

# Putting the Community Back in Community Benefit: Proposed State Tax Exemption Standard for Nonprofit Hospitals

MICHELE R. GOODMAN\*

## INTRODUCTION

Are philanthropists really interested in funding innovative, cutting-edge healthcare and community projects?<sup>1</sup> Robert Goldstein, a managing partner at the New York hedge fund Gotham Capital, would answer this question with a resounding “yes.”<sup>2</sup> In 2001, Mr. Goldstein’s mother was diagnosed with advanced ovarian cancer. With a desire to improve her bleak prognosis, Mr. Goldstein sought out numerous specialists hoping to hit upon the greatest “new idea” in cancer research.<sup>3</sup> Mr. Goldstein soon ran into a common research roadblock: competition over grants and patents produces a culture of secrecy, which stands in the way of idea sharing.<sup>4</sup>

After his mother’s passing, Mr. Goldstein, along with a business partner, Joel Greenblatt, decided to donate one million dollars of their own money to cancer research.<sup>5</sup> However, rather than donate to cancer research in the typical fashion, where donations are funneled into an organization for general research purposes, they decided to start the Gotham Prize for Cancer Research. Applicants may submit any novel cancer research idea through the Web site<sup>6</sup> regardless of their ability to see it through. All idea submissions are posted on the Web site to encourage research sharing. The one million dollar prize will be awarded each year to the best new cancer research idea and the money may be used for anything the recipient wishes.<sup>7</sup> While criticized as something short of the best possible use of the money, “the unusual nature of the prize illustrates the lengths to which patients and patient advocates are increasingly willing to go to boost research into their disease.”<sup>8</sup>

What if patients were willing to go to the same lengths to selectively improve the availability of healthcare in their communities? Further, what if potential donors like Goldstein and Greenblatt could be attracted to nonprofit hospitals willing to invest in

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\* J.D. Candidate 2009, Indiana University Maurer School of Law — Bloomington. In loving memory of Daniel Goodman.

1. Dr. Leland Kaiser, associate professor in health administration and former hospital administrator, believes that philanthropists have lost interest in traditional hospital fund-raising projects and are instead drawn to exciting and innovative healthcare projects. See Leland R. Kaiser, *Funding Innovation with Philanthropy*, Philanthropy Series - 7, [http://www.kaiser.net/seriesdetail.cfm?article\\_id=291](http://www.kaiser.net/seriesdetail.cfm?article_id=291).

2. This introduction describes the story of the Gotham Prize for Cancer Research. See Amy Dockser Marcus, *Will Sharing Ideas Advance Cancer Research?*, WALL ST. J., Sept. 18, 2007, at D1.

3. *See id.*

4. *See id.*

5. *Id.*

6. Gotham Prize for Cancer Research, <http://www.gothamprize.org/>.

7. Dockser Marcus, *supra* note 2.

8. *Id.*

medical innovation? With the soaring number of uninsured in America,<sup>9</sup> many are looking for nonprofit hospitals to accommodate the increasing societal demand for charity care. Such accommodation would justify the generous federal and state tax exemptions received by charitable hospitals.<sup>10</sup> Senator Charles Grassley, Ranking Member of the Senate Finance Committee, has been particularly vocal on the subject. Raising concerns about community benefit standards in the nonprofit healthcare industry, Grassley contends that “hospitals are all over the map in defining charity care. We need common terms and measurements so taxpayers can have confidence that nonprofit hospitals are providing benefits commensurate with the billions of dollars in tax breaks they receive every year.”<sup>11</sup> While hospitals sift through myriad guidelines as to what constitutes community benefits and how they should be measured,<sup>12</sup> perhaps healthcare policymakers should take note of the community’s stance on how the community should benefit.

With the ability to affect public health policy through donative behavior, the community can both directly and indirectly influence healthcare policy. First, donations can ease the mounting financial pressures on nonprofit hospitals.<sup>13</sup> Second, donation levels can signal to policymakers the level of community support, or lack thereof, for each nonprofit hospital’s tax exemption.<sup>14</sup> Under Mark Hall and John Colombo’s donative theory of charitable tax exemption, a nonprofit entity’s deservedness of federal or state tax exemption relates directly to levels of charitable subsidies provided by individual donors. These donors divert some of their otherwise taxable dollars to activities they deem socially valuable.<sup>15</sup> Thus, the theory takes social worthiness determinations out of the hands of government and tax authorities and places them in

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9. U.S. Census figures indicate that the number of uninsured increased from 44.8 million in 2005 to 47.0 million in 2006. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 18 (2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf>.

10. See Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 315 (1991) [hereinafter Hall & Colombo, *Charitable Status of Nonprofit Hospitals*].

11. Press Release, Senator Chuck Grassley, Senate Fin. Comm. (July 19, 2007), available at <http://www.senate.gov/~finance/press/Gpress/2007/prg071907c.pdf>.

12. For a table summary of charity care and community benefit resources available to the healthcare industry, see PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INST., ACTS OF CHARITY: CHARITY CARE STRATEGIES FOR HOSPITALS IN A CHANGING LANDSCAPE 20 (2005).

13. See Jane Haderlein, *Unleashing the Untapped Potential of Hospital Philanthropy*, 25 HEALTH AFF. 541, 541–42 (2006) (stating that a number of factors, including shrinking operating margins and an increase in uncompensated care, are placing financial pressure on nonprofit hospitals and more hospital administrators are turning to philanthropy to relive this pinch).

14. See Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 402–03. For a more detailed description of the donative theory, including an overview of practical implementation and potential impact on the nonprofit sector, see Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. 1379 (1991) [hereinafter Hall & Colombo, *Donative Theory*].

15. See Hall & Colombo, *Donative Theory*, *supra* note 14, at 1431 & n.146.

the hands of individual members of the community.<sup>16</sup> Despite the community focus of the donative theory, legislative entities have not yet implemented the theory in state or federal tax exemption schemes.<sup>17</sup>

Unfortunately, while government entities and representatives of the nonprofit healthcare sector spar over the distinctions between services offered by nonprofit and for-profit hospitals,<sup>18</sup> these government and nonprofit entities have ignored general community opinion outside of the litigation context. Numerous uninsured patients have expressed discontent with nonprofit hospitals through the recent initiation of over fifty lawsuits.<sup>19</sup> These lawsuits allege that hospitals charge unreasonable rates for care, employ aggressive collection techniques, and are unjustly enriched by their concurrent enjoyment of tax exemptions while failing to provide free or reduced-cost healthcare to lower-income patients.<sup>20</sup> Negative national publicity surrounding the lawsuits is drawing public attention to the consensus that not all nonprofit hospitals are earning their exemptions.<sup>21</sup> However, acknowledging the exemption quandary is a long way

16. *See id.*

17. In recent years, John Colombo has even failed to mention the donative theory as a feasible tax exemption solution and instead seems to support an access-enhancing approach to exemption for nonprofit hospitals. *See* John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y & L. 623, 637–38 (2006); *see also* Statement of John D. Colombo, Senate Fin. Comm. Minority Staff Roundtable on Tax Exemption Standards for Nonprofit Hospitals 1–2 (Oct. 30, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg102607c.pdf>. The access enhancing approach is based on the observation that nonprofits provide services not otherwise available from their for-profit counterparts, and such services should be counted, along with charity care, when making exemption determinations. *Id.* However, Colombo admits that this is a fuzzy standard of accountability. Colombo, *supra*, at 638.

18. *See* Harold L. Kaplan & Linda S. Moroney, *Hospitals Face New Financial Threat of Charity Care Legislation*, 25 AM. BANKR. INST. J. 28, 58–59 (2006).

19. *See* Terry Carter, *Who Pays Hefty Hospital Tabs?*, A.B.A. J., Jan. 2005, available at [http://www.abajournal.com/magazine/who\\_pays\\_hefty\\_hospital\\_tabs/](http://www.abajournal.com/magazine/who_pays_hefty_hospital_tabs/).

20. *See* Leah Snyder Batchis, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 506–09 (2005).

In June of 2004, while three congressional committees held hearings on the crisis of access to affordable hospital care by uninsured Americans, dozens of uninsured patient plaintiffs . . . filed more than fifty federal lawsuits in twenty-five states against more than 300 non-profit hospitals for overcharging uninsured patients in violation of state and federal law.

*Id.* at 495 (citations omitted).

21. *See id.* at 538; *see also* Reed Abelson & Jonathan D. Glater, *Suits Challenge Hospital Bills of Uninsured*, N.Y. TIMES, June 17, 2004, at C1 (discussing the attention drawn to hospitals' billing and collection practices as a result of patient lawsuits). Legislators responded by proposing reforms such as rigid charity care and community benefit formulas, enhanced reporting requirements, and limitations on debt collection practices and amounts charged to uninsured patients. *See* Kaplan & Moroney, *supra* note 18, at 58. Hospital proponents argue that such stringent requirements would increase the number of nonprofit hospitals operating at a loss, which would result in numerous bankruptcies and increasing costs for insured patients and private payers. *See id.* at 28–29 (discussing the Illinois Hospital Association's response to proposed Illinois legislation that would require all tax-exempt hospitals to provide charity care

from identifying and implementing an administrable solution that incorporates community preference.<sup>22</sup>

This Note supports donative theory as a mechanism to distinguish between nonprofit hospitals that fulfill their charitable purpose and nonprofit hospitals that violate their “explicit or implied contract with the government”<sup>23</sup> to provide affordable healthcare in exchange for beneficial tax exemptions. Donations could provide a direct measure of public support. Further, tethering exemptions to donative support would hold nonprofit hospitals continuously accountable to the communities they serve. This Note will evaluate the current legislative landscape for federal and state tax exemption and propose revisions that could incorporate donative theory and give the community an effective voice in exemption determinations.

Part I of this Note will review the history of nonprofit hospital tax exemption and discuss current federal and state legislation including the shortfalls of approaches adopted by federal and various state governments. Part II will critically examine the difference between nonprofit and for-profit hospitals, with a particular emphasis on the differences that exist beyond the provision of free care for the indigent population. Part III will provide an overview of Hall and Colombo’s donative theory of the charitable tax exemption and its potential application to nonprofit hospitals. Part IV proposes new state legislation, incorporating both charity care requirements and donative theory. Part IV also explains how policymakers could integrate donative theory to more objectively determine which nonprofit hospitals meet acceptable community benefit standards.

Part V discusses recent trends in hospital philanthropy that may make the application of donative theory, as a descriptive theory of community desire, more accurate than it seemed when first proposed in 1991. Part V will review the information on hospital finances and hospital quality available to already motivated donors and will build on this discussion by providing a glimpse at the new IRS Form 990. Form 990 greatly increases reporting requirements for nonprofits providing community benefits. Enhanced filing requirements, in turn, will provide more information to the community. With a renewed interest in hospital philanthropy and its recent emphasis on making informed donation decisions, the community can provide legislators with a particularly useful perspective concerning the desired mix of available nonprofit, government, and for-profit healthcare.

