SPECIAL  SECTION

COMMUNITY BENEFIT PREVAILS

Are Radical Changes in Hospital Tax-Exemption Laws Necessary?

BY J. DAVID SEAY, JD

Recently, the advisability of continuing to accord our nation's voluntary, not-for-profit hospitals an exemption from various forms of taxation—including the federal income tax and its implicit government subsidy—has been called into question. By now, most involved with healthcare are well aware of developments at the local, state, and national levels questioning hospital behavior and examining it against, not the extant community benefit standard, but a stricter implicit standard. Legislators, local tax officials, and other public policymakers forge ahead in a debate that appears to assume our nation's laws should shift—or have already shifted—from the current community benefit standard to a stricter, more narrow charity care approach. (On p. 38, James J. McGovern discusses the views of groups that will be affected by proposed revisions of tax-exemption standards.)

This narrower standard would look at how much uncompensated or "charity care" a hospital provides in relation to its budget or revenues and deny exemption or otherwise penalize a hospital that fails to provide at least a predetermined level of such care to the medically indigent. Although the relief of poverty has long been a common-law category of charity, hospitals generally have been considered charitable under the broader, more flexible community benefit standard. It might be wise, therefore, to question whether radical changes in the law really are called for or whether a more thoughtful and careful examination of the community benefit concept itself might be more appropriate and consistent with our nation's legal history.

Mr. Seay is vice president and counsel, United Hospital, Fund, New York City.

Summary Voluntary, not-for-profit hospitals are in danger of losing their tax-exempt status as policymakers lean toward stricter charity care requirements that would penalize hospitals which failed to provide at least a predetermined level of charity care. Proposed legislation abandons community benefit and advocates a relief-of-poverty standard. The relief-of-poverty standard advances the notion that hospitals are not providing enough charity care to merit their tax exemption. However, the voluntary hospitals' share of uncompensated care costs (as a percentage of total costs) increased from 70 percent in 1981 to 75 percent in 1989.

The relief-of-poverty standard is inferior to the community benefit standard because it does not take into account that the character of community benefit varies among hospitals and communities. However, community benefit must be better defined. Some current activities—individual hospital reassessments, collective hospital reassessments, voluntary development of criteria, and statutory standards—will be instructive in efforts to arrive at a definition of community benefit that is appropriate for the specific community.

Leaders in voluntary, not-for-profit hospitals need to develop positive and equitable criteria for hospital tax exemption. These hospitals' accountability is in question, but it is their integrity that is at stake.

Tradition of Tax Exemption

Tax exemption for hospitals is not new. In fact, U.S. hospitals were exempt from taxation even

before the establishment of an income tax or the Internal Revenue Code.[1] The notion of community benefit—the current legal standard by which federal tax exemption is accorded to not-for-profit hospitals—is itself quite old. The idea dates back to the early seventeenth century, when laws regulating the charitable use of property were first enacted in England.[2] Later, in 1891, in a restatement of the English law of charity (which has long been recognized as a leading authority in the United States), Lord MacNaghten clearly delineated community benefit as a separate and distinct category of activity that is deemed charitable: "Charity in its legal sense comprises four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for *other purposes beneficial to the community*, not falling under any of the preceding heads" (emphasis added).[3] More recently, the U.S. Supreme Court has reaffirmed this community benefit standard as correct and appropriate for purposes of determining hospital tax-exempt status,[4] and the Internal Revenue Service (IRS) has embraced it.[5]

According to the IRS, a voluntary, not-for-profit hospital qualifies as a Section 501(c)(3) charity so long as it promotes the health of a sufficiently broad class of individuals to benefit the larger community it serves. In this case, the promotion of health is considered to be charitable even if the class of direct beneficiaries does not include everyone in the community, even the indigent, so long as the group or class of people who are served is not so small that the community, as a whole, does not benefit.[6]

By its very nature and by administrative practice, the community benefit is decided by a "facts-and-circumstances test" (i.e., on a case-by-case basis). The community benefit standard certainly does not, in concept, exclude the relief of poverty through the provision of charity or uncompensated care as an appropriate benefit to the community; it just does not make it the exclusive or even primary test.

In addition to this general community benefit criterion are the other criteria applicable to charities. These include the "nondistribution constraint," or prohibition of private inurement or private benefit; the requirement of the not-for-profit form of incorporation; and the prohibitions against political involvement, substantial lobbying activities, and operation for a purpose contrary to established public policy. Together, these operational or procedural criteria, along with the community benefit requirement, represent the qualitative rules within which hospitals must now operate.

