care choices as selecting an HMO, a hospital for inpatient care, and the like.⁴⁸⁷

⁴⁸⁷ See *Health Care Report Cards*, N.Y. TIMES, July 10, 1995, at A12 (editorial suggesting health care report cards of health plans in order to permit public scrutiny of the plans); Milt Freudenheim, *People Want More Information for Health Choices, Survey Finds*, N.Y. TIMES, Sept. 17, 1995, § 1, at 38 (reporting on the findings of a new survey by Louis Harris and Associates).

4. Summary

The tax regime proposed by the author to stimulate discussion is complex, and likely to pose numerous administrative challenges—but, so is the current system. The proposed system is designed to foster the underlying missions of current not-for-profit health care organizations, which are often stated in terms of charity, quality of care, and community service. It attempts to provide a broad base of support for improving health care delivery, quality, access, and research; for training medical personnel; for providing health care education to communities' populations; for educating consumers about health care providers, facilitators and arrangers; and for advancing medical technology. It promotes cooperative, as well as independent, efforts of health care organizations for the achievement of these goals. It acknowledges that health care needs and values for comparable health care activities and programs may be location-dependent. It is devised to be sufficiently flexible in its implementation to account for changing societal values and sentiments, as well as evolving health care structures. Finally, it is intended to strengthen the ability of independent and affiliated health care organizations to achieve financial and structural efficiencies.

CONCLUSION

Federal tax laws, and therefore IRS interpretations, have failed to keep up with the quickly evolving health care environment, perceived medical needs, and societal values. Scholars, commentators, legislators, tax administrators, and representatives of interest groups have repeatedly discussed this problem, but solutions are still in the making. At this time, a number of bills await the attention of Congress that, if enacted, would change the current progressive income tax system to either a flatter income tax, a flat tax, or a consumption tax system.

While we are in the state of rethinking our federal income tax system, it is appropriate to once again direct attention to the nation's health care system, which is affected by our federal income tax system. The author has reviewed the structural changes in our health care system, has indicated the response of the IRS to the altered health care landscape, and has concluded with a new tax proposal designed to foster the underlying missions of current not-for-profit health care organizations.

Part I began with a brief statement about the federal tax statutes that confer tax-exempt treatment on health care organizations. Focusing largely on the past forty years, part II of the article highlighted the

evolution of the for-profit and not-for-profit dichotomy of our health care system and its delivery structures. Parts III and IV detailed the development and application of criteria utilized by the IRS over the past forty years to determine whether a not-for-profit health care provider, facilitator, or arranger deserved an initial grant or retention of tax-exempt status, with special attention directed to qualification under I.R.C. § 501(c)(3). In particular, it concentrated on the operational exclusivity requirement, the prohibitions against private inurement and excessive private benefit, and the public policy doctrine. It addressed freestanding voluntary hospitals and reviewed the evolution of the applicable criteria under the community benefit standard. It indicated that among the many factors impacting tax-exempt qualification pursuant to that standard, a voluntary hospital has the option of either providing inpatient charity care to the medically indigent to the extent of the hospital's financial ability or of making medical care available on an outpatient basis in its emergency room to medically indigent without discrimination under Medicare and Medicaid laws. By contrast, the article pointed out later that IDSs must satisfy a somewhat different community benefit standard. In that context, it noted that the IRS views charity care as an essential component of the community benefit standard. HMOs and other health care organizations were reviewed in light of the various tests and criteria. Concentrating on HMOs and MSOs in particular, trends were identified concerning I.R.C. § 501(c)(3) tax-exempt status for evolving health care structures. Speculations were set forth that tax-exempt qualification in the future for such organizations may turn on classification as a health care provider.

After detailing these trends and noting that the IRS seems to be taking a rather slow, deliberate, and conservative tack (including the regeneration of a charity care requirement), it was suggested that the federal tax system has not kept pace with the swift and dramatic changes in our health care system's delivery structures. To renew the impetus to totally rethink the impact that the federal tax system has on the health care sector, part V presented a proposal for a new tax plan to foster financial support for the underlying missions of current not-for-profit health care organizations.

The proposed tax plan attempts to achieve a number of goals that the current tax system may not be accomplishing. It strives to promote cooperative and independent efforts of health care providers, facilitators, and arrangers for the achievement of numerous goals: the improvement of health care delivery, quality, access, and research; the stimulation of medical personnel training and medical technological

advances; and the enhancement of health care education to communities' populations and of consumer education about health care organizations. It attempts not to hinder health care organizations' quests for financial security and efficiency. As conceived, it incorporates flexibility to account for changing societal values and sentiments, as well as evolving health care structures. Never losing sight of these goals and attempting to dispel certain assumptions made about our current health care and federal tax systems, the tax proposal provides an alternative means of reacting to limitations inherent in the intersection of those two systems as they now exist.