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in an amount at or above eight percent of their total operating costs). Others argue that legislators are overlooking the possibility that nonprofit hospitals offer unprofitable, but desirable services, such as trauma centers, that would not otherwise be available in a largely for-profit healthcare market. See Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 *YALE J. ON REG.* 139, 194 (2007).

22. Interestingly, it may also be time for the community to become its own spokesperson. Richard Scruggs, the lead attorney behind the class action suits against nonprofit hospitals, recently plead guilty for attempting to bribe a judge in a mass settlement between an insurance company and Hurricane Katrina victims. Abha Bhattarai, *Class-Action Lawyer Gets 5 Years in U.S. Bribery Case*, *INT’L HERALD TRIB.*, Aug. 4, 2008 (Web edition), <http://www.iht.com/articles/2008/06/27/business/28tort.php>.

23. Batchis, *supra* note 20, at 507.

## I. HISTORY AND EXISTING LAW OF THE NONPROFIT HOSPITAL TAX EXEMPTION

Charitable organizations have enjoyed a long history of exemption from both federal and state tax, dating at least as far back as the Revenue Act of 1894.<sup>24</sup> The notion of charity as caring for the poor and less fortunate dates even further back to the days of ancient Egypt.<sup>25</sup> Because of this extensive history, scholars note that the custom of exempting charitable organizations is now inherent in our tax laws.<sup>26</sup> But as the nonprofit hospital form has evolved, so has the basis for its exemption.

A. *The Evolution of the Nonprofit Hospital and the Federal Tax Exemption*

Nineteenth century nonprofit hospitals were established by religious societies, funded largely by donations, and operated primarily to serve the poor and indigent population.<sup>27</sup> This is the early notion of “charity care” in the healthcare context, as hospitals were often the only source of medical assistance available to those unable to afford private professional medical care.<sup>28</sup> Early nineteenth century hospitals were often termed “voluntary hospitals,” because the “hospitals’ income was derived largely or entirely from voluntary charitable donations, not government subsidies, taxes, or patient fees.”<sup>29</sup> With a mission founded on the relief of poverty, voluntary hospitals fit squarely within the definition of “charitable.”<sup>30</sup>

The classification of hospitals as traditional charitable organizations became increasingly cloudy during the late nineteenth and early twentieth century.<sup>31</sup> Technological developments in healthcare delivery and surgical techniques attracted paying patients,<sup>32</sup> and a newly cultivated interest in health insurance introduced third-

24. Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 310 & n.2.

25. See Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL’Y 302, 304 (2007).

26. See Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 310.

27. See *id.* at 318.

28. See Jardon McGregor, *supra* note 25, at 305. However, early hospitals served more of a welfare function rather than a medical function, assisting patients primarily through religious and moralistic avenues. *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 270 n.7 (Utah 1985).

29. *Utah County*, 709 P.2d at 270.

30. See NICHOLAS P. CAFARDI & JACLYN FABEAN CHERRY, UNDERSTANDING NONPROFIT AND TAX EXEMPT ORGANIZATIONS 143 (2006).

Voluntary hospitals were charities for the quite obvious reason that they housed and tended to those who were both sick and poor, i.e., those without resources and in need of charity. Because hospitals performed no medical treatment function and because they were largely institutions for the poor, the nonpoor in need of medical treatment and their treating private physicians overwhelmingly avoided them. *Utah County*, 709 P.2d at 270 n.7.

31. See generally Jardon McGregor, *supra* note 25, at 306–10.

32. See Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 319. Rather than something that could only be obtained by the wealthy through private practitioners, the practice of medicine became increasingly associated with hospitals. See *Utah County*, 709

party payers into the system.<sup>33</sup> Health insurance gained popularity as the demand for and cost of medical care increased. Cost increases derived in part from advances in anti-infection techniques, which moved treatments once performed in private homes to hospitals. Additionally, increased physician licensure requirements bolstered patients' faith in medicine and in hospitals as an institution for healing, thereby increasing demand.<sup>34</sup> Changes in government tax policy also led to the growth of the health insurance industry. Generally, employers and employees were not taxed on contributions to employee health plans, and insurance plans became bargaining chips used by employers to attract workers.<sup>35</sup>

The government also increased access to healthcare benefits by passing Medicare and Medicaid program legislation in 1965. In 2004, Medicare and Medicaid, along with the State Children's Health Insurance Program (another public health expenditure) provided financing for \$607 billion in healthcare services.<sup>36</sup> The dollar figures flowing into the healthcare system are staggering, with health spending increasing from \$27.6 billion in 1960 to \$916.5 billion in 1993.<sup>37</sup> As a result of these changes and the lucrative opportunities they created, for-profit entities began to enter the healthcare market. Faced with new competitors, "nonprofit hospitals have increasingly taken on the appearance of business enterprises by serving mostly paying patients, decreasing their reliance on donations or volunteer labor, and striving to generate as much surplus revenue as possible through commercial transactions."<sup>38</sup> Taken together, these factors indicate a "substantial change in the nature of the hospital; a part of that change was the gradual disappearance of the traditional charitable hospital for the poor."<sup>39</sup>

In response to these drastic changes in the form and behavior of nonprofit hospitals, the charitable purpose determination for tax-exempt status under Section 501(c)(3) of the Internal Revenue Code (IRC) has taken on several new shades of gray.<sup>40</sup> In 1956,

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P.2d at 270 n.9 ("[H]ospitals ceased being custodial holding institutions for the poor and instead became centers of medical treatment, especially surgery, attractive, for the first time, to private physicians and paying patients.").

33. See Jardon McGregor, *supra* note 25, at 307.

34. See Melissa A. Thomasson, *From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance*, 39 EXPLORATIONS ECON. HIST., 233, 235–37 (2002).

35. See *id.* at 240–41 (discussing employers' use of health benefits to attract and retain workers during the wage and price controls of World War II, and the codification of the special tax treatment of employer contributions to health plans in the Internal Revenue Code of 1954).

36. EARL DIRK HOFFMAN, JR., BARBARA S. KLEES & CATHERINE A. CURTIS, CENTERS FOR MEDICARE & MEDICAID SERVICES, BRIEF SUMMARIES OF MEDICARE AND MEDICAID 4 (2006).

37. *Id.*

38. Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 319.

39. *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 271 (Utah 1985).

40. The IRC does not specifically exempt healthcare activities, but voluntary hospitals fall within the exemption for organizations operated for charitable purposes. Section 501(c)(3) exempts organizations from federal income tax that are "organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes . . . or for the prevention of cruelty to children or animals." I.R.C. § 501(c)(3) (2006). In order to qualify as a charitable organization under section 501(c)(3) the entity must: "(a) be organized as a nonprofit corporation under state law and comply with that state's requirements; (b) comply with the proscription against private inurement; (c) comply with the nontax federal health regulatory statutes, including the Medicare fraud abuse laws prohibiting patient dumping; and (d) meet the 'community benefit' standard." Gabriel O. Aitsebaomo, *The Nonprofit Hospital: A*

Revenue Ruling 56-185 stated that a nonprofit hospital “must be operated to the extent of its financial ability for those not able to pay.”<sup>41</sup> This ruling reflected the traditional notion of charitable purpose, requiring hospitals to provide a certain amount of free care to the indigent population (charity care).

Lobbyists from the nonprofit industry claimed that the advent of Medicare and Medicaid would reduce the need for charity care and therefore make it difficult to meet exemption requirements.<sup>42</sup> With the support of these lobbyists, Revenue Ruling 69-545 relaxed the exemption requirements for nonprofit hospitals.<sup>43</sup> It recognized a promotion of public health standard as a *per se* charitable purpose.<sup>44</sup> A substantial factor in determining whether a hospital promotes public health is operation of an emergency room that does not deny treatment on the basis of ability to pay.<sup>45</sup> Essentially, the IRS merely redefined “charitable purpose” to allow nonprofits to maintain exemption in a changing healthcare system rather than undertaking an analysis of whether the exemption itself is indispensable in a changing healthcare system.<sup>46</sup> Nevertheless, the standard was relaxed even further with Revenue Ruling 83-157, which removed the emergency room requirement as long as other significant factors<sup>47</sup> indicate that the hospital is operating exclusively to benefit the community (the “community benefit” standard).<sup>48</sup> One problem with a loosely defined community benefit standard is that it does not clearly differentiate the behavior necessary for a nonprofit to gain exemption status from the behavior of a regular for-profit hospital.<sup>49</sup>

Courts have interpreted the 1983 ruling to mean that in order to justify the charitable exemption, nonprofit hospitals must make their services available to the

*Call For New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption*, 26 CAMPBELL L. REV. 75, 81 (2004). For a brief overview of hospital changes during the twentieth century and corresponding Revenue Rulings from the Internal Revenue Service (IRS), see CAFARDI & CHERRY, *supra* note 30, at 143–46.

41. Rev. Rul. 56-185, 1956-1 C.B. 202.

42. See M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 305–06 (1995).

43. See Rev. Rul. 69-545, 1969-2 C.B. 117 (“Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost.”).

44. See *id.* (“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.”).

45. See *id.*

46. Revenue Ruling 69-545 was challenged, but was upheld by the D.C. Circuit based on a broad interpretation of charitable purpose. See *E. Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1287–88 (D.C. Cir. 1974) (“[T]here is no authority for the conclusion that the determination of ‘charitable’ status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society.”), *vacated*, 426 U.S. 26 (1976).

47. Significant factors include “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 the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research.” Rev. Rul. 83-157, 1983-2 C.B. 94.

48. See *id.*; see also Jardon McGregor, *supra* note 25, at 315–16.

49. See Colombo, *supra* note 17, at 626 (noting that one basic requirement of the community benefit standard is treatment of Medicare/Medicaid patients, and even for-profit providers treat Medicaid patients).

entire community *plus* provide additional public benefits.<sup>50</sup> Courts have enumerated several ways to navigate the “additional plus” inquiry, such as provision of free or below-cost services, conducting research, or offering free education to the public.<sup>51</sup> However, courts have yet to define “exactly which or how much of these ‘plus’ behaviors are necessary to exemption.”<sup>52</sup>

With neither the IRS nor the courts able to provide a precise definition of community benefit, the 1983 ruling appears to have no workable rationale and leaves some critics wondering whether to abolish it as a “historical relic.”<sup>53</sup> Was the promotion of a public health standard an attempt to bring the exemption in line with contemporary society, or was the IRS swayed by a strong nonprofit lobby?<sup>54</sup> Ironically, the government passed Medicare provisions in favor of community demand for nationalized health insurance despite years of strong opposition from the medical profession.<sup>55</sup> Perhaps the government should once again look to community demand to re-evaluate tax exemption for modern nonprofit hospitals.

