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ABSTRACT

The tax-exemption system for American hospitals was created both to optimize care for those who cannot afford it and to encourage good deeds by hospitals. But despite well-intentioned attempts by the IRS to implement these lofty policy goals, for-profit hospitals today pay taxes despite at times providing more public benefit than their nonprofit brethren while nonprofit hospitals are incentivized to seek profit rather than provide free care. This rise of this state of affairs coincides with changes by the IRS to the standards required to obtain the exemption. Originally, the nonprofit system operated on a quid pro quo model, where hospitals were thought to relieve a burden on the government and receive tax exemption in return. But in 1969, the IRS migrated to the ambiguous "promotion of health" model introduced in Revenue Ruling 69-545. With its enactment, the IRS effectively freed nonprofit hospitals from accountability to the original policy goals behind nonprofit status and introduced the problems above. To fix the imbalance faced by hospitals today, this Article proposes a modification to federal policy that returns to the quid pro quo model but keeps the flexible attitude of Revenue Ruling 69-545 towards community benefit. Under this suggested approach, all *hospitals must provide a threshold amount of community benefit to receive tax exemption, but they will have sufficient flexibility in the means to reach that goal. This places all hospitals on a level playing field and will hopefully increase charitable services provided to the needy.*

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INTRODUCTION

Benjamin Franklin famously said that "in this world, nothing can be said to be certain except death and taxes."[1] Hospitals across the United States face both certainties day in and day out—unless they are nonprofit.[2]

1. Kevin McCormick, *Death & Taxes Quote Origin + Who Said It (Ben Franklin?)*, MIGHTY TAXES, https://www.mightytaxes.com/death-taxes-quote/ [https://perma.cc/EFC6-XFSN]; Gary Martin, *The Meaning and Origin of the Expression: Nothing is Certain but Death and Taxes*, THE PHRASE FINDER, https://www.phrases.org.uk/meanings/death-and-taxes.html [https://perma.cc/JYD2-KCCY].

2. *See Population and Housing Unit Estimates*, U.S. CENSUS BUREAU (July 22, 2022), https://www.census.gov/programs-surveys/popest.html [https://perma.cc/WD8U-

Nearly half of all United States hospitals are, according to the American Hospital Association, with 48.6% receiving a combined tax exemption from the federal and state governments.[3] In contrast, only about 20.2% of hospitals are investor-owned, for-profit enterprises.[4] The remaining 31.2% of hospitals are either government-run or facilities that operate in schools, prisons, and the like.[5]

Section 501(c)(3) of the Internal Revenue Code governs the applicability of federal tax exemption to nonprofit hospitals. Yet despite the modern ubiquity of nonprofit hospitals, they are nowhere explicitly mentioned in the text. Instead, hospitals and the services they provide are swept in under the definition of "charity."[6] However, a look at the amount of "charitable" medical care that most nonprofit hospitals provide calls these same hospitals' exemption into question.[7] How do nonprofit hospitals continue to receive tax-exempt status for serving a charitable purpose without *actually* serving it? The answer is that under the federal standard, they need only engage in the "'promotion of health' . . . even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community . . . ."[8] Under this "community benefit" standard, under

L8AG] (estimating rise and decline of the United States population). No doubt a fair amount of decline occurs in the 920,531 total beds staffed by American hospitals. *Fast Facts on U.S. Hospitals, 2022*, AM. HOSP. ASS'N (Jan. 2022), https://www.aha.org/statistics/fast-facts-us-hospitals [https://perma.cc/VRY3-F4KG] [hereinafter *Fast Facts*]. "Nonprofit" and "not-for-profit" are interchangeable terms. *See Nonprofit corporation*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("Also termed *not-for-profit corporation*."). This Article will refer to charitable hospitals and other tax-exempt entities as "nonprofit."

3. There were a total of 2,960 "Nongovernment Not-for-profit Community Hospitals" out of a total of 6,093 U.S. hospitals, or 48.6% (when rounded to the nearest tenth of one percent, as all percentages in this Article are). *See Fast Facts*, *supra* note 2; MARK A. HALL & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS IN A NUTSHELL 241 (4th ed. 2020) [hereinafter IN A NUTSHELL].

4. *Fast Facts*, *supra* note 2.

5. *Id.* For purposes of this Article, this category will not be discussed.

6. *See* I.R.C. § 501(c)(3); Helena G. Rubinstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX: J.L.-MED. 381, 383 (1997).

7. *See* George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 144–45 (2010) (noting "most charitable hospitals do very little to provide health care for the uninsured and underinsured") [hereinafter *Wolves in Sheep's Clothing*].

8. Jack E. Karns, *Justifying the Nonprofit Hospital Tax Exemption in a Competitive Market Environment*, 13 WIDENER L.J. 383, 402–03 (2004); *see* Rev. Rul. 69-545, 1969-2 C.B. 117, 117–18.

certain circumstances, the hospital need not even operate an emergency room nor provide free emergency care.[9]

In contrast, state governments guard tax-exempt status far more jealously. While some states follow the federal model, more aggressive states do not see qualifying for federal tax-exempt status as dispositive.[10] Instead, state and local governments whose coffers feel the hunger pangs of forgone property taxes require that hospitals relieve a burden on the state or pay their property taxes.[11]

This Article suggests that for two main reasons, states have the right idea. First, as mentioned before, nonprofit hospitals are exempt from most of their tax liabilities, yet do not provide equal value in the form of charitable care in return.[12] Paradoxically, it is in some cases the for-profit hospitals—that are ineligible for the "reward" of tax exemption—that provide more charitable care than the nonprofit, tax-exempt hospitals.[13] This state of affairs at the federal level is an unintended byproduct of policy decisions that can, and should, be corrected.