GLOSSARY

Dedicated and Ordinary Group Model HMO. See HMO, Dedicated and Ordinary Group Model.

Diagnostic-Related Groups (DRGs). Diagnostic-related groups were first introduced in 1975 as a measurement of a hospital's output based on patient groups by discharge diagnosis. They subsequently were extended to nonhospital medical care to establish a means of setting uniform reimbursement. Patients are grouped by homogeneous disorders or medical conditions for reimbursement purposes. There are 467 specific categories and one catchall classification representing "other" procedures.

Exclusive Provider Organization (EPO). An exclusive provider organization is a hybrid between a PPO and an HMO. An EPO is a means of directing enrolled patients to health care providers within a specific provider network. An enrollee has the choice of paying to see a physician or to be treated in a hospital outside of the established network, or to use the contractual network of physicians with the EPO assuming full responsibility to pay the providers. Some PPOs have offered EPO options. The dominant distinction between an EPO and an HMO is that generally the EPO is not at financial risk for providing health care services to enrollees.

Foundation Model IDS. See IDS, Foundation Model.

Health Maintenance Organization (HMO). HMOs are organizations that integrate the financing, management, and delivery functions of medical care by contracting to provide medical services to an enrolled population on a prepaid basis. Their purpose is to provide health care at low costs, i.e., a form of managed care. HMOs began as an alternative form of health care delivery in 1929, but after slow acceptance, they finally became a focus of health care in the 1970s.

There are basically four models of HMOs: the independent practice association model, the network model, the staff model, and the group model. There are two types of group model HMOs, a dedicated group model and an ordinary group model.

HMO, Dedicated and Ordinary Group Models. In the dedicated group model, the HMO contracts with the physicians to provide medical services at the HMO's facilities. Physicians in an ordinary group model may treat patients who are not members of the HMO.

HMO, Independent Practice Association Model (IPA). Independent physicians and groups of physicians, provide their services to HMO subscribers at their own medical facilities. The IPA contracts with the HMO on behalf of the physicians.

HMO, Network Model. Two or more independent medical groups provide services to HMO subscribers at the medical groups' own facilities. Usually the medical groups contract with more than one HMO and also maintain a fee-for-service practice.

HMO, Staff Model. Physicians are the direct employees of the HMO and provide medical services exclusively to HMO-enrolled patients at the HMO's facility.

Horizontal Networks of Hospitals. Affiliated hospitals that can include acute-care hospitals as well as specialized hospitals, such as pediatric, psychiatric, and oncology hospitals.

Independent Practice Association Model (IPA) HMO. See HMO, Independent Practice Association Model.

Integrated Delivery System (IDS). IDSs are organized primarily for the purpose of penetrating the managed care business. The health care industry defines an IDS as a group of affiliated organizations joined to provide comprehensive managed health care services to patients. Therefore, it is a network of health care providers, arrangers, and facilitators which may, but do not necessarily, include a payment component (e.g., an HMO). By comparison, the IRS defines an IDS as a "health care provider (or one component entity of an affiliated network of providers) created to integrate the provision of hospital services with professional medical (e.g., physician) services."

Various levels of integration exist, but at a minimum, an IDS delivers hospital, physician and related ancillary services. In its simplest form, an IDS may be created by a hospital that hires physicians who thereafter provide medical services as salaried employees. More complex IDSs provide fuller groups of services, such as preventive medicine, rehabilitation, long-term care, hospice care, and mental health care. Currently, there are three IDS models: the foundation model, the management services organization (MSO) model, and the total integration model.

IDS, Foundation Model. In the medical foundation model, a hospital forms a nonprofit affiliated corporation (a medical foundation) that generally reports to a tax-exempt parent. (The parent is usually a corporate member of the foundation and of the hospital.) The

medical foundation is governed typically by a board of trustees with hospital, medical group, and community representatives. The medical foundation is responsible for providing health care services, and to do so, contracts with one or more physician groups for the delivery of outpatient medical services to the foundation's patients. The foundation acquires the tangible and intangible assets of the physician group, so the medical foundation owns all medical practice assets and the medical practice itself. The foundation can employ all nonphysician personnel and supply all administrative and managerial services necessary to operate a medical practice. This model is typical of those states, such as California, Wisconsin, Texas, and Pennsylvania, that restrict the ability of a nonprofit corporation, such as a hospital, to employ physicians. The foundation model structure satisfies the technical requirements of those laws by having the group practice, usually a professional for-profit corporation, employ the physicians.