### *B. The State Tax Exemption*

In addition to the federal income tax exemption, nonprofit hospitals must navigate a maze of state income, property, and sales tax exemptions, which are no less critical to the hospitals’ ability to function.<sup>56</sup> Taken together, the value to nonprofit hospitals of state and federal tax exemptions was \$12.6 billion in 2002, with the state and local exemptions accounting for half.<sup>57</sup> Roughly half the states automatically grant income tax exemption to organizations that have obtained federal income tax exemption status.<sup>58</sup> A majority of states regard the promotion of health for the benefit of the community as a charitable purpose, regardless of whether the organization is providing free or below-cost care to the poor.<sup>59</sup> However, a significant minority of states have

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50. *See* IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1198 (10th Cir. 2003).

51. *See id.* at 1200–01.

52. Colombo, *supra* note 17, at 626.

53. *See generally* M. Gregg Bloche, *Tax Preferences for Nonprofits: From Per Se Exemption to Pay-For-Performance*, 25 HEALTH AFF. W304 (2006).

54. *See* Bloche, *supra* note 42, at 309–10 (arguing that the IRS reviewed the charity care requirement under the watchful eye of nonprofit lobbyists and failed to seek input from the general public).

55. The American Medical Association successfully defeated proposals for nationalized health plans in 1935 and 1949. *See* Melissa Thomasson, *Health Insurance in the United States*, in *EH.NET ENCYCLOPEDIA* (Robert Whaples ed., 2003), <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

56. *See* David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J.L. & MED. 327, 330 (1990) (stating that losing state property tax exemption would increase the tax burden on hospitals by \$1.35 billion).

57. CONG. BUDGET OFFICE, *NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS* 3 (2006).

58. Kathryn J. Jervis, *A Review of State Legislation and a State Legislator Survey Related to Not-for-Profit Hospital Tax Exemption and Health Care for the Indigent*, 32 J. HEALTH CARE FIN. 36, 38 (2005).

59. These states adopt the federal view. *See* Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 323–24.



grown dissatisfied with the ambiguity surrounding the federal community benefit standard and tightened their charity care and reporting requirements in response to a recent wave of state property tax exemption challenges.<sup>60</sup> The minority state statutes can be grouped into two categories: (1) the process approach, which requires a community needs assessment and planned response to those needs; and (2) the prescriptive approach, which requires minimum amounts of charity care and/or community benefit.<sup>61</sup>

### 1. The Process Approach: California

The process approach has been adopted in several states including California, Indiana, Idaho, and New York.<sup>62</sup> California will be used as a process approach model because despite having a relatively high number of uninsured residents,<sup>63</sup> the state favors the process approach over recent efforts to enforce more stringent charity care requirements.<sup>64</sup> The California statute does not adhere to a strict charity care or community benefit standard. Instead, it emphasizes regular community needs assessments and the development of community benefit plans (CBPs) in response to those needs.<sup>65</sup> Nonprofit hospitals must conduct a community needs assessment every three years that evaluates “the health needs of the community serviced by the hospital.”<sup>66</sup> This assessment must include a “process for consulting with community groups and local government officials in the identification and prioritization of community needs.”<sup>67</sup> The hospital must also submit an annual CBP to the Office of Statewide Health Planning and Development<sup>68</sup> that includes the following: (a) mechanisms to evaluate the plan’s effectiveness, *including a method for soliciting the views of the community served by the hospital*; (b) measurable objectives to be achieved within specified timeframes; and (c) categorized community benefits.<sup>69</sup>

Criticisms of the process approach<sup>70</sup> echo those of the federal tax exemption. The lack of uniform reporting requirements and quantitative/qualitative standards for

60. See Jervis, *supra* note 58, at 40–41; see also Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 324. In 2004, charity care legislation was introduced in sixteen states and passed in nine; legislation was introduced in another fifteen states in 2005, including Indiana, Mississippi, Maryland, Wyoming, and Washington. PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INST., *supra* note 12, at 12–13.

61. Batchis, *supra* note 20, at 511.

62. *Id.*

63. See Jervis, *supra* note 58, at 50 (noting that over twenty percent of California’s population was uninsured between 2001 and 2003).

64. See S.B. 24, 2005–2006 Leg., Reg. Sess. (Cal. 2005) (requiring nonprofit hospitals to provide charity care at a certain percent of net patient revenues).

65. See Aitsebaomo, *supra* note 40, at 97 (providing an overview of the California legislation and definition of community benefits).

66. CAL. HEALTH & SAFETY CODE § 127350(b) (West 2006).

67. *Id.*

68. *Id.* § 127350(d).

69. *Id.* § 127355 (emphasis added).

70. Indiana has also employed the process approach to charity care and community benefit legislation. The statute very much mirrors California’s statute. See, e.g., IND. CODE § 16-21-9-4 to -8 (2008).

determining the community benefit make the review of CBPs complicated and inconclusive.<sup>71</sup> Furthermore, in some states, submitted CBPs garner little attention due to insufficient funding or infrastructure to properly review and audit the information provided.<sup>72</sup> “Thus, the regulation’s status is effectively that of a self-reporting mechanism rather than traditional regulation.”<sup>73</sup> In response to this criticism, scholars suggest that communities should have more of a voice in the process; this could be achieved by determining acceptable benefit standards and holding hospitals accountable for meeting those standards, thereby enhancing the regulatory effect of the provision.<sup>74</sup> Under a donative theory, the community could serve this function by researching information reported by nonprofit hospitals before making charitable contributions.

## 2. The Prescriptive Approach: Texas

The prescriptive approach has been adopted in a handful of states, including Pennsylvania, Utah, and Texas.<sup>75</sup> Texas was the first state to employ the prescriptive approach by mandating specific requirements for charity care and community benefits.<sup>76</sup> The legislation was enacted as a direct response to a suit brought by the Attorney General of Texas against one of the state’s largest nonprofit hospitals for not providing sufficient charity care.<sup>77</sup> Under the statute, a nonprofit hospital must develop a CBP<sup>78</sup> and an organizational mission statement that outlines the hospital’s commitment to serving the healthcare needs of the community.<sup>79</sup> However, in order to qualify as a charitable organization for state property tax exemptions, hospitals must also comply with one of the following charity care and community benefit standards:

(1) charity care . . . must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;<sup>80</sup>

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71. See Kevin M. Wood, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make Any Difference?*, 20 REV. LITIG. 709, 735 (2001) (citing Alice A. Noble, Andrew L. Hyams & Nancy M. Kane, *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116 (1998)).

72. See *id.*

73. *Id.*

74. See Noble et al., *supra* note 71, at 131.

75. Batchis, *supra* note 20, at 511; Wood, *supra* note 71, at 725.

76. See Wood, *supra* note 71, at 725 (noting that Texas passed this new charity care/community benefit legislation in 1993). In early 2006, Illinois Attorney General Lisa Madigan proposed similar legislation in Illinois that would require all tax-exempt hospitals to provide uncompensated care in an amount equal to or greater than eight percent of their total operating costs. See Kaplan & Moroney, *supra* note 18, at 28. This proposed legislation has yet to pass.

77. See Aitsebaomo, *supra* note 40, at 93.

78. TEX. HEALTH & SAFETY CODE ANN. § 311.044(a)(2) (Vernon 2001).

79. *Id.* § 311.044(a)(1).

80. TEX. TAX CODE ANN. § 11.1801(a)(1) (Vernon 2004).

(2) charity care . . . must be provided in an amount equal to at least four percent of the hospital's or hospital system's net patient revenue;<sup>81</sup>

(3) charity care . . . must be provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits,<sup>82</sup> excluding federal income tax;<sup>83</sup> or

(4) charity care and community benefits must be provided in a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care . . . [is] provided in an amount equal to at least four percent of net patient revenue.<sup>84</sup>

It is important to note the difference between charity care and community benefit. Charity care is the unreimbursed cost of providing medical care to the financially indigent.<sup>85</sup> Community benefits—which may include charity care—also include the unreimbursed cost of providing donations, health education services, research, and other subsidized health services.<sup>86</sup> Charity care is the central focus of the Texas statute; community benefits enter the calculus in the fourth exemption option, but that provision still requires charity care equal to four percent of patient revenue.<sup>87</sup>

Some critics are concerned about the prescriptive approach's focus on charity care. First, charity care measurements may be inconsistent across the board.<sup>88</sup> The amount of charity care a hospital provides can be computed from the hospital's actual costs *or* its charges (which are greater),<sup>89</sup> and costs can be derived from average costs *or* marginal costs.<sup>90</sup> Also, opinions differ as to whether bad debt (unpaid bills) should count as charity care. It is ideal for lower-income patients to be guaranteed at the outset that they will not be charged for treatment rather than receiving a bill and haggling with

81. *Id.* § 11.1801(a)(2). “‘Net patient revenue’ is an accounting term and shall be calculated in accordance with generally accepted accounting principles for hospitals.” TEX. HEALTH & SAFETY CODE ANN. § 311.042(8).

82. Tax-exempt benefits means: “the dollar amount of federal, state, and local taxes foregone,” plus “the dollar amount of contributions received,” plus “the value of tax-exempt bond financing received.” TEX. HEALTH & SAFETY CODE ANN. § 311.042(12).

83. TEX. TAX CODE ANN. § 11.1801(a)(3).

84. *Id.* § 11.1801(a)(4).

85. TEX. HEALTH & SAFETY CODE ANN. § 311.031(2).

86. *Id.* § 311.042(2).

87. TEX. TAX CODE ANN. § 11.1801(a)(4).

88. *See* Colombo, *supra* note 17, at 636–37 (explaining common disagreements regarding charity care measurement methodology).

89. *See* John D. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 LOY. U. CHI. L.J. 493, 511–12 (2006) (“[U]sing charges to measure charity care is patently ridiculous. . . . [H]ospitals operate akin to hotels, which have a ‘rack rate’ for their rooms. Like the rack rate on hotel rooms, virtually no one actually pays the hospital’s ‘rack rate’ for services . . .”).

90. *See id.* at 512–13. Marginal cost measures prevent hospitals from being credited for overhead that they would have invested for paying patients regardless. However, marginal cost measures tend to overlook the fact that hospitals need to replenish their assets in order to continue providing services, whereas average cost measures, favored by most academics, include this fact and tend to be more of a “true” measure in the long run. *See id.*

collection agents.<sup>91</sup> However, the hospital will go unpaid either way and “if [the] government keeps piling on uncompensated care obligations without some kind of offsetting revenue enhancement, the hospital will simply no longer be able to operate.”<sup>92</sup>

Second, an emphasis on charity care, even if measured by a reasonableness standard, overlooks many of the intangible benefits a hospital may be providing to the community. Nonprofit hospitals may conduct valuable research, offer community outreach and education programs, and provide a mix of unprofitable services that would otherwise be unavailable or hard to access.<sup>93</sup>

Third, linking the exemption directly to charity care could encourage many uninsured to forego preventive health services in lieu of free emergency room and other hospital services.<sup>94</sup> It is generally accepted that providing preventive treatment is much more cost effective than treating people in an emergency room when they are seriously ill.<sup>95</sup>

Finally, many worry that a bright-line state or national charity care requirement would “sink some hospitals.”<sup>96</sup> Critics doubt the viability of applying the same formula to nonprofit hospitals in rural, low-income urban neighborhoods, and wealthy suburbs,<sup>97</sup> moreover, many small, urban hospitals, already weak economically, might not survive the loss of tax-exempt status. A case study evaluating the effect of losing tax-exempt status authored by PricewaterhouseCoopers’ Health Research Institute estimated that a typical 300-bed acute care hospital with a \$6.5 million tax benefit, including over \$5 million in state tax exemptions, would go from a 2.6% profit margin to a loss without the exemptions.<sup>98</sup>

Clearly, neither the process nor the prescriptive approach guarantees that nonprofit hospitals are earning their exemptions through provision of charity care or substantial community benefits. Former IRS Commissioner Mark Everson once pushed for “better

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91. *See id.* at 513.