Second, nonprofit hospitals themselves engage in for-profit behaviors when the business climate is "too difficult to continue operations with a truly charitable mission."[14] In fact, "[i]n the vast majority of cases . . . insurance companies and the government are the principal sources of operating revenues" of nonprofit hospitals.[15] These third-party payors push nonprofit hospitals "'toward becoming . . . commercial nonprofits—organizations that generate most of their revenues from the sale of services rather than from charitable donations'" and are used to a steady stream of

9. IN A NUTSHELL, *supra* note 3, at 242–43; *see* Rev. Rul. 83-157, 1983-2 C.B. 94, 94–95 (providing an example where a nonprofit hospital could retain its tax-exempt status without operating an emergency room).

10. *See* BARRY R. FURROW ET AL., THE LAW OF HEALTHCARE ORGANIZATION AND FINANCE, 643–44 (West Academic 8th ed. 2018) [hereinafter ORGANIZATION & FINANCE]; *see also* Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1144 (Ill. 2010), *superseded by statute*, 35 ILL. COMP. STAT. 200/15-86 (2015) (providing an example of a state not tying tax-exempt status to the federal rule). Illinois now requires the value of services provided that relieve the burden on the government to "equal or exceed" its projected property tax liability based on the property's fair market value. *See* ORGANIZATION & FINANCE, at 650.

11. *See* Karns, *supra* note 8, at 396–97.

12. *See Wolves in Sheep's Clothing*, *supra* note 7, at 144–46.

13. *Id.* at 178.

14. IN A NUTSHELL, *supra* note 3, at 252.

15. Karns, *supra* note 8, at 488–89.

revenue greater than what charity would provide.[16] One scholar argues that "the mission of . . . modern tax-exempt hospital[s] is to keep their tax exemption and *then* provide the best health care at the lowest cost."[17] Thus, the very structure of how nonprofit hospitals generate their revenue pushes them toward seeking profits and away from focusing on charitable care or useful research, yet they receive special treatment for the same behaviors carried on by for-profit hospitals.

In short, the system is out of balance. Because private citizens lack standing to pursue change in the courts, the correction must be made by Congress and the IRS.[18] Happily, a ready blueprint already exists. Acting as "Brandeisian laboratories," many states have a more intelligent system of holding the tax-exempt to account: instead of amorphous guidelines, many simply demand a quantifiable exchange of charitable care for relief from taxes.[19] Using this quid pro quo idea as the foundation of tax exemption, the federal system can be corrected by retaining some of the flexibility of Revenue Ruling 69-545 but by largely returning to the earlier Revenue Ruling 56-185, modified by a deletion of the organizational test.[20] Thus, a modified version of Revenue Ruling 56-185 with only the operational test would apply both the state definitions of "charity" and the prescriptive measures for assessing the burdens that the hospitals must relieve. This modified system will also necessitate exempting shareholder dividends from the prohibition on private inurement to allow for-profit hospitals to pursue federal tax-exempt status if they choose to do so. Nonprofit hospitals should have to provide sufficient charitable services to earn their tax-exempt status, and for-profit hospitals should not face the organizational test's insurmountable barriers precluding them from being rewarded for their charitable services.

Part I of this Article examines the application of both federal and state tax law to both for-profit and nonprofit hospitals. Part II compares the federal application to the various states' applications and offers insight into what motivates these differences. Part III proposes the revised revenue ruling that only applies the operational test and exempts shareholder

16. Rubinstein, *supra* note 6, at 405 (quoting Bradford H. Gray, *Why Nonprofits? Hospitals and the Future of American Health Care*, 6 EXEMPT ORG. TAX REV. 729, 733 (1992)).

17. *Wolves in Sheep's Clothing*, *supra* note 7, at 180 (emphasis added).

18. *See* Simon v. E. Ky. Welfare Rts. Org., 426 U.S. 26, 28 (1976).

19. *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory . . . .").

20. *See* Rev. Rul. 56-185, 1956-1 C.B. 202, 202–04.

dividends from the private inurement prohibition. This part will also raise potential objections and defend the proposal. Part IV concludes.

I. APPLICATION OF FEDERAL AND STATE TAX-EXEMPTION LAW TO FOR-PROFIT AND NONPROFIT HOSPITALS

A. Federal Tax Exemption

Federal tax-exempt status is attractive, and carries several benefits including, but not limited to: (1) exemption from corporate income taxes for the entity; (2) exemption from various "federal unemployment taxes" for the entity; and (3) deductibility of donations made to the entity.[21] However, a hospital is not immune from all taxation. It is still subject to taxation on Unrelated Business Taxable Income (UBTI).[22] Before delving into how the federal tax exemption operates, it is necessary to understand the history of how the system reached its current stage.

Hospitals first operated as almshouses for the sick and relied heavily on private donations of money and time to provide services to those who could not afford to pay.[23] Consistent with the theory of uplifting the poor, the IRS with Revenue Ruling 56-185 required hospitals to provide free services "to the extent of [their] financial ability . . . ."[24] Exempt hospitals were also required to be organized as charitable organizations with the purpose of "operating a hospital for the care of the sick[,]" to maintain an "open staff provision," and to avoid private inurement.[25]

This framework operated well until the advent of the Medicare and Medicaid programs in 1965, which took over subsidizing much of the free

21. ORGANIZATION & FINANCE, *supra* note 10, at 589. Among other benefits, these organizations enjoy preferred postal rates and the ability to issue tax-exempt bonds under IRC § 145. *See id*.

22. *Id.* at 612. UBTI is any income "which is not substantially related [to the] . . . purpose or function constituting the basis for exemption . . . . [Income received from] [a]ny trade or business carried on . . . primarily for the convenience of its . . . patients . . . or employees [is not UBTI.]" Treas. Reg. §§ 1.513-1(a), (e)(2) (as amended in 2020). *See also* IN A NUTSHELL, *supra* note 3, at 250 (explaining that while conveniences like parking garages or cafeterias may be exempt, lab services, pharmacies, and gift shops—unrelated to patient convenience and more commercial in nature—are not granted an exemption).