IDS, Management Services Organization (MSO) Model. In the MSO model, a hospital and physician group remain separate but are bound together by contract. The MSO, generally a nonprofit or for-profit corporation, is governed by representatives of the hospital and physician group. Like a medical foundation, an MSO owns most or all of the tangible assets (e.g., equipment, office facilities, etc.); however, the MSO leases these assets and management services and nonphysician personnel back to the hospital and physician group pursuant to a management services agreement. Through the professional services agreement, the group of physicians, who, unlike in the medical foundation model IDS, continue to own and operate their medical practice, provide all professional medical services. Thus, the MSO functions as a management component, part of which is an insurance function in that the MSO monitors finances and physicians' performances.

IDS, Total Integration Model. The total integration model is a single delivery entity that results from the legal merger of the hospital and physician group or groups. Total integration model IDSs will not be found in California and other states whose laws prohibit hospitals from employing physicians.

Managed Competition. Managed Competition is price competition, with total annual premiums paid for comprehensive health care services as the focal point.

Management Services Organization (MSO) Model IDS. See IDS, Management Services Organization Model (MSO).

Network Model HMO. See HMO, Network Model.

Physician-Hospital Organization (PHO). A physician-hospital organization is usually formed as a limited liability company or as a corporation. It is analogous to an IPA that includes a hospital and seeks payer contracts with HMOs and employers. Therefore, a PHO is a vehicle through which a hospital's medical staff of physicians and the hospital can offer and respond to solicitations from large employers, insurers, and other managed care groups, and can bid to provide health care. Basically, then, a PHO is a collective negotiating entity that enables physicians and hospitals to contract with HMOs, large employers, and health insurance companies. A PHO may also provide management and support services, as does an MSO. A PHO is a centralized framework for credentialing and educating physicians and for monitoring health care improvements. It does not require the integration of financial incentives common to an IDS. Typically, the physicians and hospital govern the PHO. The physicians retain autonomy over clinical decisions. The hospital provides administrative and financial expertise to manage capitated payments.

Preferred Provider Organization (PPO). A preferred provider organization is a hybrid health care payer system that developed through the 1970s and 1980s in response to the economic pressures of rising health care costs, competition for patients resulting from excess provider capacity, and significant increases in indemnity health insurance premiums. A PPO is essentially a network of hospitals, physicians, and other health professionals who, under contract, provide health care services at an agreed price to a group of beneficiaries. PPO arrangements then are a form of managed care that combine features of managed care and indemnity insurance. The arrangements typically encompass sets of contractual relationships between the PPO and health care providers, and between the PPO and the beneficiaries. Reimbursement of the physicians and other health care providers is predetermined on a prospective pricing basis, which reflects a negotiated fee-for-service payment rather than a capitated payment.

PPOs take on a variety of forms, depending on the sponsor. A "provider-based" PPO is a group of physicians or hospitals, or both, that contracts with commercial insurers or self-insured employers for

the provision of health care to their patient base. A "payer-based" PPO is owned by the payer or insurer, or both, which negotiates and maintains a contract with physicians and hospitals to furnish health care to beneficiaries/patients. An "employee-owned" PPO is formed and owned by a group of employees who are neither providers nor payers, but whose responsibilities are exclusively to manage the ongoing operations of the PPO. In this form of PPO, the payer could be either a commercial insurer or a self-insured employer. An "entrepreneur-based" PPO typically provides administrative services, such as organizing the payment of insurance claims, to a related third party who secures agreements with both the insurance payer and the physicians and hospitals.

One of the principal distinctions between PPOs and HMOs is that the former rarely submits the health care provider to financial risk with respect to the economic outcome associated with the actual delivery of the health care services. Moreover, PPOs have permitted the health care provider to maintain a fee-for-service practice and payment structure. Finally, PPOs typically give patients the final choice in selecting their physicians or hospitals.

Prospective Payment System (PPS). A reimbursement system first utilized on a large scale by Medicare. It strives to standardize payments to health care organizations for the provision of medical services. Payment is fixed and predetermined as based on the diagnostic-related groups.

Staff Model HMO. See HMO, Staff Model.

Total Integration Model IDS. See IDS, Total Integration Model.

Vertical Integration. In the context of managed care and health care organizations, physicians, HMOs, hospitals, clinics, and other health care organizations combine or consolidate, often under a parent corporation, to offer health care services. Efficiency, price competition, and full range health care services are common goals of vertical integration.