92. *Id.* As a result, in a 2005 PricewaterhouseCoopers Charity Care Survey, ninety-two percent of responding hospitals indicated that some of their bad debt could be included in charity care calculations. PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INST., *supra* note 12, at 10.

93. *See* Colombo, *supra* note 89, at 515–16.

94. *See* Colombo, *supra* note 17, at 636.

95. *See* Colombo, *supra* note 89, at 516. In Indianapolis, the Health and Hospital Corporation of Marion County, operator of nonprofit Wishard Memorial Hospital, is investing one million dollars annually in the Indianapolis Housing Trust Fund, which provides free or affordable housing to the area’s homeless and low-income families. Matthew Gutwein, president of Health and Hospital Corp., states: “When our patients have access to stable housing, they remain healthier. They use Wishard’s emergency room less. They use Wishard’s ambulance service less. They have less need for long and costly stays in the hospital. This is simply a smart investment for us.” Press Release, Coalition for Homelessness Intervention and Prevention, Indianapolis Housing Trust Fund Gets \$1 Million Annual Boost (Mar. 23, 2007), *available at* [http://www.endlongtermhomelessness.org/press\\_center/indianapolis\\_housing\\_trust\\_fund.aspx](http://www.endlongtermhomelessness.org/press_center/indianapolis_housing_trust_fund.aspx).

96. John M. Quirk, *Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption*, 43 WILLAMETTE L. REV. 69, 90 (2007) (quoting Tiffany Himmelreich of the Ohio Hospital Association).

97. *Id.* at 89–90.

98. *See* PRICEWATERHOUSECOOPERS’ HEALTH RESEARCH INST., *supra* note 12, at 31.

intermediary sanctions . . . so that you don't just have a de minimis penalty or that very strong option."<sup>99</sup>

His statement is evidence that state and national legislators are still at odds over how to best approach exemptions and how best to enforce them. With the ambiguity surrounding tax-exempt status and an increasing number of questions about the uncertain distinction between nonprofit and for-profit hospital operations,<sup>100</sup> legislators could simply abolish the exemptions altogether.<sup>101</sup> However, the lack of a suitable exemption standard should not obscure the important distinctions between nonprofit hospitals and their for-profit counterparts.<sup>102</sup>

## II. THE DIFFERENCE BETWEEN NONPROFIT AND FOR-PROFIT HOSPITALS: LOOKING BEYOND CHARITY CARE

The modern hospital industry consists of three main ownership forms: nonprofit, for-profit, and government facilities. With sixty-eight percent of the nation's 630,000 beds in Medicare-certified community hospitals, nonprofits have the largest representation.<sup>103</sup> Nonprofit hospitals are private, like for-profit hospitals, but subject to non-distribution constraints which require them to invest all revenue surpluses in operations for community benefit.<sup>104</sup> Despite differences in surplus distribution, nonprofits and for-profits have similar cost structures and sources of financial capital.<sup>105</sup> These similarities have led policymakers to question the significance of the nonprofit form.<sup>106</sup>

99. *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways & Means*, 109th Cong. (2005) (statement of Mark Everson, Former Commissioner, Internal Revenue Service), available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=3193>.

100. See Frank A. Sloan, *Commercialism in Nonprofit Hospitals*, 17 J. POL'Y ANALYSIS & MGMT. (SPECIAL ISSUE) 234, 243–45 (1998) (reviewing studies that suggest nonprofit and for-profit hospitals provide similar rates of charity care and earn similar revenues from Medicare and Medicaid).

101. Hyman, *supra* note 56, at 379 (concluding that “[t]here is little in the way of theoretical, intellectual or financial reasoning to maintain the current structure of tax exemption.”); *id.* at 380 (suggesting that “[i]f there is truly a value in the nonprofit form, patients should be willing to encourage their existence directly.”). This assertion is in line with donative theory, which indicates that a nonprofit's deservedness of tax exemption is indicated by the presence of public support. See Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 390.

102. See Mark Schlesinger & Bradford H. Gray, *How Nonprofits Matter in American Medicine, and What To Do About It*, 25 HEALTH AFF. W287, W290–92 (2006) (stating the differences in hospital ownership emerge when studies focus on single services or outcomes rather than combining them into a single analysis).

103. CONG. BUDGET OFFICE, *supra* note 57, at 3.

104. *Id.* at 7; see *supra* note 86 and accompanying text (defining “community benefit”).

105. See Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1360 (2003).

106. See CONG. BUDGET OFFICE, *supra* note 57, at 8 (“Two studies have also reported that when nonprofit hospitals were acquired by for-profit corporations, they did not reduce their provision of uncompensated care or other community benefits.”); see also Horwitz, *supra* note 21, at 153–56.

In response to this growing line of questions, several empirical studies have compared nonprofit and for-profit hospitals' behavior, levels of uncompensated care, and provision of other services. For instance, for-profit hospitals, since they are not subject to profit distribution constraints, tend to favor profit-maximizing behaviors.<sup>107</sup> In the 1980s, adjustments made to the Medicare reimbursement system enabled hospitals to bill Medicare twice for acute care services by billing once for the acute visit and again for the follow-up visit.<sup>108</sup> However, the Balanced Budget Act of 1997 put an end to the profitability of post-acute care through limitations on Medicare payments.<sup>109</sup> For-profit hospitals responded to both of these changes to a higher degree than both nonprofit and government hospitals, greatly increasing their post-acute service offerings when they were profitable and decreasing them when profitability disappeared.<sup>110</sup> In addition, for-profits are more likely to inflate diagnosis codes<sup>111</sup> in order to obtain higher rates of reimbursement.<sup>112</sup>

As previously discussed, legislators have focused on the provision of charity care in determining whether a nonprofit hospital has earned its tax-exempt status. Numerous researchers have looked at levels of uncompensated care provided by for-profit and nonprofit hospitals, often to find very small differences.<sup>113</sup> In 2006, the Congressional Budget Office (CBO) examined data from hospitals in California, Florida, Georgia, Indiana, and Texas.<sup>114</sup> Adjusting for possible confounding variables such as hospital size, location, percent uninsured, and community income level, the data indicated that nonprofit hospitals provided 0.6 percentage points more uncompensated (charity) care, a small but statistically significant difference.<sup>115</sup> Notably, the CBO found that this disparity was due solely to nonprofit status.<sup>116</sup> While not providing a strong argument

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107. See Horwitz, *supra* note 105, at 1367–76.

108. *Id.* at 1370.

109. *Id.* at 1371.

110. *Id.*

111. Diagnosis codes are standardized numeric codes that define the medical condition treated for billing and reporting purposes.

112. Horwitz, *supra* note 21, at 157. Other studies indicate that nonprofits charge lower prices or markups than do for-profits. Several studies have also concluded that for-profit hospitals appear to react more strongly than nonprofits do to the reimbursement environment by altering the mix of services they provide, by limiting increases in the wages of hospital employees, and by more aggressively coding services provided so as to increase reimbursement rates.

CONG. BUDGET OFFICE, *supra* note 57, at 9; see also Schlesinger & Gray, *supra* note 102, at W289–91 (noting that in a review of 162 studies, for-profit hospitals consistently inflated prices).

113. CONG. BUDGET OFFICE, *supra* note 57, at 8.

114. *Id.* at 1–2.

115. *Id.* at 10–15. The CBO estimates that if nonprofit hospitals in the five states provided the same level of uncompensated care as similar for-profit hospitals, they would have provided \$100 million to \$700 million less than they actually did provide. *Id.* at 15.

116. *Id.* at 16–17 (noting the similarity between unadjusted charity care results and results adjusted for location, income, poverty, rate of uninsured). This is contrary to previous studies, which noted that location accounted for any differences in provision of charity care. See generally Edward C. Norton & Douglas O. Staiger, *How Hospital Ownership Affects Access to Care for the Uninsured*, 25 RAND J. ECON. 171 (1994).

in favor of nonprofit form,<sup>117</sup> the results did indicate that differences in the provision of uncompensated care between nonprofit and for-profit hospitals were the largest in Texas and Indiana, which impose the strictest requirements on nonprofit hospitals.<sup>118</sup>

However, more meaningful differences between nonprofit and for-profit hospitals emerge when looking beyond uncompensated care to the provision of other services. According to the CBO research, nonprofit hospitals were significantly more likely than for-profit hospitals to provide emergency room care as well as labor and delivery services, both identified as generally unprofitable services.<sup>119</sup> In her research, Jill Horwitz also noted that for-profit hospitals were less likely than nonprofits to offer unprofitable services, such as psychiatric emergency care, and for-profits were slightly more likely than nonprofits to offer profitable services, for example, open heart surgery.<sup>120</sup> This tendency to provide more unprofitable services, when combined with other behavioral aspects of nonprofit hospitals—such as willingness to locate in impoverished communities and ability to survive harsh economic climates—may markedly increase access to healthcare for both insured and uninsured in certain communities.<sup>121</sup>

Another line of research shifts the focus from analyzing nonprofit and for-profit hospitals in isolation to establishing the most efficient mix of hospital ownership.<sup>122</sup> This research is pertinent given the commercialization of the healthcare industry over the past century.<sup>123</sup> In a market where nonprofit and for-profit hospitals exist together, the competition may influence operational changes in both ownership types.<sup>124</sup> Nonprofits can suffer from inefficient production of services due to the lack of oversight from shareholders with financial incentives.<sup>125</sup> However, with competition from cost-conscious for-profit hospitals, nonprofits will implement cost-effective strategies to remain competitive.<sup>126</sup> And for-profits, in order to compete with the public's assumption that nonprofits are more "trustworthy" (because they are not motivated by profits),<sup>127</sup> will increase their quality of care.<sup>128</sup> The ideal ownership mix

117. Some studies indicate, however, that the difference between for-profits and nonprofits in provision of charity care is increasing as the healthcare market becomes more competitive. See Schlesinger & Gray, *supra* note 102, at W293 & n.23.

118. CONG. BUDGET OFFICE, *supra* note 57, at 17.

119. *Id.* at 20 ("Those services were selected because they have been identified by other researchers as being generally unprofitable.").