23. IN A NUTSHELL, *supra* note 3, at 242; *see also Wolves in Sheep's Clothing*, *supra* note 7, at 155–56.

24. *See* Rev. Rul. 56-185, 1956-1 C.B. 202, 203; *see also* IN A NUTSHELL, *supra* note 3, at 242; Karns, *supra* note 8, at 401.

25. Rev. Rul. 56-185, C.B. at 203–04; Rubinstein, *supra* note 6, at 395.

and below-cost healthcare that hospitals provided to earn their tax exemption.[26] Two competing (but erroneous) views on the effect of subsidies led the IRS to scramble to preserve the federal tax exemption for hospitals.[27] Ultimately, the IRS did only that, but did not require nonprofit institutions to justify earning their exemptions as they had to previously.[28] Instead, the IRS responded with Revenue Ruling 69-545 and the infamous "promotion of health" standard—providing that hospitals must "promote the health of a class of persons broad enough to benefit the community and must be operated to serve the public rather than a private interest."[29] The Revenue Ruling laid out several guidelines that the nonprofit hospitals should follow, such as the "existence of a governing board composed of 'independent civic leaders' drawn from the community, an emergency room open to all, an open medical staff, and treatment of government-insured patients . . . ."[30] Yet, even the requirement to treat the indigent fell away years later.[31] With the release of Revenue Ruling 83-157 in 1983, circumstances such as a perceived lack of need or a facility's specialization suggested that hospitals could keep their tax-exempt status without operating an emergency room or providing free care.[32] In effect, this new regulation released nonprofit hospitals from accountability to their charitable mission.

The statutory source of the federal tax exemption is Internal Revenue Code Section 501(c).[33] To qualify for an exemption under this section, hospitals must satisfy both an organizational and an operational test.[34] The organizational test simply demands that the institution be organized for an exempt purpose.[35] But under the operational test, the organization must satisfy three requirements. First, while healthcare is not explicitly

26. Rubinstein, *supra* note 6, at 396–97.

27. *Compare* IN A NUTSHELL, *supra* note 3, at 242 (explaining the argument that the rise of social programs would end the need for charitable donations), *with* ORGANIZATION & FINANCE, *supra* note 10, at 591 (suggesting that policymakers were wrong to believe the rise of social programs would "obviate the need for charity care").

28. ORGANIZATION & FINANCE, *supra* note 10, at 591.

29. *Wolves in Sheep's Clothing*, *supra* note 7, at 168; Rev. Rul. 69-545, 1969-2 C.B. 117, 118.

30. ORGANIZATION & FINANCE, *supra* note 10, at 591 (quoting Rev. Rul. 69-545, C.B. at 118).

31. *See* IN A NUTSHELL, *supra* note 3, at 243 ("In essence, hospital care is treated like education—as being a *per se* charitable service.").

32. *Id.* at 242–43; *see* Rev. Rul. 83-157, 1983-2 C.B. 94, 95.

33. *See* I.R.C. § 501(c).

34. *See* Rev. Rul. 69-545, C.B. at 117; *see also* ORGANIZATION & FINANCE, *supra* note 10, at 590.

35. ORGANIZATION & FINANCE, *supra* note 10, at 590.

mentioned in the text of the law, hospitals fall under the "general heading of charity," and must show that they provide charitable services to receive federal tax exemption.[36] Second, the operational test has an "exclusivity" requirement: the organization is to be "operated exclusively for religious, charitable, scientific, testing for public safety, literacy, or educational purposes . . . ."[37] Third, and finally, to maintain tax exemption, hospitals need also take care that

> no part of [its] net earnings . . . inures to the benefit of any private shareholder or individual, no substantial part of [its] activities . . . is carrying on propaganda, or otherwise attempting, to influence legislation . . . , and [it] does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.[38]

The clause discussing "inurement" is the source of the "prohibition on private inurement."

In practice, the difficulty that applying entities have in satisfying the organizational and operational tests is not identical. Regarding the organizational test, the "[d]ocuments establishing the entity are especially important, and their specificity as to compliance with statutory prescriptions is critical."[39] However, as one scholar points out, this really just amounts to showing "that certain clauses—promising to eschew lobbying and political activity and all private inurement, for example—have been included in the organization's founding documents."[40] Hence, it is considered by some to be in substance nothing more than "a 'magic words' test."[41]

The operational test, on the other hand, requires much more in-depth analysis. Each requirement of that test—charity, exclusivity, and inurement—will be taken in turn.

1. Charity

Because hospitals are considered charitable organizations, understanding the operational test begins with understanding the definition of

36. Rubinstein, *supra* note 6, at 383; *see* I.R.C. § 501(c)(3).

37. I.R.C. § 501(c)(3).

38. *Id.*

39. Karns, *supra* note 8, at 405.

40. Thomas Kelley, *Rediscovering Vulgar Charity: A Historical Analysis of America's Tangled Nonprofit Law*, 73 FORDHAM L. REV. 2437, 2473 n.226 (2005).

41. *Id.*

charity.[42] With the advent of Revenue Ruling 69-545 and the public-benefit standard, the definition broadened to embrace more than a narrow mandate to provide free or below-cost care.[43] But one must turn to the case law to determine what actually is required of hospitals.

i. IHC Health Plans Inc.

In *IHC Health Plans, Inc. v. Commissioner of Internal Revenue*, the Tenth Circuit decided that the Tax Court correctly denied IHC Health Plans, Inc. (IHC Health) tax-exempt status under Section 501(c)(3) as a charitable organization.[44] IHC Health was created by a restructuring of two nonprofits: Intermountain Health Care, Inc., a Utah nonprofit corporation owning fifteen hospitals previously run by the Latter Day Saints Church, and IHC Health Services, Inc.[45] The board and unitary corporate members were the same persons that ran Intermountain Health Care, Inc.—managing the assets as a parent company controlling three health-maintenance organizations.[46]

While the Tenth Circuit admitted the definition of charity and the idea in Revenue Ruling 69-545 and others of "'community benefit' is somewhat amorphous," the court held that it nevertheless "provide[d] a workable standard for determining tax exemption under section 501(c)(3)."[47] Recognizing the sweep of the statutory language, the court narrowed the benefit standard, stating that "engaging in an activity that promotes health, *standing alone*, offers an insufficient indicium of an organization's purpose. Numerous for-profit enterprises offer products or services that promote health."[48] To qualify for an exemption, an organization must go beyond providing health services to the community, which

42. *See supra* note 33 and accompanying text.