Beyond its historical and precedential appeal, the community benefit standard is superior to a relief-of-poverty standard in several ways.

The Narrow View

Recently garnering much attention are two separate pieces of legislation introduced in the House of Representatives by Rep. Brian J. Donnelly, D-MA,[7] and by Rep. Edward R. Roybal, D-CA.[8] Although the two bills differ significantly, both would move the standard for hospital tax exemption dramatically away from the community benefit concept, to the "relief-of-poverty" or "charity care" standard.

This relief-of-poverty concept advances the notion that somehow hospitals are, if not behaving badly, at least not being held accountable enough in exchange for the subsidy or "tax expenditure" implied by their exemption from taxation. Of course, one could readily agree that more accountability would be a good thing and that perhaps the community benefit standard is too vague to be implemented effectively. It does not logically follow, however, that the relief-of-poverty option is the most desirable or even an appropriate alternative. Before that discussion, however, the concept behind both the Donnelly and Roybal bills has weaknesses of both substance and procedure that must be examined.

Compared with the community benefit standard, a relief-of-poverty standard is inferior for numerous substantive or philosophical reasons. Based on considered policy judgments and legal precedent, the community benefit standard has been the law in the United States for many years. A shift to a standard developed for other types of activities, however well-intentioned, would ignore the reasons hospitals have been treated differently and could upset the delicate balance of community service and institutional survival priorities that many voluntary hospitals have attempted to maintain. But beyond its historical and precedential appeal, the community benefit standard is superior to a relief-of-poverty standard in several other ways.

First, it is inherently more flexible. It is both more institution- and community-specific than a national standard or percentage formula could be. In communities with a single provider hospital, the provision of community benefit may be quite different than in a large urban area where many hospitals are operating under differing auspices. Similarly, the community benefit may vary according to the relative payment levels of state Medicaid programs, prevailing hospital occupancy rates, and the sociodemographic mix of the primary service community. Each of these factors, and no doubt many others, should be taken into account when determining the adequacy of a hospital's contribution to the benefit of its community. The community benefit notion is inherently more amenable to a consideration of these vari-

ous factors than a relief-of-poverty rule. The formulaic approaches, such as the Donnelly and Roybal bills, are simply not up to this task.

Another substantive problem with the relief-of-poverty notion for hospital tax exemption is made clear by carrying this idea to its logical conclusion, national health insurance. Canada has benefited from a national health insurance, or universal access, plan since 1970. For all intents and purposes, medical indigence disappeared in Canada when the program was introduced. The majority of Canadian hospital beds are operated under voluntary, not-for-profit auspices *and* continue to be exempt from taxation.

Canadians agree that hospitals ought to be encouraged to find ways of benefiting their communities beyond the minimum benefit package established under the national healthcare plan. They continue to use their tax policy as one incentive to do so. But if U.S. policy were to convert to a relief-of-poverty standard and Congress enacted national health insurance or universal access legislation, voluntary hospitals would lose their tax exemptions. The underlying rationale—providing charity care—would no longer exist. Should the United States ever enjoy the benefit of a national healthcare access plan, it would rely, like Canada, on a minimum-benefit package. It might be wise to continue to base hospital tax exemption on something other than a poverty standard to encourage hospitals to provide benefits to their communities over and above the bare minimum.

Quagmire of Complexities

The Donnelly and Roybal bills have procedural problems as well. Although Donnelly made it clear at hearings held on July 10, 1991, before the House Ways and Means Committee that his legislation was not intended to solve the problem of healthcare access, most others involved in this debate have pointed to this problem as a compelling factor for a change in the law. Nonetheless, neither bill will come anywhere close to making a dent in this enormous national problem. Also, neither bill will produce any significant revenue for the federal government. Cost-containment strategies by major payers, principally the federal and state governments, will combine to effectively return hospital financial statements to their historically break-even status.

Bruce C. Vladeck has noted that a change in the fiscal reporting incentive will likely create a very different bottom line for voluntary hospitals, through legal and legitimate accounting and reporting procedures.[9] As Vladeck also suggested, if federal officials hope to generate new revenue by taxing the voluntary hospitals, they might be given pause by examining the tax returns of the for-profit hospital chains.