120. Horwitz, *supra* note 21, at 175. In order to classify services by profitability, Horwitz reviewed a variety of sources: Medicare payment reports, physician salaries, socioeconomic and insurance status of patients, interviews with hospital administrators and physicians, and trade journal reports of profitability. See *id.* at 164–65.

121. See Schlesinger & Gray, *supra* note 102, at W296 ("The combined impact of these practices may be multiplicative, rather than additive.").

122. See generally Rexford E. Santerre & John A. Vernon, *Hospital Ownership Mix Efficiency in the US: An Exploratory Study* (Nat'l Bureau of Econ. Research, Working Paper No. 11192, 2005).

123. See *supra* notes 27–39 and accompanying text.

124. See Santerre & Vernon, *supra* note 122, at 3–5.

125. See *id.*

126. See *id.*

127. One 1995 survey reported that sixty-five percent of Americans believe that nonprofit hospitals are more beneficial to the community than for-profits. KAISER FAMILY FOUND.,

is likely to vary by community and consumer demand.<sup>129</sup> This would indicate the need for a tax policy sensitive to this variation to ensure nonprofits remain in place where they are most beneficial to their respective communities.<sup>130</sup>

Research, therefore, supports the more general concern that by tying exemptions directly to provision of charity care—excluding other community benefits—legislators may very well overlook community-valued services that nonprofit hospitals are more likely to provide. A statewide or nationwide charity care requirement would also threaten the exemption status and, potentially, the existence<sup>131</sup> of nonprofit hospitals that help to maintain an efficient mix of ownership types in certain communities.

A community benefit analysis, exemplified by California's process approach, would provide a community focus to help alleviate these concerns. However, policymakers would still be left with the ambiguous definition of community benefit and lack of infrastructure to review community reports. Rather than relying on specific legislative enactments dictating which services a community should value, legislation based on donative theory would allow communities to justify nonprofit hospital exemptions by deciding which healthcare services are important and how to benefit from them.

### III. THE DONATIVE THEORY OF TAX EXEMPTION

#### *A. Donative Theory Overview*

In *Bob Jones University v. United States*, the Supreme Court stated that “[w]hen the Government grants exemptions or allows deductions all taxpayers are affected; the very fact of the exemption or deduction for the donor means that other taxpayers can be said to be indirect and vicarious ‘donors.’”<sup>132</sup> However, Mark Hall and John Colombo contend that while the “government can coerce purchase [of health services] by everyone via the power of taxation,” sometimes the government fails to provide “the optimal level of a public good.”<sup>133</sup> Hall and Colombo believe that legislators can

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SURVEY ON AMERICANS' PERCEPTIONS ABOUT FOR-PROFIT AND NOT-FOR-PROFIT HEALTH CARE (1995), available at <http://www.kff.org/insurance/1107-profittop.cfm>.

128. See Santerre & Vernon, *supra* note 122, at 3–5 (noting that researchers have found support for this in the nursing home market, where increase in nonprofit market share improved the overall quality of for-profit nursing homes).

129. In an empirical analysis of hospital data from 1999, Santerre and Vernon suggest that for-profit hospitals should maintain a greater market share when inpatient care is the community focus, and nonprofit hospitals should increase their market share in outpatient services. *See id.* at 11–13.

130. This Note does not maintain that nonprofit hospitals are justified in every community, or that all nonprofit hospitals should be granted exemption from state income and property tax. Some nonprofit hospitals have been able to operate and maintain nonprofit status after losing their tax exemption. See Bruce Japsen, *Despite Taxes, Provena Hospital Healthy*, CHI. TRIB., Nov. 1, 2007 (Web edition), [http://www.chicagotribune.com/business/chithu\\_notebook\\_1101nov01,0,954482.story](http://www.chicagotribune.com/business/chithu_notebook_1101nov01,0,954482.story) (describing Provena Covenant Medical Center's ability to triple operating cash flow despite paying more than \$5 million in property taxes after losing its state tax-exempt status).

131. This assertion assumes that the nonprofit hospital sector could not continue operation without tax exemptions. *See, e.g., supra* note 98 and accompanying text.

132. 461 U.S. 574, 591 (1983).

133. Hall & Colombo, *Donative Theory, supra* note 14, at 1391.



remedy this sub-optimal provision of affordable and accessible health services by recasting the view of the community as direct, rather than indirect, donors: “Because the impulse to give stems from the public’s recognition of a socially valued service, the donative theory assures that donations are directed to activities worthy of subsidy.”<sup>134</sup> The theory postulates that activities worthy of support are consistently underfunded and therefore need to be subsidized through public donations.<sup>135</sup> The tax exemption for nonprofit organizations then acts as a “shadow subsidy,” allowing the charitable contributions to “go further” and enable the organization to supply more socially worthy activities by relieving it of tax obligations.<sup>136</sup>

Donative theory is based on the economics of the private market and the notion of public goods. Public goods are goods that will not be depleted as people use them and goods which, once produced for an individual consumer, may be consumed by all.<sup>137</sup> Public goods are undersupplied in the private market because consumers typically have little or no incentive to pay for their share of the good due to free-riders—consumers who refuse to contribute after realizing that other consumers will pay for the public good.<sup>138</sup> Theoretically, the government should be able to compensate for the free-rider problem by mandating the purchase of public goods through taxation.<sup>139</sup> However, Hall and Colombo argue that the voting majority largely dictates governmental policy decisions, leaving certain underrepresented segments of voters powerless to express their public-good needs through the voting mechanism.<sup>140</sup> These voters may then rely on making voluntary contributions to desired organizations to sustain provision of what they deem to be “preferred public goods” (such as various healthcare services).<sup>141</sup> The contributions can then serve as a form of community needs assessment under the process approach to tax exemption.<sup>142</sup> And since donations are relatively easy to measure and review, executing the process approach through review of donative behavior will bypass many of the criticisms of the traditional process approach.<sup>143</sup>

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134. Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 402.

135. *See id.*

136. *See* Hall & Colombo, *Donative Theory*, *supra* note 14, at 1393.

137. *See* Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 391.

138. *See id.* at 391–92.

139. *See id.* at 392.

140. *See id.* at 392–93.

This system of majoritarian politics works reasonably well provided the desire for a public good is fairly homogenous . . . . This logic does not hold, though, for public goods for which there are heterogeneous, widely divergent tastes. In such situations, voting logic predicts an undersupplied minority of high demanders . . . .

This supramedian group has no ready alternative other than to make voluntary contributions to a private organization.

*Id.* at 394 (citations omitted).

141. *See id.* at 394–95.

142. *See supra* notes 65–69 and accompanying text.

143. Common criticisms include lack of uniform reporting requirements, quantitative standards, and sufficient infrastructure to review reported information. *See supra* notes 70–74 and accompanying text. As compared to a subjective community needs assessment, donations serve as a more direct measure of community support, and measurement procedures would be the same for all hospitals, therefore requiring less time and effort to implement and review.

How much voluntary support must an organization receive from the public to indicate that the organization provides a desirable public good and is therefore worthy of tax exemption? According to Hall and Colombo, the framework for this answer already exists in the Internal Revenue Code and Treasury Regulations. These sources draw distinctions between publicly supported and private charitable entities for the purposes of the charitable gift income tax deduction.<sup>144</sup>

Section 170 of the Code limits the availability of higher charitable deductions (fifty percent of the taxpayer's contribution base as compared to thirty percent for other contributions) to certain types of gifts.<sup>145</sup> Specifically, § 170 requires that qualifying gifts go to a list of organizations grouped by activity, and also to a subcategory of publicly supported entities that receive a *substantial part of their total support* from the general public (gifts, contributions, membership fees, admission fees, sales of merchandise) or the government (grants).<sup>146</sup>

The Code and Revenue Regulations also provide the appropriate definitions of "support" for the gross revenue denominator of the substantial part of total support equation. According to I.R.C. § 509(d), support is the sum of gifts, grants, contributions, membership fees, gross receipts, net income from unrelated business activities, gross investment income, tax revenues expended on behalf of the organization, and the value of services furnished free of charge by the government.<sup>147</sup> Section 170 sets forth a similar definition of support, although it eliminates from the support denominator gross income received in the entity's exercise of its charitable function.<sup>148</sup> Hall and Colombo largely accept the support definition from § 509 for the purposes of the donative theory; however, they would include in the gross revenue base receipts from the sale or exchange of capital assets and receipts from unrelated business income. They contend that the "entity's entire operation is what will receive the benefit of the exemption and will produce the subsidy effect. Accordingly, the base against which to measure donations is simply the gross revenue of the organization."<sup>149</sup>

Under the donative theory, the entity must obtain a certain percentage of this support base of gross revenues from donations in order to qualify as a charitable organization worthy of exemption. Hall and Colombo find the one-third of gross revenue threshold to be an adequate starting point for their theory.<sup>150</sup> This conclusion follows after examining donation revenues of traditional charitable institutions and thresholds noted in Treasury Regulations §§ 509(a)(2) and 170.<sup>151</sup> Despite support for

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144. See Hall & Colombo, *Donative Theory*, *supra* note 14, at 1447.

145. See *id.* at 1447–50.

146. See I.R.C. § 170(b)(1)(A) (2006) (granting a fifty percent of contribution base deduction for gifts to churches, certain medical and educational organizations, governmental units, and organizations which receive a substantial part of their support from contributions).

147. I.R.C. § 509(d) (2006). Hall and Colombo present a thorough comparison of the application of §§ 170 and 509 to the donative theory of tax exemption, so another analysis is not necessary here. See generally Hall & Colombo, *Donative Theory*, *supra* note 14, at 1446–58.

148. See I.R.C. § 170(b)(1)(A)(vi).

149. Hall & Colombo, *Donative Theory*, *supra* note 14, at 1452.

150. See *id.* at 1453–55.

151. See *id.*

the one-third threshold, however, it will jeopardize exemption status for many, if not most, existing nonprofit hospitals, as noted by Hall and Colombo themselves.<sup>152</sup>

### *B. Donative Theory Applied to Nonprofit Hospitals*

Modern nonprofit hospitals receive a very small proportion of their gross revenues from charitable donations, with various statistics indicating donation levels in the range of 0.4 to 2 percent of total hospital revenue.<sup>153</sup> This is a very different picture compared to the early 1900s, when philanthropy accounted for one-quarter to one-third of a hospital's gross operating budget.<sup>154</sup> During this time, many hospitals were formed and managed by religious and ethnic groups and offered distinct value-based treatments.<sup>155</sup> Therefore, the hospitals could attract substantial charitable support from interest groups wishing to ensure that specific services delivered in a specific manner would be available when they were needed.<sup>156</sup> With the introduction of private insurance, Medicare and Medicaid, and direct government subsidies, hospitals began to rely less and less on charitable support.<sup>157</sup>

Hall and Colombo contend that the current "lack of donative support is evidence either that nonprofit hospitals do not provide a service materially different than that otherwise available, or that if they do, they are sufficiently supported in more direct ways."<sup>158</sup> This is so because the donative theory posits that philanthropy exists where desirable public goods are undersupplied by the government and private market.<sup>159</sup>

However, full-service nonprofit hospitals are finding it increasingly hard to cross-subsidize many unprofitable but necessary services (such as emergency rooms) due to insufficient government funding and the loss of paying elective diagnostic and surgery patients to physician-owned and specialty clinics.<sup>160</sup> Critics suggest that "until the pinch becomes severe enough to motivate hospitals to enter the philanthropy market more aggressively, and donors to respond with more enthusiasm . . . [T]here is a weak case for supplementing this support with a tax subsidy."<sup>161</sup> Granting valuable exemptions only to those hospitals with charitable support equal to or greater than one-third of their revenue base could have serious consequences. Most nonprofit hospitals

152. See Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 406–08 (stating that modern nonprofit hospitals receive very little support from public donations, most notably after the introduction of third-party payer systems that replaced the "quasi-insurance function" originally served by donations).