43. *Compare* Rev. Rul. 83-157, 1983-2 C.B. 94, 94 (requiring hospitals to provide charitable care "to benefit the community"), *with* Rev. Rul. 69-545, 1969-2 C.B. 117, 118 (requiring hospitals engage in the "promotion of health"), *and* Rev. Rul. 83-157, C.B. at 94–95 (eliminating the requirement to operate an emergency room open to all in certain circumstances). Despite unsuccessful legislative attempts to grant hospitals de jure *per se* charitable status, the IRS rulings accomplished the mission by making hospitals de facto *per se* charitable institutions. *See* IN A NUTSHELL, *supra* note 3, at 243; Rubinstein, *supra* note 6, at 396.

44. IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188, 1199 (10th Cir. 2003).

45. *Id.* at 1191.

46. *Id.* at 1191–92.

47. *Id.* at 1197.

48. *Id.*; *see also* Rev. Rul. 98-15, 1998-1 C.B. 716, 719 ("[S]elling prescription pharmaceuticals certainly promotes health, but pharmacies cannot qualify for . . . exemption under § 501(c)(3) on that basis alone.").

Revenue Rulings 69-545 and 83-157 require; hospitals must "provide some additional 'plus.'"[49]

To determine whether the organization satisfied the "plus" requirement, the court held that "a health-care provider must make its services available to all in the community *plus* provide additional community or public benefits. The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy."[50]

ii. St. David's Health Care System

Building upon *IHC Health Plans, Inc.*, the Fifth Circuit established a more concrete definition of charity in *St. David's Health Care Systems v. United States*. The court placed Revenue Ruling 69-545 at the center and treated the *IHC Health Plans, Inc.* factors as "relevant . . . for determining whether a hospital confers a significant community benefit . . . ."[51] In this case, St. David's Health Care System sued to recover taxes it paid after the IRS denied its tax-exempt status.[52] The point of contention was whether St. David's lost its exempt status by forming a partnership with a for-profit entity that had a majority of control over the partnership.[53]

In defining charity, the *St. David's* court first looked to the "'community benefit standard'" from Revenue Ruling 69-545, determining that:

> [A] non-profit hospital can qualify for a tax exemption if it: (1) provides an emergency room open to all persons, regardless of their ability to pay; (2) is willing to hire any qualified physician; (3) is run by an independent board of trustees composed of representatives of the community ("community board"); and (4) uses all excess revenues to improve facilities, provide educational services, and/or conduct medical research.[54]

49. *IHC Health Plans, Inc.*, 325 F.3d at 1197 (providing that "additional plus" can take several forms); *see also* Rev. Rul. 83-157, 1983-2 C.B. 94, 94–95 (suggesting that while the operation of an emergency room is a strong indicator of providing a public benefit, other activities such as treating Medicare and Medicaid patients, using surplus funds to improve facilities, and improving training and research also indicate public-benefit activity).

50. *IHC Health Plans, Inc.*, 325 F.3d. at 1198.

51. St. David's Health Care Sys. v. United States, 349 F.3d 232, 235 (5th Cir. 2003) (citing *IHC Health Plans, Inc.*, 325 F.3d at 1197 n.16).

52. *Id.* at 233.

53. *Id.*

54. *Id.* at 235.

The court then laid out the second tier of analysis for the charitable purposes test, citing *IHC Health Plans, Inc.* favorably, noting as relevant factors whether the hospital "includ[es] the provision of free or below-cost care; the treatment of individuals eligible for Medicare or Medicaid; the use of extra funds for research and educational programs; and the composition of the board of trustees."[55] However, citing a Third Circuit case called *Geisinger Health Plan v. Commissioner*, the Fifth Circuit held that "[a] hospital need not demonstrate all of these factors to qualify for § 501(c)(3) tax-exempt status."[56]

IHC Health Plans Inc. and *St. David's Health Care System* converge on a few points. First, both the Tenth and the Fifth circuits stressed that when the board is representative of the community—rather than composed of subscribers seeking profit—that factor leans in favor of tax-exempt status.[57] Second, the courts were also in agreement regarding how excess funds should be used.[58] Finally, both cases acknowledge that the provision of below-cost or free medical care is not required for a hospital to satisfy the community benefit standard.[59]

iii. Synthesized Test

Taken together, a definition of charity emerges. To satisfy the community benefit standard, hospitals must: (1) "provide[] an emergency room open to all persons, regardless of their ability to pay," or satisfy *Geisinger*'s totality-of-the-circumstances test by providing a sufficient quantity of other services such as teaching, researching, or using excess funds to improve facilities;[60] (2) be "willing to hire any qualified physician";[61] (3) be guided by "an independent board of trustees composed of representatives of the community";[62] and finally, (4) use "all excess reve-

55. *Id.* at 235–36 (citing *IHC Health Plans, Inc.*, 325 F.3d at 1197 n.16).

56. *Id.* at 236 (citing Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1219 (3d Cir. 1993) (noting "the determination must be based upon the totality of the circumstances").

57. *See IHC Health Plans, Inc.*, 325 F.3d at 1201; *St. David's Health Care Sys.* 349 F.2d at 241–42.

58. *See IHC Health Plans, Inc.*, 325 F.3d at 1197 n.16; *St. David's Health Care Sys.*, 349 F.2d at 235–36.