Yet other practical and procedural problems exist. Both the Donnelly and Roybal bills would create quagmires of complexity, making effective enforcement and administration a costly nightmare, turning hospital community service into a numbers game that the hospitals will most likely win, at least with the measurement tools now available.[10] The intricate and restrictive formulas that would determine whether a hospital loses its tax exemption, or is taxed as a penalty, would attempt to quantify, measure, and evaluate a hospital's charity care burden by numbers, largely ignoring its relationship to all its other activities, as well as the environmental factors. These formulas would, in effect, determine whether a hospital is a charitable organization. The bills' formulas give rise to considerable definitional and quantification judgments and would result in a field day for hospital accountants, consultants, and lawyers for years to come.

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The necessity of the legislation is also questionable, given the problems these pieces of legislation and other attacks on tax-exempt hospitals are attempting to correct. The IRS, the Office of the Inspector General (OIG) of the Department of Health and Human Services, and other enforcement agencies could adequately address most examples of egregious hospital behavior through better enforcement of existing laws. For example, executive compensation or physician recruitment schemes that are considered out of hand may run afoul of extant prohibitions on private inurement or private benefit. Perceived abuses in defining what is "related to" a charity's exempt purpose can be addressed adequately with proper enforcement of the unrelated business income tax law as it now stands, especially after the recent reporting changes implemented in the revised IRS Form 990. And cases of patient dumping violate the Consolidated Omnibus Budget Reconciliation Act antidumping provisions, implemented through the Medicare and Medicaid laws, which Congress specifically enacted to curb these abuses. Of course, effective enforcement takes both commitment and resources. Rather than enacting new and complex regulatory schemes, better use should be made of scarce enforcement dollars by focusing attention on existing laws.

"Ain't Misbehavin'"

Just how badly are the nation's voluntary hospitals behaving? According to data recently analyzed and released by the Prospective Payment Assessment Commission, from 1981 to 1989 the voluntary hospitals' share of uncovered indigent care costs nationwide increased dramatically (see

Table). The voluntary hospitals' share of uncompensated care costs (as a percentage of total costs), net state and local government subsidies, increased from 70 percent in 1981 to 75 percent in 1989. Their share of Medicaid shortfalls (as a percentage of total costs) increased from 42 percent in 1981 to 63 percent in 1989. Together, they represent some $8.3 billion in that year alone, up from just over $2 billion in 1981.[11] In other words, the amount of uncovered indigent care costs borne by the voluntary hospitals more than tripled in that eight-year period—the same period when they are alleged to have become more corporate and less charitable.

These data suggest that, as a whole, and even using a relief-of-poverty standard, the country's voluntary, not-for-profit hospitals are behaving even more charitably now than they were a decade ago. Public policymakers must be able to distinguish the exception from the rule and not overreact to isolated examples—however egregious—of bad hospital behavior, especially when those types of abuses are already addressable under existing law.

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Taking Stock

All this, however, is not a brief for the status quo. It may be true that the community benefit standard is appropriate for hospital tax exemption, that anecdotal abuses can be corrected with better enforcement of existing law, and that voluntary hospitals are providing increasing amounts of uncompensated care at a time when their other financial indicators are falling. Nevertheless, community benefit must be better defined so hospitals can be held accountable. But if quantitative standards and outcome measures are apparently not the best way to go, what is?

Some grassroots efforts within the hospital sector itself provide examples of how best to put flesh on the skeletal definition of community benefit so that it affords both accountability and flexibility. Several interesting and potentially instructive activities are occurring around the United States.

Individual Hospital Reassessments Individual hospital reassessments are taking place in nearly every state. Not-for-profit multi-institutional systems, as well as individual institutions, are undertaking these exercises in institutional self-examination. These hospitals are rediscovering the value of a mission-driven purpose and the importance of making it clear to their communities that they are indeed public charities. Some are voluntarily taking corrective actions to realign their service priorities to better serve community needs.

HOSPITAL COSTS AND CHARITY CARE (1981 AND 1989)*

Type of Hospital	Cost (Billions $) 1981	Cost (Billions $) 1989	Cost Attributable to Charity Care 1981	Cost Attributable to Charity Care 1989
Uncompensated Care Costs				
Voluntary	$2.2	$6.0	70%	75%
Proprietary	0.2	0.7	6	8
Government	0.8	1.3	24	17
Medicaid Shortfalls				
Voluntary	$0.3	$2.3	42%	63%
Proprietary	0.0	0.4	0	10
Government	0.4	1.0	58	27
Total Uncovered Indigent Care Costs				
Voluntary	$2.5	$8.3	65%	71%
Proprietary	0.2	1.1	5	9
Government	1.2	2.3	30	20

From Prospective Payment Assessment Commission, "The Trend and Distribution of Medicaid Shortfalls and Uncompensated Care Costs," Washington, DC, June 1991.