153. See *id.* at 406 n.350.

154. See *id.* at 407 & n.351.

155. See *id.* at 407.

156. See *id.* ("Catholics desired a hospital where last rites would be administered and Jews desired one where the staff spoke Yiddish and served kosher food.").

157. See *id.* at 407–08.

158. *Id.* at 408.

159. *Id.*

160. See AM. HOSP. ASS'N, PREPARED TO CARE: THE 24/7 ROLE OF AMERICA'S FULL-SERVICE HOSPITALS 3 (2006), available at <http://www.aha.org/aha/research-and-trends/AHA-policy-research/2006.html> (stating that the shortfall from uncovered Medicare and Medicaid costs was \$22 million in 2004, and that uncompensated care will continue to rise from the \$26.9 billion figure in 2004 as the total number of uninsured patients reaches 48 million by 2010).

161. Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 408.

do not meet this criterion<sup>162</sup> and would be forced to close or convert to for-profit hospitals.<sup>163</sup>

Although it is not clear whether communities would benefit more from having the additional state tax revenues,<sup>164</sup> policymakers must also be mindful of future demands in the healthcare market. The first wave of “Baby Boomers” will reach the age of sixty-four in 2010. This generation will live longer and therefore manage more chronic conditions, such as diabetes and obesity.<sup>165</sup> By 2030, there will be four million more emergency department visits, and hospital admissions will greatly increase.<sup>166</sup>

It is critical that the healthcare system be equipped to satisfy the increasing demand with an appropriate mix of facilities and service options as dictated by the changing needs and preferences of the community.<sup>167</sup>

Considering that the Boomers are more educated and possess \$ 1 trillion in annual disposable income, analysts predict that they will be more involved in their healthcare decisions and spend money on delivery options that best suit their preferences.<sup>168</sup> The most reasonable healthcare system will be one that responds to and accommodates the wants and needs of the changing population gradually, as more people demand more healthcare. A successful hospital tax exemption regime will need to ensure this result. This will be most important at the state level, as Boomers select new domiciles for retirement and change the demographics of each state.<sup>169</sup> Therefore, implementing the donative theory progressively through a multi-factor approach may make the most economic and social sense.

#### IV. PROPOSED STATE STATUTORY REFORM

This Note proposes statutory reforms at the state level, borrowing from the “states as laboratory” model, which endorses a “period of legal experimentation that tends to identify a principal statutory formulation that is adopted by a majority of states.”<sup>170</sup>

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162. See *supra* note 153 and accompanying text.

163. See, e.g., Sloan, *supra* note 100, at 235 (describing the decision of Baptist Hospital in Tennessee to consider a switch to for-profit status, claiming it would no longer contribute \$30 million annually in community benefits and would have to pay \$10 to \$15 million in taxes). Also, through charity law, state attorneys general have more ability to regulate nonprofit hospitals and the loss of ability to regulate a hospital that has converted to for-profit status may have consequences. See Horwitz, *supra* note 21, at 195; see also Alice M. Maples, *State Attorney General Oversight of Nonprofit Healthcare Corporations: Have We Reached an Ideological Impasse?*, 37 CUMB. L. REV. 235, 235–50 (2007).

164. “Additional state tax revenues” refers to the dollars that would be paid by non-exempt nonprofit hospitals to the state in the form of property and income taxes.

165. See AM. HOSP. ASS’N, WHEN I’M 64: HOW BOOMERS WILL CHANGE HEALTH CARE 4–6 (2007), available at <http://www.aha.org/aha/research-and-trends/AHA-policy-research/2007.html> (noting that the number of people managing multiple chronic conditions will increase from 8.6 million to almost 37 million in 2030).

166. See *id.* at 10.

167. Refer to the discussion of enhanced market efficiency through an ideal mix of nonprofit and for-profit ownership types. See *supra* notes 122–30 and accompanying text.

168. See AM. HOSP. ASS’N, *supra* note 165, at 7.

169. *Id.*

170. Roberta Romano, *The States as a Laboratory: Legal Innovation and State Competition*

Determining exemptions based on donation level would radically depart from current state and federal legislative schemes. Consequently, gradual implementation on the state level will provide more of a grace period for hospitals that will have to greatly alter their operating practices in order to maintain tax-exempt status. This will allow for the least amount of disruption to the healthcare community while providing a viable mechanism for testing the donative theory in practice. Further, gradual implementation would provide an opportunity to determine proper donation thresholds on a smaller scale. However, eventual implementation on the federal level is certainly not precluded. The same reforms proposed for state statutes could be adopted on the federal level, especially given the notion that donative theory exemptions are already, to some degree, based on existing federal tax code.<sup>171</sup>

State legislatures should consider adopting the multifactor Texas approach to nonprofit hospital tax exemption, but modify one of the factors to implement the donative theory as a way to quantitatively measure community need as a function of community support. Thus, this proposed statutory framework would incorporate elements from both the process and the prescriptive approaches.

First, states should adopt one or more of the prescriptive Texas provisions that allow nonprofit hospitals to qualify for some state tax exemptions through the provision of charity care. The charity care provided must equal, at a minimum, between four and five percent of the hospital's net patient revenue, or 100% of the hospital's tax-exempt benefits (excluding federal income tax).<sup>172</sup>

This would grant tax relief to hospitals that are still dedicated to the more traditional rationale for exemption by providing adequate levels of charity care. With an increasing number of uninsured,<sup>173</sup> it is likely that there are certain communities with a substantial need for free care.<sup>174</sup> Furthermore, empirical data revealed that when comparing California and Texas (states with similarly high uninsurance rates), Texas nonprofit hospitals provided twice as much charity care as California nonprofit hospitals.<sup>175</sup> Texas imposes quantitative charitable care standards, whereas California employs a community benefit system to justify tax exemptions.<sup>176</sup> This suggests that strict charity care requirements may be useful in stimulating provision of charity care in areas where it is needed, but underprovided.

Second, the provision that requires charity care at a level that is reasonable in relation to community needs<sup>177</sup> should be abandoned. This provision lacks an objective basis for needs measurement and does not provide a clear standard. Rather, states should incorporate the process approach through a "safety net" provision that will

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*for Corporate Charters* 1 (European Corporate Governance Inst., Working Paper No. 34/2005, 2005), available at <http://ssrn.com/abstract=706522>.

171. See *supra* notes 144–48 and accompanying text.

172. See TEX. TAX CODE ANN. § 11.1801(a) (Vernon 2004). States may wish to adjust the level of charity care required to better fit the needs of their particular communities.

173. See AM. HOSP. ASS'N, *supra* note 160, at 11.

174. A review of state legislative bills reveals an emphasis on charity care. See Jervis, *supra* note 58, at 50 ("In reviewing legislative bills, most describe the problem of health care needs of the underinsured and uninsured in the state and the need for task forces, study groups, and improved indigent care policies.").

175. *Id.*

176. *Id.*

177. See TEX. TAX CODE ANN. § 11.1801(a)(1).

allow exemptions for hospitals that do not meet the minimum charity care requirements, but provide a mix of services that are valued by members of the community. Value-added services include unprofitable but desirable services that would be underprovided in a largely for-profit environment.

The most common criticisms of the process approach, as mentioned in Part I.B.1, are the lack of quantitative and qualitative standards and uniform reporting requirements for community benefits.<sup>178</sup> Thus, states should design this provision around a donative theory framework with a donation threshold sensitive to the current and future healthcare needs of the community.<sup>179</sup> This would placate commentators requesting quantitative measures of community benefit.<sup>180</sup> However, some would opt to remedy this problem by awarding tax subsidies for provision of specific services, weighted according to their desirability and community benefit.<sup>181</sup> Taking into account that community needs within a given state may vary widely by location, it would be challenging for legislators to derive a statewide list of subsidized services tailored to all factions.<sup>182</sup> Under donative theory, state legislators would merely set the donation threshold for exemption. The members of each community would determine whether a given nonprofit is behaving at an optimal level for that location and donate (or not) to that nonprofit accordingly.

While the one-third threshold proposed by Hall and Colombo is well-grounded in existing legislation, they also suggest that legislators could relax this threshold for certain “historically-exempt” entities, such as “schools, churches, hospitals, and the like.”<sup>183</sup> In fact, the Treasury Regulations propose an alternative to the one-third threshold. They suggest that an entity may be classified as a public charity if it receives ten percent of its support from donations and is “so organized and operated as to attract new and additional public or governmental support on a continuous basis.”<sup>184</sup> Given that this threshold will apply to organizations that have not relied on donations for significant support since World War II, ten percent might be a more feasible figure. It would certainly provide a less catastrophic starting point for hospitals not already earning exemption through charity care provisions.

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178. See Hyman, *supra* note 56, at 375–76 (“Even the most vigorous proponents of community benefit are unable to develop anything more than a thirty-two page checklist which provides no way to judge which factors are most important, or how many positive responses are needed to qualify as a community benefiting organization.”).

179. “The donative exemption employs a mechanism that makes these intensely empirical determinations automatically by targeting, within the universe of activities that conceivably deserve support, those activities that actually earn the exemption by providing services that are not otherwise available.” Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10, at 402.

180. See Jervis, *supra* note 58, at 50.

181. See Bloche, *supra* note 53, at W306 (“Public subsidies fashioned specifically to reward health promotion, quality improvement, provision of care to the poor, and other desired activities would accomplish more.”).

182. See Jervis, *supra* note 58, at 61; see also Horwitz, *supra* note 105, at 1395 (noting that definitions of appropriate care can change quickly, making it difficult for states to specify required terms of healthcare).