59. *See IHC Health Plans, Inc.*, 325 F.3d at 1200 (failing to treat IHC Health Plans Inc.'s lack of free emergency care as dispositive); *St. David's Health Care Sys.*, 349 F.2d at 236 (noting that a hospital can satisfy the community benefit standard by a totality of the circumstances even without providing free or below-cost care).

60. *St. David's Health Care Sys.*, 349 F.2d at 235; *see Geisinger Health Plan*, 985 F.2d at 1219.

61. *St. David's Health Care Sys.*, 349 F.2d at 235.

62. *Id.*

nues to improve facilities, provide educational services, and/or conduct medical research."[63]

2. Exclusivity

While Section 501(c)(3) mandates that hospitals be "organized and operated *exclusively*"[64] for charitable purposes, "the statute has been interpreted to mean 'primarily' or 'substantially.'"[65] The United States Tax Court has held that "the 'operational exclusivity' requirement applies to the organization's purposes."[66] Therefore, "the business may not engage in activities that are not in furtherance of its tax-exempt purpose, unless such non tax-exempt activities constitute an 'insubstantial' part of the business's overall activities."[67] Again, one must turn to the case law to determine how the requirement operates in practice.

In *IHC Health Plans, Inc*., the Tenth Circuit held that "more than an insubstantial part" of IHC's activities were not in furtherance of an exempt purpose because IHC Health Plans' insurance services appeared to the court to serve a "risk-bearing function" rather than a community benefit.[68] Additionally, the petitioner, while offering discounted health services, mainly was in the business of providing coverage for a fee.[69] Thus, because the majority of the petitioner's activities were aimed at seeking profit rather than providing a community benefit, they failed to satisfy this requirement.[70]

63. *Id.*

64. I.R.C. § 501(c)(3) (emphasis added).

65. *Wolves in Sheep's Clothing*, *supra* note 7, at 164; IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188, 1194 (10th Cir. 2003) ("[A]n organization will be regarded as 'operated exclusively' for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3)." (quoting 26 C.F.R.§ 1.501(c)(3)-1(c)(1))).

66. Karns, *supra* note 8, at 415 (quoting Sound Health Ass'n v. Commissioner, 71 T.C. 158, 190 (1978)).

67. *Wolves in Sheep's Clothing*, *supra* note 7, at 164.

68. *See IHC Health Plans, Inc.*, 325 F.3d at 1194, 1199 ("'[I]t is difficult to distinguish the plaintiff corporation from a mutual insurance company . . . .'" (quoting Hassett v. Associated Hosp. Serv. Corp. of Mass., 125 F.2d 611, 614 (1st Cir. 1942))).

69. *See id.* at 1200 ("'[A]n organization which does not extend some of its benefits to individuals financially unable to make the required payments [generally] reflects a commercial activity rather than a charitable one.'" (quoting Fed'n Pharmacy Servs., Inc. v. C.I.R., 625 F.2d 804, 807 (8th Cir.1980))). The court also noted the fact that petitioner did not conduct research or provide free education for the community "bolster[ed its] conclusion that petitioners did not operate for the purpose of promoting health for the benefit of the community." *Id.* at 1200–01.

70. *Id.* at 1201–02.

The court in *St David's Health Care Systems* warned that the analysis is not only "whether the organization's activities further its charitable purposes," but that a corollary condition exists, namely, that courts "must also ensure that those activities do *not* substantially further other (non-charitable) purposes."[71] Courts do so by "examin[ing] the structure and management of the organization."[72] In other words, courts are looking to who controls the organization, reasoning that organizations controlled mainly by for-profit entities are more likely to further the purpose of profit rather than the purpose of charity.[73] In short, the charitable actors must be in control, and the organization must dedicate a majority of its resources toward its charitable functions.

3. Private Inurement

The final requirement of the operational test of § 501(c)(3) is a prohibition of private inurement. Private inurement is "a financial benefit that 'represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to accomplishing exempt purposes.'"[74] Functionally, this restriction is "a per se rule," because even a *de minimis* violation means that the tax exemption must be revoked or denied without exception.[75] The IRS Treasury Regulations make clear that the prohibition applies "only to 'insiders,' defined as private shareholders or individuals having a personal and private interest in or opportunity to influence the activities of the organization from the inside."[76]

However, private inurement must be distinguished from private *benefit transactions*. Instead of a limitation to insiders, the latter is "a broader inquiry" than private inurement that includes a "weighing [of] private benefits against community benefits."[77] Further, unlike private inurement, the

71. St. David's Health Care Sys. v. United States, 349 F.3d 232, 237 (5th Cir. 2003).

72. *Id.*

73. *See id.* at 237, 239–40 (noting that St. David's cession of control to the for-profit entity left the court uncertain as to whether it was organized primarily for charitable purposes). Conversely, when a charitable organization is mainly in control, the court has an easier time finding that the exclusivity requirement is met. *See id.* at 239. Also important to the court's analysis was Revenue Ruling 98-15, suggesting charitable hospitals can in fact proceed with joint ventures provided the hospital "can establish that it has retained control over the partnership's activities." *Id.*

74. Karns, *supra* note 8, at 408 (quoting I.R.S. Gen. Couns. Mem. 38,459 (July 31, 1980)).

75. ORGANIZATION & FINANCE, *supra* note 10, at 636.

76. *Id.*

77. *Id.*

prohibition of private benefit transactions also reaches those outside the organization.[78] But in either case, "the actual accomplishment of the entity's exempt activities and not the organization's statement of purpose" is key to testing whether these requirements are met.[79]

While private inurement is generally prohibited, there are exceptions. One is physician recruitment. Hospitals can "expend significant resources to recruit physicians" without losing their tax-exempt status.[80] However, payments must be "reasonable compensation for the services the physician is providing in return."[81]

Private benefit is policed through enforcing against "excess benefit transactions," which are defined as:

> transaction[s] in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person if the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received for providing such benefit.[82]

"The core prohibited transactions are . . . non-fair market transactions[;] . . . unreasonable compensation arrangements; or proscribed revenue sharing arrangements."[83] The prohibition is enforced by a levy of a tax, which can vary from 25% of the benefit up to 200% of the benefit if the inurement problem is not corrected quickly.[84] Organizational managers are sanctioned 10% of the value of the benefit, but the organization it-

78. *Id.* Private benefit transactions, unlike private inurement, do not necessarily sound the death knell of an organization's exempt status and are instead policed by excess benefit transactions. *See id.* at 638. These will be discussed in more detail.