*With government subsidy offset.

Collective Hospital Reassessment In addition to self-examination, some organizations are encouraging collective hospital reassessments. Perhaps the best example of this is the Catholic Health Association's (CHA's) *Social Accountability Budget.*[12] This project provides a definition and examples of the broad range of hospital community benefit activities and helps hospitals better understand, quantify, measure, plan, and budget for these activities as part of their overall mission and service plan.

Voluntary Development of Criteria The Robert F. Wagner School of Public Service of New York University, with funding from the W. K. Kellogg Foundation, is conducting a national demonstration project on voluntary accreditation.[13] The Hospital Community Benefit Standards Program has developed a set of four community benefit standards (discussed later), defined primarily in procedural terms, and is in the process of implementing a nationwide demonstration program to assess the feasibility and the efficacy of such a voluntary accreditation process. Although this effort is designed to establish the highest standards to which mission-driven institutions would aspire, the principles underlying the four standards can provide guidance to those seeking to better understand and to more fully define the notion of community benefit as it is used for the minimum or threshold determinations for tax-exempt status.

Statutory Standards Taking a regulatory approach, the state of New York has recently adopted a legislative requirement that hospitals maintain community service plans.[14] This statute includes several process-oriented requirements that speak to the qualitative rather than quantitative characteristics of community service institutions.

Developing Clear Criteria

The New York State community service plan requirements and the Hospital Community Benefit Standards Program offer the most promise for guidance to those contemplating changes in criteria for hospital tax exemption. The New York legislation, which has been in effect for a year, requires the governing board of each not-for-profit general hospital to maintain the facility's mission statement. The statement identifies the community and the population the hospital serves and delineates its commitment to meet identified healthcare needs of that target community. Also, each hospital's governing board must:

- Review and amend the mission statement as necessary
- Establish a process for soliciting the community's views on issues such as the hospital's performance and service priorities
- Demonstrate the hospital's operational and financial commitment to meeting the community's healthcare needs, including providing charity care services and improving healthcare access for the underserved
- Publish a statement or report that reflects the financial resources of the hospital and its related corporations and the allocation of surpluses, if any, to the hospital's community service plan[15]

New York's voluntary hospitals must file these reports annually, along with the mission statement and revisions. The hospitals are encouraged to more broadly disseminate the results of the reporting requirements.

The New York State community service plan requirements are clearly structural or process requirements. Rather than trying to hold hospitals accountable for particular outcomes, such as predetermined levels of uncompensated care, and the attendant quantification problems entailed, these criteria look to institutional intent, motivation, and structure in an effort to implement, in good faith, a plan to serve the entire community. In this sense, these requirements are qualitative rather than merely quantitative. They speak more to encouraging particular types of institutions and institutional behavior patterns and are entirely consistent with the other, albeit minimal, process or structural requirements under the Internal Revenue Code (e.g., the requirements that a hospital be organized as a not-for-profit corporation and that there be no private inurement or private benefit). The underlying assumption in these types of standards is that societal interests are served by promoting and encouraging structures and processes that are intended and designed to at least attempt to benefit the community in ways that either the government will not or commercial enterprises cannot.[16]

Similarly, the standards developed by the National Steering Committee of the Hospital Community Benefit Standards Program are also qualitative and procedural and seek to examine the specific indicia of an individual hospital's effort to establish and maintain a community benefit mission. Again, like the New York State criteria, these standards look more to institutional intent and process, as evidenced by specific structural changes and mechanisms, than to quantitative outcome measures. The four standards of the Hospital Community Benefit Standards Program are as follows:

- There is evidence of the hospital's formal commitment to a community benefit program for an identified community.
- The scope of the program includes hospital-sponsored projects for the community in the areas of improving health status; addressing the

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QUALITATIVE OR PROCEDURAL CRITERIA

EXISTING CRITERIA

- Organized for an exempt purpose
- Public versus private benefit served: (1) no private inurement or private benefit, (2) no profits (the "nondistribution constraint"), and (3) organized as a not-for-profit corporation
- Political activities and substantial lobbying prohibited
- Not operated contrary to public policy
- Income from unrelated business taxed

POTENTIAL CRITERIA

- A written mission statement or other formal commitment to community benefit
- Community benefit plan—special emphasis on poor and underserved
- Processes for community input and collaboration with others
- Use of surpluses, if any, for community benefit
- Identification and reporting of community benefit activities and resources

health problems of minorities, the poor, and other medically underserved populations; and containing the growth of healthcare costs.