183. Hall & Colombo, *Donative Theory*, *supra* note 14, at 1456.

184. Treas. Reg. § 1.170A-9(e)(3)(ii) (2002).

This raises the issue of timing. For the purposes of the donative provision of the proposed state statute, Hall and Colombo's suggestions for periodic entity-by-entity evaluation<sup>185</sup> and grace period for start-up entities will be sufficient. They again borrow from §§ 170 and 509 to suggest using a four-year average for the calculation of public support, and entities meeting the threshold with this four-year average will enjoy exemptions for the succeeding two years.<sup>186</sup> Start-up entities may be able to earn an advance exemption for a two- or five-year period, after which they must meet the donation threshold for nonprofit tax exemption based on the four-year average previously mentioned.<sup>187</sup>

With regard to the proposed provision, this opportunity for advance exemption should also be made available to existing entities subject to a new state exemption provision. In other words, if a state adopts the suggested provisions, nonprofit hospitals failing to meet the charity care requirements should be granted a two- or even five-year grace period in order to restructure. During this period, nonprofit hospitals could provide more charity care or focus on programs for increasing community awareness and soliciting donations in order to satisfy the donative provision. This will give existing nonprofits time to adapt to new requirements without fear of immediately losing valuable exemptions.

Notably, a ten percent standard would still not be met by most hospitals today; however, the aging Baby Boomers and recent developments in tax policy, hospital philanthropy, and donative behavior may make this standard attainable within a few years.<sup>188</sup>

## V. DONATIVE THEORY: A SOUND PRINCIPLE IN 1991, A SOUND PRACTICE TODAY

### A. *The Revitalization of Hospital Philanthropy*

The proposed state tax exemption statute would be a radical departure from existing state legislation; however, it may not be such a radical departure from ideas already brewing in the current healthcare market. Hospital administrators are investigating philanthropy as a way to ride out economic storms,<sup>189</sup> and are "incorporating explicit expectations of fundraising into their financial planning."<sup>190</sup> In a survey of hospital chief executive officers, over fifty percent expected to invest more time and money in

185. See Hall & Colombo, *Donative Theory*, *supra* note 14, at 1468.

186. See *id.* at 1469.

187. See *id.* at 1470.

188. It is important to mention a critical assumption of this proposed statute. Some nonprofit hospitals may deserve exemption but are located in impoverished communities that are not capable of contributing much in the form of charitable donations. This Note assumes that these communities also have higher rates of uninsured and are in need of charity care. Thus, hospitals in these communities, unless they are able to solicit support from donors outside the community, must earn exemption by providing the specified amount of charity care.

189. Nonprofit hospitals, unlike for-profits, are not as free to enter and leave markets based solely on financial conditions. The legal privileges associated with tax exemption are often viewed as a "promise" to remain during financial downturns and cross-subsidize through other means. See Horwitz, *supra* note 105, at 1400.

190. Haderlein, *supra* note 13, at 541.

fundraising than they had in prior years.<sup>191</sup> One California hospital opted to increase spending on solicitation and, with a new direct mailing, generated \$100,000 in three weeks, twice the amount brought through typical mailings in a year.<sup>192</sup> With a renewed interest in fundraising, earning at least ten percent of the hospital's net revenue through donations may not be such a far leap.<sup>193</sup>

Nonprofit hospitals are also in an especially good position to attract donations through innovation.<sup>194</sup> As nonprofits, hospitals are free to conduct worthwhile but expensive or unprofitable research because such activities will not be vetoed by a board of shareholders. They are also free to pursue research into politically unpopular diseases such as AIDS.<sup>195</sup> Also, innovative community projects, such as public housing partnerships,<sup>196</sup> may provide new ways for hospitals to manage costs through prevention and "develop new community partnerships with other agencies that will pay off in multiple ways."<sup>197</sup> Pioneering new ways to realize community benefits, in addition to solicitation, may be an effective way to stimulate philanthropy.<sup>198</sup> Plus, state and federal tax exemptions for nonprofits help to ensure that more of the donations can be used for hospital operations and innovation.<sup>199</sup>

An increased reliance on philanthropy could also assist with accountability.<sup>200</sup> "Nonprofit hospitals are thought to be more responsive to and representative of the community they serve because of the involvement of community members on the boards of these hospitals."<sup>201</sup> However, nonprofit and for-profit hospitals alike are facing stifling economic conditions, including changes in reimbursement and increased

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191. *Id.* at 542.

192. Larry Riggs, *Hospital Scores with New Mail Package*, DIRECT, Jan. 1, 2007, at 40, available at [http://directmag.com/casehistories/nonprofit/marketing\\_hospital\\_scores\\_new/](http://directmag.com/casehistories/nonprofit/marketing_hospital_scores_new/).

193. Haderlein also mentions foundation grants as a source of funding. *See* Haderlein, *supra* note 13, at 544. She describes the Robert Wood Johnson Foundation, which provides funding to improve hospital efficiency, staffing, quality, and patient safety. *See id.*

194. *See id.*

195. Hospitals funded entirely by the government may not be able to offer research or services that conflict with majority political views. *See* Horwitz, *supra* note 105, at 1395.

196. *See supra* note 95 (discussing nonprofit Wishard Hospital's investment in public housing as a way to help people manage health and living conditions to keep them out of costly emergency rooms).

197. Kaiser, *supra* note 1.

198. *See* Dean G. Smith, Jan P. Clement & John R.C. Wheeler, *Philanthropy and Hospital Financing*, 30 HEALTH SERVICES RES. 615, 627-31 (1995) (finding through an empirical analysis of California nonprofit hospitals that hospitals were able to increase donations through donor-pleasing returns). Smith, Clement, and Wheeler provide a disclaimer, which notes that hospitals may not realize a large short-term gain from community benefit and solicitation efforts. However, they believe that this combination "is one of the best hopes for the survival of the voluntary hospital sector. We believe this observation is central to the policy implications of our results. The finding that community benefits increase donations implies that people continue to view the not-for-profit hospital as an agency where they can invest their funds for a social purpose." *Id.* at 632.

199. *See supra* note 136 and accompanying text.

200. *See supra* notes 19-21 and accompanying text.

201. Hyman, *supra* note 56, at 366.



malpractice liability.<sup>202</sup> While for-profits are able to accommodate this by withdrawing unprofitable services and reinvesting financial assets, nonprofits have limited economic solutions due to nondistribution constraints. Further, they must generally try to maintain unprofitable services to satisfy community need. Thus, some nonprofits attempt to cross-subsidize by charging paying patients higher fees,<sup>203</sup> while others stave off cross-subsidies by “dumping” unprofitable patients and “skimming” uncomplicated cases.<sup>204</sup> This behavior hardly lives up to the nonprofit hospital’s reputation as a trustworthy community representative. Through philanthropy, hospitals can generate additional revenue, which should deter the temptation to engage in behavior inconsistent with community expectations.<sup>205</sup> Plus, using donative theory to justify exemptions would foster an even greater reliance on hospital philanthropy as a source of revenue.

Nonprofit hospitals’ attempts to increase revenues through philanthropy may be fruitful. According to a report from the Association for Healthcare Philanthropy, donations to hospitals grew 8.3% from 2005 to 2006.<sup>206</sup> This was actually down from the 12.9% increase from 2004 to 2005, a loss attributed, in part, to negative publicity from tax exemption challenges.<sup>207</sup> Harkening back to accountability, one might speculate that hospitals can continue to drive up donation rates by maintaining quality, ethical practices consistent with community demand, and generating positive press coverage through exemplary behavior.<sup>208</sup>

202. John J. Whitney, *Hospital Philanthropy: Strengthening the Financial Base of Nonprofit Hospitals*, 6 HEALTH CARE MGMT. REV. 19, 19–24 (1981).

203. Hospitals located in states with strict rate regulation programs may be unable to raise fees, which may lead the hospitals to cut corners on the provision of charity care. See RICHARD G. FRANK, DAVID S. SALKEVER & JEAN MITCHELL, NAT’L BUREAU OF ECON. RESEARCH, MARKET FORCES AND THE PUBLIC GOOD: COMPETITION AMONG HOSPITALS AND PROVISION OF INDIGENT CARE 22–23 (1989).

204. Hyman, *supra* note 56, at 366.

205. See Whitney, *supra* note 202, at 24 (stating philanthropy, generated by a well-managed foundation dedicated to that purpose, can “encourage the growth of alternative financial resources to support health care delivery, and to protect those resources from erosion”).

206. Donations grew to \$7.9 billion. Debra E. Blum, *Donations to Hospitals Grew 8.3% in 2006, Report Finds*, CHRON. PHILANTHROPY, Nov. 1, 2007, at 60.

207. *Id.*

208. Also, “mega gifts” may result when a hospital’s mission matches a donor’s desires, especially if the donor has deep pockets. See Susan Kreimer, *Mega Gifts Let Hospitals Rapidly Expand Their Missions*, HHN: HOSP. & HEALTH NETWORKS, Mar. 2007, at 26 (reporting on recent large gifts of \$400 million and \$75 million to hospitals and health systems). In Texas, donors to the nonprofit Baylor Health Care System threatened to withhold substantial gifts to Baylor University when it proposed to sell its affiliated hospitals. Diane Jennings, *Baylor Aims for Accord on Hospital*, DALLAS MORNING NEWS, Mar. 3, 1997, at 1A. Hospitals that have met the ten percent donative threshold, therefore earning exemption status, may also have an easier time with subsequent solicitation for donations. See Cagla Okten & Burton A. Weisbrod, *Determinants of Donations in Private Nonprofit Markets*, 75 J. PUB. ECON. 255, 271 (2000) (finding a positive effect of government subsidy on donative revenue and suggesting that receipt of such subsidies provides donors with positive information about the organization’s reputation and trustworthiness).

Hospitals should also be willing to work with potential donors through a variety of avenues and levels: outright gifts, trusts, bequests, real estate, securities, and stocks.<sup>209</sup> However, in order to “capture the idealism, the advocacy and the resources of donors,”<sup>210</sup> donors must have access to information that will enable them to make donation decisions consistent with their personal and community goals.

*B. Expanding Resources for Researching Donation Decisions*

The American Hospital Association reports that Boomers, on average, are more educated than previous generations and more engaged in their healthcare decisions.<sup>211</sup> Like Robert Goldstein and Joel Greenblatt, this generation may also educate themselves with regard to making informed donation decisions, especially when those decisions can affect healthcare availability.<sup>212</sup> In fact, they are strongly encouraged to do so. Many state attorneys general encourage members of the community to be “informed donors” by urging them to “[a]sk questions, gather information and donate only when [they] are satisfied that [their] money will be used in ways [they] consider appropriate.”<sup>213</sup> The pool of free, accessible, and searchable information on various nonprofit organizations is also growing, with extensive online databases reporting everything from Form 990<sup>214</sup> images to nonprofit sector statistics.<sup>215</sup> Moreover, healthcare consumers will soon have access to independent quality assessments of hospitals.<sup>216</sup>

Some nonprofit hospitals are also taking strides to make their communities aware of the types of services provided and resulting community benefits. In Illinois, Carle

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209. See Haderlein, *supra* note 13, at 543–44 (suggesting that hospitals can engage donors by appealing to the donors’ values and demonstrating a willingness to work with donors to achieve common goals).

210. *Id.* (quoting the Association for Healthcare Philanthropy).