79. *See* Karns, *supra* note 8, at 408.

80. ORGANIZATION & FINANCE, *supra* note 10, at 629. Among other things, hospitals can provide the following for physicians: relocation expenses, signing bonus, home mortgage expenses, loan forgiveness, and income guarantees. *Id.*

81. Rev. Rul. 97-21, 1997-1 C.B. 121, 123. The ruling suggests that factors such as: showing objective evidence of the physician's need, showing a reasonable relation to the hospital's exempt purpose, and overall reasonableness of the benefits conferred weigh in favor of not finding private-inurement violation. *See id*. at 123–24.

82. I.R.C. § 4958(c)(1)(A). Disqualified persons include "any person who was, at any time during the 5-year period ending on the date of such transaction, in a position to exercise substantial influence over the affairs of the organization, . . . a member of the family of [such] an individual," or a holder of over 35% of voting power in the entity. *Id.* § 4958(f)(1).

83. ORGANIZATION & FINANCE, *supra* note 10, at 638.

84. *See* Treas. Reg. § 53.4958-1(a) (2002).

self is never penalized.[85] There is also a presumption of reasonableness that attaches if the transaction was approved by a committee with no conflicts of interest and that relied upon documented comparability data before making the decision.[86] In short, these "intermediate sanction[s]" seek to recover part of the private benefit but do not attack the entity's tax-exempt status.[87]

The federal system is out of balance. At the same time that nonprofit hospitals benefit without bearing a commensurate burden, for-profit hospitals are not justly rewarded for their charitable deeds. Fortunately, there are workable alternatives in many states that are already in place that can serve as a foundation, and it is to them that this Article turns next.

B. State Tax Exemption

As laboratories of democracy, the states have chosen several methods of regulating hospital tax exemption. While some mirror the federal "community benefit" standard, many demand more tangible good works from hospitals.[88] They have good reason to do so. In many states, exempt status grants freedom from state income and property taxes.[89] The importance of this to the states and its effect on policy will be discussed in the next part. For the following discussion, however, it should be kept in mind that an organization can always be exempt from federal taxation but not state taxation, and vice versa.[90] To illustrate a few of the possible approaches, the Article will survey five state tax-exemption policies.[91]

85. *See id.*

86. *See id.* §§ 53.4958-1(d)(2), -6(a).

87. *See* ORGANIZATION & FINANCE, *supra* note 10, at 638.

88. ORGANIZATION & FINANCE, *supra* note 10, at 643–44 (noting that historically, states modeled their tax-exemption policies after the federal approach before pursuing their own policies).

89. *See* Karns, *supra* note 8, at 399; *see also* Rubinstein, *supra* note 6, at 382–83 n.5.

90. *See* United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665, 668 (E.D. Mich. 2011) ("Blue Cross is subject to federal taxation but is exempt from state and local taxation under Michigan law."); Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1144 (Ill. 2010), *superseded by statute*, 35 ILL COMP. STAT. 200/15-86 (2015) ("[T]ax exemption under federal law is not dispositive of whether real property is exempt from property tax under Illinois law."); Rubinstein, *supra* note 6, at 381–83 (showing that tax exemption is implemented separately at the federal and state levels).

91. For purposes of this Article, the survey will necessarily be short. For a deeper dive into a broader analysis of state tax-exemption schemes, see Brody's article *supra* note 133.

1. Illinois

Illinois presents an interesting first illustration of the push-and-pull between courts and the legislature on the issue. At first, courts used a modified community-benefit standard until, in response, the legislature codified a prescriptive method.[92] In the case that triggered the response, *Provena Covenant Medical Center v. Department of Revenue*, the Illinois Supreme Court examined whether subsidiary hospitals of the nonprofit Provena Health were entitled to an exemption from property taxes on parcels of land that they owned and operated on.[93] The issue in the case was whether the fact that Provena's subsidiary hospitals contracted with for-profit entities disqualified them from property tax exemption.[94]

Right out of the gate, the court made clear that tax exemption is a hard-earned "exception," whereas "taxation is the rule."[95] Furthermore, the organization must prove its entitlement to exemption by meeting a clear and convincing evidentiary standard.[96] The Illinois high court also announced that the property tax exemption flows "from article IX, section 6 of the 1970 Illinois Constitution[,]" which allows the legislature to impose additional conditions on the exempt status.[97] The legislature exercised this option requiring "not only that the property be 'actually and exclusively used for charitable or beneficent purposes, and not . . . used with a view to profit,' but also that it be owned by an institution of public charity . . . ."[98]

Thus, for tax exemption to be appropriate under the Illinois constitution and then-existing statutory law, the hospitals had to be charitable institutions and provide charitable services "exclusively."[99] Before concluding that Provena's subsidiary hospitals were not "charitable institutions," the court set forth a qualifying organization's characteristics:

92. *See* 35 ILL. COMP. STAT. 200/15-86 (2015).

93. Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1135 (Ill. 2010), *superseded by statute*, 35 ILL. COMP. STAT. 200/15-86 (2015).

94. *Provena*, 925 N.E.2d at 1136–42 (Ill. 2010). The court acknowledged that exempt organizations can contract with for-profit entities for their day-to-day functions so long as there is no private inurement, but the court denied Provena its exempt status on account of failing the other factors of the test. *Id.* at 1146.

95. *Id.* at 1143.