- The hospital's program includes activities designed to stimulate other organizations and individuals to join in carrying out a broad healthcare agenda in the community.
- The hospital fosters an internal environment that encourages hospital-wide involvement in the program.[17]

The New York State statutory scheme and the Hospital Community Benefit Standards Program criteria are similar. For example, both seek evidence of community involvement in the hospital's process, speak to having a mission statement and plan as evidence of a formal commitment to community benefit, and give prominence to efforts to help the poor and medically underserved as important elements within the notion of community benefit.

LEADERS WANTED

These types of qualitative or process criteria, when added to the existing community benefit criteria, can go a long way toward providing a clearer, more detailed, and more understandable definition of what community benefit means within the context of hospital tax-exempt status (see **Box**). Yet this approach remains flexible enough to allow for a case-by-case, facts-and-circumstances application of the criteria to any particular institution. This is preferable to the other attempts to improve the community benefit standard.

What is needed now is courage and leadership from within the voluntary, not-for-profit hospital community to transcend a mere defense of the status quo and to develop positive and equitable criteria for hospital tax exemption. CHA is rising to this challenge in establishing a special task force on tax exemption to examine the national scope of challenges to tax exemption and to advise its own leaders about what its public policy stand ought to be with regard to healthcare tax exemption. CHA, the American Hospital Association, and others studying this issue would be wise to examine and learn from the important efforts already under way within the hospital community. The accountability of voluntary hospitals is in question, but it is their integrity that is at stake. □

Qualitative criteria, when added to the existing community benefit standard, can go a long way toward providing a clearer definition of what community benefit means.

NOTES

1. Revenue Act of 1894 (Act of August 15, 1894, Chapter 349, 28 Stat. 553); 26 U.S.C. (1939); 26 C.F.R. (1939) 39.101 (6)-1 (Regulations 118); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, Basic Books, New York City, 1989; Paul A. Hattis, "What the Hospital Should Do to Merit Tax Exempt Status and How to Measure It: Evaluation of Legal Standards for Hospital Tax Exemption," presented at the George Bugbee Symposium, Chicago, 1989.
2. Statute of Charitable Uses, Eliz. 1, ch. 4 (1601); Hattis.
3. MacNaghten, Restatement of Charitable Trusts, ref. in *Commissioners v. Pemsel*, A.C. 531,583 (1891); also 4 A. Scott, Law of Trusts 2d, Sec. 368, 2853-2854 (3d ed. 1967); and *Bob Jones University v. United States*, 461 U.S. 574, 588 (1983).
4. *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976).
5. Rev. Rul. 69-545 and 83-157; and Treas. Reg. Sec. 1.501(c)(3)-1(d)(2).
6. Rev. Rul. 69-545 and 83-157.
7. H.R. 1374, 102d Cong. (1991).
8. H.R. 790, 102d Cong. (1991).
9. Bruce C. Vladeck, "Taxing Logic," president's letter, United Hospital Fund, New York City, April 1991.
10. Vladeck.
11. Prospective Payment Assessment Commission, "The Trend and Distribution of Medicaid Shortfalls and Uncompensated Care Costs," Washington, DC, June 1991.
12. *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, Catholic Health Association, St. Louis, 1989.
13. Anthony R. Kovner and Paul A. Hattis, "Benefiting Communities," *Health Management Quarterly*, Winter 1990.
14. N.Y. Pub. Health Law, Sec. 2803-1 (McKinney 1991).
15. N.Y. Pub. Health Law Sec, 2803-1.
16. J. David Seay and Bruce C. Vladeck, "Mission Matters," in J. David Seay and Bruce C. Vladeck, eds., *In Sickness and in Health: The Mission of Voluntary Health Care Institutions*, McGraw-Hill, New York City, 1988, pp. 9, 31.
17. Kovner and Hattis.