211. AM. HOSP. ASS’N, *supra* note 165, at 7.

212. See Jennings, *supra* note 208 (noting donors’ decisions to withhold donations from an organization if it had decided to sell its affiliated nonprofit hospitals).

213. LISA MADIGAN, ILL. ATT’Y GEN., BE AN INFORMED DONOR 1 (2007), [http://www.illinoisattorneygeneral.gov/charities/informed\\_donor1203.pdf](http://www.illinoisattorneygeneral.gov/charities/informed_donor1203.pdf).

214. Nonprofit organizations that report gross receipts of more than \$25,000 in a fiscal year and all private foundations are required to file a Form 990 with the IRS. INTERNAL REVENUE SERV., INSTRUCTIONS FOR FORM 990 AND FORM 990-EZ, at 2–4 (2007), available at <http://www.irs.gov/pub/irs-pdf/i990-ez.pdf>.

215. See, e.g., GuideStar, <http://www.guidestar.org/index.jsp>; National Center for Charitable Statistics, <http://nccs.urban.org/>.

216. See Colombo, *supra* note 17, at 633. The Centers for Medicare and Medicaid Services have partnered with the Agency for Healthcare Research and Quality (both of which are agencies within the U.S. Department of Health & Human Services) to develop the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the “first national, standardized, publicly reported survey of hospital patients’ perspectives of their care.” CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., THE CAHPS HOSPITAL SURVEY (HCAHPS): FACT SHEET (2008). The first public reporting of results occurred in March 2008. *Id.* The goal is to use patient perspectives to provide meaningful data to consumers, create incentives for hospitals to improve care quality, and increase transparency of the quality of care provided in return for public investment. *Id.*

Foundation Hospital and Provena Covenant Medical Center were publicly scrutinized for overcharging, failing to provide adequate charity care, and for other practices deemed inconsistent with a charitable mission.<sup>217</sup> Both hospitals now publish extensive community benefit brochures for the public. These brochures describe community mission statements, statistical and financial information, personal stories from uninsured patients, and various outreach programs in the areas of housing, education, and prevention.<sup>218</sup> Carle Foundation emphasizes the provision of numerous services operated at a loss to the hospital and even includes a half-page statement regarding the importance of its tax-exempt status.<sup>219</sup>

Taken together, all of this information will form a substantial arsenal of both objective and subjective material for the donor contemplating a contribution to his or her community hospital. Implementation of a donation-based state tax exemption will increase the burden on nonprofit hospitals to continuously promote their services in the community. Plus, the disclosure created by nonprofit promotion can make potential donors aware that they will be responsible for maintaining the tax-exempt status of some nonprofit hospitals. Additionally, knowing that they are under the watchful eye of the general public, nonprofits may be more motivated to raise the level of care or innovate new ways to serve public health needs. They may also have a new way to report their efforts. The IRS hopes to add to the community's information arsenal by imposing new community benefit reporting requirements in the Form 990 for nonprofit entities.<sup>220</sup>

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217. See Colombo, *supra* note 89, at 493–94.

There is a glaring juxtaposition of a “charitable” hospital allowing doctors complete, unfettered access to and use of their “exempt” facilities to pursue private gain while this same “charitable” hospital continues an unfair policy of overpricing and suing the uninsured. This juxtaposition can not be ignored, and it violates one’s sense of fairness and what is right. It is my view that any institution that permits these unfair practices to exist can not be considered “charitable” or tax-exempt.

*The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means*, 109th Cong. 96 (2005) (statement of Stan Jenkins, Chairman, Champaign County (Ill.) Board of Review).

218. See CARLE FOUND. HOSP., 2006 COMMUNITY BENEFIT REPORT (2006), available at [http://www.carle.org/pdf/Carle\\_CommunityBenefitReport\\_2006.pdf](http://www.carle.org/pdf/Carle_CommunityBenefitReport_2006.pdf); PROVENA HEALTH, MANY HANDS, ONE MISSION: 2006 COMMUNITY BENEFIT ANNUAL REPORT (2006), available at <http://www.provena.org/documents/Publications/ProvenaAnnualReport2006.pdf>.

219. See CARLE FOUND. HOSP., *supra* note 218, at 12 (“Revoking the property tax exemption of not-for-profit hospitals will not improve the health of any community. . . . These actions are a real threat which, if effective, will put an enormous strain on our health care system not previously experienced.”).

220. Numerous studies have analyzed the effect of nonprofit characteristics on donations. See Michelle H. Yetman & Robert J. Yetman, *The Effect of Nonprofits’ Taxable Activities on the Supply of Private Donations*, 56 NAT’L TAX J. 243, 246 (2003). In doing so, all studies assumed that donors gather financial information on nonprofits from the IRS 990. *Id.*

*C. The New and Improved Form 990*

Form 990 is the “key transparency tool relied on by the public, state regulators, the media, researchers, and policymakers to obtain information about the tax-exempt sector and individual organizations.”<sup>221</sup> Given Form 990’s status as a “key transparency tool,” Senator Grassley endorsed revisions to Form 990 to generate more meaningful, uniform disclosures about activities that qualify hospitals for tax-exempt status.<sup>222</sup> The redesign of Form 990, which was released for discussion on June 14, 2007, is based on the principles of enhancing transparency, promoting tax compliance, and minimizing the burden on the filing organization.<sup>223</sup>

Form 990’s new Schedule H, to be completed by hospitals and facilities that provide medical care, is part of this redesign. One primary section of Schedule H focuses on objectively quantifying community benefit, based on the reporting model designed by the Catholic Health Association.<sup>224</sup> Schedule H includes a worksheet for describing, in detail, community benefit operations including staff/volunteer hours, number of persons served, expenses, and offsetting revenue (grants and voluntary contributions).<sup>225</sup> Facilities are also asked to provide a detailed list of services (for example, psychiatric, rehabilitation, orthopedic, obstetrics and gynecology, etc.), activities, and programs offered.<sup>226</sup> Other sections attempt to increase transparency in the reporting of billing and collection practices, inurement and private benefit issues, and procedures for community needs assessment.<sup>227</sup>

The new Form 990 will be available for the 2008 tax year.<sup>228</sup> With this new extensive and detailed filing requirement, and the fact that completed forms are publicly available through online databases, donors will be more informed than ever before with regard to the healthcare sector:

The 990 filing is often the public’s only look at a non-profit’s finances. If you’re making a donation, you may want to research what proportion of your money is going to executive salaries rather than helping people in need. With the current form, transparency is lacking. A potential donor might get frustrated and give up. That doesn’t help charities. And the lack of transparency doesn’t serve taxpayers.

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221. OFFICE OF EXEMPT ORGS., INTERNAL REVENUE SERV., BACKGROUND PAPER REDESIGNED DRAFT FORM 990 1 (2007), *available at* [http://www.irs.gov/pub/irs-tege/form\\_990\\_cover\\_sheet.pdf](http://www.irs.gov/pub/irs-tege/form_990_cover_sheet.pdf).

222. For an overview of Senator Grassley’s lengthy nonprofit healthcare legislation movement, see Quirk, *supra* note 96, at 88–97.

223. OFFICE OF EXEMPT ORGS., *supra* note 221, at 2.

224. *Id.* at 5; *see also* THE CATHOLIC HEALTH ASS’N OF THE U.S., A GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFIT (2006).

225. OFFICE OF EXEMPT ORGS., INTERNAL REVENUE SERV., DRAFT FORM 990 REDESIGN PROJECT – SCHEDULE H worksheet 4 (2007), *available at* [http://www.irs.gov/pub/irs-tege/draftform990redesign\\_schh\\_instr.pdf](http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf).

226. *Id.* at 8.

227. *Id.* at 1, 5–7.

228. INTERNAL REVENUE SERV., WHAT’S NEW: REDESIGNED FORM 990 AND INSTRUCTIONS FOR 2008 TAX YEAR 1, *available at* [http://www.irs.gov/pub/irs-tege/990\\_whatsnew\\_purpose.pdf](http://www.irs.gov/pub/irs-tege/990_whatsnew_purpose.pdf). The IRS released the latest draft of Schedule H in July 2008. INTERNAL REVENUE SERV., FORM 990, SCHEDULE H (2008), *available at* <http://www.irs.gov/pub/irs-dft/f990sh--dft.pdf>.

They deserve accountability for the generous tax breaks the federal government offers to tax-exempt groups. The IRS' revisions are on the right track.<sup>229</sup>

As a result, donative theory can serve an important role in the decision-making process for state tax exemption for nonprofit hospitals. Not only will hospitals have a new way to justify their exemptions, but it will be based primarily on community preference, as assessed by *the community* and not through a hospital-conducted community needs assessment.

#### CONCLUSION

In 1991, Hall and Colombo proposed and supported donative theory as an alternative rationale for the charitable tax exemption for nonprofit hospitals.<sup>230</sup> Yet, donative theory has yet to be incorporated in nonprofit hospital exemption legislation for the most likely reason that the majority of hospitals do not substantially rely on donations. States vary in their approaches to hospital tax exemption, however they all agree that modern nonprofit hospitals have very little in common with their nineteenth century almshouse ancestors. Healthcare is now a profitable industry. With the commercialization of healthcare, tax policymakers responded to industry representatives with modern, albeit ambiguous, exemption reforms.

However, the same economic factors that changed the face of healthcare are leading some nonprofit hospitals back to their charitable roots. Hospitals are once again looking to donations to relieve the economic pinch of a competitive and unstable healthcare industry. Donors appear to be responding and now have access to the information they need to investigate nonprofits and make sound donation decisions. Perhaps it is once again time to evaluate nonprofit hospital exemptions and bring them in line with these recent trends through donative theory.

While politicians and legislators scrutinize nonprofit hospital practices, and hospitals are busy defending themselves, both sides could be overlooking the most important voice: the community. If the predictions are accurate, and the aging Baby Boomers are more educated, have more assets, and are dedicated to defining their healthcare needs and thoroughly investigating their options, the environment could be prime for a hospital tax exemption system based in part on donative behavior. This would give an effective and influential voice to the communities who benefit from the community benefits. The most appropriate mix of nonprofit and for-profit healthcare options will vary by community and must therefore be decided at the local level. The proposed legislation for state tax exemption outlined in this Note is a radical departure from current exemption policy and will undoubtedly require fine-tuning through several trial phases. Nonprofit hospitals will need to invest time and effort into re-establishing their charitable identities in the wake of negative national publicity. If they

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229. Memorandum from the U.S. Senate Fin. Comm. to Reporters and Editors (June 14, 2007), available at <http://www.senate.gov/~finance/press/Bpress/2007press/prb061407b.pdf> (statement of Senator Charles Grassley).

230. See Hall & Colombo, *Charitable Status of Nonprofit Hospitals*, *supra* note 10. By asking whether “the public chooses to support nonprofit hospitals with donations, it is possible to evaluate the need for tax subsidization on a more objective basis.” *Id.* at 411.

are successful, future Goldsteins and Greenblatts may be willing to carry out their innovative ideas through deserving nonprofit hospitals.