96. *Id*. at 1144. The burden is a heavy one since "every presumption is against the intention of the state to exempt property from taxation . . . ." *Id*.

97. *See id*.

98. *Id*. at 1145.

99. *Id*.

> (1) it has no capital, capital stock, or shareholders; (2) it earns no profits or dividends but rather derives its funds mainly from private and public charity and holds them in trust for the purposes expressed in the charter; (3) it dispenses charity to all who need it and apply for it; (4) it does not provide gain or profit in a private sense to any person connected with it; and (5) it does not appear to place any obstacles in the way of those who need and would avail themselves of the charitable benefits it dispenses.[100]

Turning to the exclusive-use provision, the court held that the provision mandates that charitable use must be the "primary" use of the property, and "[s]econdary or incidental charitable benefits will not suffice, nor will it be enough that the institution professes a charitable purpose or aspires to using its property to confer charity on others."[101] Getting at the heart of why the exemption is granted, the court explained that the hospital must relieve a burden on the government to receive its tax exemption.[102] Ultimately, Provena's subsidiaries did not qualify here, either.[103]

Not long after *Provena* was decided, the Illinois legislature superseded the decision by changing the test for tax exemption to a prescriptive one.[104] Previously, Illinois law never required "a direct, dollar-for-dollar correlation between the value of the tax exemption and the value of the goods or services provided by the charity."[105] But the new statute required just that: to receive an exemption, the value of the services the hospital provides must at least equal its potential property tax liability.[106] The state, in other words, sought to get its money's worth and not to leave what that looked like to the courts.[107] But Illinois is not alone in its prescriptive approach; indeed, a handful of other states with varying requirements and metrics use it.[108]

100. *Id*. at 1146. Charity is defined as "in some way reducing the benefits of the government." *Id*. at 1145.

101. *Id*. at 1147.

102. *Id*. at 1147–48.

103. *Id*. at 1147–49.

104. *See* ORGANIZATION & FINANCE, *supra* note 10, at 650–51; *see also* 35 ILL. COMP. STAT. 200/15-86 (2015).

105. *Provena*, 925 N.E.2d at 1148.

106. *Provena*, 925 N.E.2d at 1148; *see* ORGANIZATION & FINANCE, *supra* note 10, at 650.

107. *See* ORGANIZATION & FINANCE, *supra* note 10, at 651.

108. *See id.* (noting states such as Pennsylvania, Nevada, and Texas tie tax exemption to a percentage of expenditures the hospital must make toward community benefits or specifying a portion of operating costs that must be dedicated toward community benefits). *Id.* Nevada, for example, requires hospitals with 100 beds or more to provide 0.6% of their revenue toward indigent care. *Id.* Texas requires 5% of revenues to be spent on indigent

2. Utah

Utah also takes a quid pro quo approach, as illustrated by *Utah County v. Intermountain Healthcare*.[109] In that case, Utah County sought review by the Utah Supreme Court of a decision by the state Tax Commission that granted a hospital owned and operated by Intermountain Healthcare an exemption from property taxes.[110] In rejecting the exemption and reversing the Tax Commission's decision, the court began by noting that grants of charitable exemption authorized by Utah's constitution are strictly construed—lest a greater burden in the form of lower revenues for public services is placed on taxpayers.[111] As the majority put it, "[a]n entity may be granted a charitable tax exemption for its property under the Utah Constitution only if it meets the definition of a 'charity' *or* if its property is used exclusively for 'charitable' purposes."[112] But the court emphasized that the "[e]ssential . . . element" of either part of the disjunctive test is the concept of "gift to the community."[113]

The court defined the important "gift to the community" element as either "a substantial imbalance in the exchange between the charity and the recipient . . . or in the lessening of a government burden through the charity's operation."[114] In considering the "exclusivity" prong, the Utah high court articulated six factors to be weighed in determining whether "a charitable purpose or gift exists in any particular case."[115] And while the

care every year. *Id*. Though the minimum requirements in these states may appear small when compared to the amount saved by avoiding taxes, the costs of operating a hospital fluctuate with the overall business climate. *See supra* notes 14–19 and accompanying text.

109. Utah Cnty. *ex rel* Cnty. Bd. of Equalization v. Intermountain Health Care, Inc., 709 P.2d 265, 268 (Utah 1985) ("These exemptions confer an indirect subsidy and are usually justified as the *quid pro quo* for charitable entities undertaking functions and services that the state would otherwise be required to perform.").

110. *Id*. at 266–67. Utah also bases its powers of granting tax exemption for charitable purposes upon its state constitution. *Id*. at 267. Interestingly, the challenge targeted the statutes as overbroad mandates to grant exemptions rather than asserting Intermountain did not meet the statutory requirements. *Id*.

111. *Id*. at 268–69.

112. *Id*. at 269 (emphasis added).

113. *Id*. at 269 (emphasis added).

114. *Id*.

115. *Id*. at 269–70. The factors are as follows: "(1) whether the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward; (2) whether the entity is supported, and to what extent, by donations and gifts; (3) whether the recipients of the 'charity' are required to pay for the assistance received, in whole or in part; (4) whether the income received from all sources (gifts, donations, and payment from recipients) produces a 'profit' to the entity in the sense that the income exceeds operating and long-term maintenance expenses; (5) whether the beneficiaries of the

court applied an exacting review, it emphasized the *sui generis* nature of the test: "each case must be decided on its own facts, and the foregoing factors are not all of equal significance, nor must an institution always qualify under all six before it will be eligible for an exemption."[116] In short, Utah applies a strict totality-of-the-circumstances test to determine whether the organization is a charity or uses its property for charitable purposes.

3. Minnesota

Minnesota established a statutory hybrid-type scheme of factors and mandatory elements.[117] Using the six common law factors that already existed in Minnesota law, the legislature merely required that three of them be met by the organization, while the remaining three allow for a "'reasonable justification' exception . . . ."[118] This approach to defining "charity" is considered by at least one commentator to be in some tension with the goals of clarity and predictability because factor balancing inherently "fails to establish a clear, predictable, and fair standard."[119]

4. Ohio

Like Minnesota, Ohio provides an ambiguous statutory approach to property-tax exemption by not including hospitals anywhere in the statute.[120] Nor does the statute provide a clear definition of charity care.[121] To qualify, a hospital's "real property must be owned by a charitable institution, and . . . must be used exclusively for a charitable purpose"—with the charitable purpose being defined as "provid[ing] uncompensated care to all who need it . . . ."[122] This spongy standard means that ultimately,

'charity' are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objectives; and (6) whether dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests, and whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones." *Id*.

116. *Id*. at 270.

117. Mintz, *supra* note 130, at 424–25.

118. Brody, *supra* note 133, at 632.

119. Mintz, *supra* note 130, at 424–25.

120. *See id*. at 428–29.

121. *See id*. at 429.

122. *Id*.

Ohio courts—like those in Utah—are left to make a totality-of-the-circumstances determination in each case.[123]

5. New Jersey

New Jersey's test provides a final unique example for this short survey. The mechanics of the test are derived from a New Jersey case called *Paper Mill Playhouse v. Millburn Township*.[124] There, the state's high court held that for tax exemption to apply, the "hospital property must: (1) have ownership by an entity exclusively organized for an exempt purpose; (2) be actually and exclusively used for a tax-exempt purpose; and (3) not be operated or used to conduct a profit."[125]

The first prong of the test concerns itself with ensuring hospital purposes are defined narrowly enough to avoid the use of elusive structures to shelter for-profit ventures from taxes.[126] The second part of the test examines how the property is used.[127] Regarding the third and final part, the "profit test," the New Jersey Supreme Court made it clear that charitable entities are not required to be operated at a loss and may still carry on some non-exempt functions on its property so long as they are not commingled with exempt functions.[128] At its most basic level, the profit test requires a "pragmatic inquiry into profitability . . . . [It requires a] realistic common-sense analysis of the actual operation of the taxpayer; mechanical centering on income and expense figures is to be avoided."[129]

Thus, there are a multiplicity of approaches used by states to determine the requisite charitable care to warrant state tax exemption. But some unifying principles can be drawn from the various state approaches. For example, the source of power to lay taxes for "[j]ust about" all the states comes from their constitutions—and state constitutions are usually

123. *Id*.; *see* Cleveland Osteopathic Hosp. v. Zangerle, 91 N.E.2d 261, 263 (Ohio 1950) ("It seems obvious that no single test is dispositive of whether a hospital, for example, is being conducted exclusively as a charitable project.")

124. Paper Mill Playhouse v. Millburn Twp., 472 A.2d 517, 518 (N.J. 1984).

125. Jillian A. Swogier, *Finding a Fit for Nonprofit Hospitals: A National Perspective of State Property Tax Exemption Laws*, 41 SETON HALL LEGIS. J. 461, 468–69 (2017); *see* Paper Mill Playhouse v. Millburn Twp., 472 A.2d 517, 518 (N.J. 1984).

126. Swogier, *supra* note 125, at 469.

127. *See id*. at 469–70.

128. *See* AHS Hosp. Corp. v. Morristown, 28 N.J. Tax 456, 500–01 (2015). In other words, profit is acceptable so long as it cannot "be traced into" the hands of private actors. *Id*. at 501.

129. *Id*. at 496 (quoting *Paper Mill Playhouse*, 472 A.2d at 517).

the source of the state's power to exempt entities from taxation.[130] And generally, in assessing real property tax exemption, the states use "a parcel-by-parcel" mode of analysis.[131] Furthermore, because hospitals are not explicitly mentioned in state constitutions for tax exemption, they have, for the most part, derived their exemptions "under the catch[-]all term of 'charity' or 'charitable use.'"[132] Finally, "having federal income-tax exemption under Internal Revenue Code section 501(c)(3) is not enough" to be exempt from state property taxes.[133]

The next section will draw comparisons between the federal approach and state approaches to tax exemption, among the state approaches themselves, and finally provide insight as to why these differences exist.

II. COMPARISON OF FEDERAL AND STATE APPROACHES AND THE MOTIVATIONS FOR THESE DIFFERENCES

A. Federal vs. State Approaches

The first major set of differences between the state and federal systems is the source of their tax-exemption powers and what those powers entail. These largely mechanical differences are that states derive their authority to tax from their constitutions while the source of federal tax exemption flows from section 501(c)(3) of the Internal Revenue Code.[134] And while federal tax exemption provides respite from federal income tax, it also "makes gifts to a tax exempt entity deductible . . . and . . . lower[s] interest rates for . . . [the] entity seeking funds in the public bond market."[135] But state tax exemption only "relieves an exempt entity from personal property taxes and real property taxes."[136]

A second major difference between the federal and state approaches is the evaluative standard used to determine whether a hospital is granted tax-exempt status. While the federal government uses the "community benefit standard," states use what both Mr. Mintz and Ms. Swogier refer to

130. Lowell R. Mintz, *The Rules of the Fight Must be Fair: States Should Pass a Uniform Code for Nonprofit Hospital Tax Exemption of Real Property*, 26 J.L. & HEALTH 415, 425 (2013).

131. *Id.* at 422.

132. *Id.* at 425.

133. Evelyn Brody, *All Charities are Property-Tax Exempt, but Some Charities are More Exempt than Others*, 44 NEW ENG. L. REV. 621, 626 (2010).

134. Mintz, *supra* note 130, at 425; *see* I.R.C. § 501(c)(3).

135. Mintz, *supra* note 130, at 419.

136. *Id.*

as a "charitable care standard."[137] This distinction reveals the expectations each level of government has for exempt hospitals. The federal standard is broad, allowing hospitals to qualify for tax exemption in more ways than just providing free or below-cost care.[138] On the other hand, states adopt a more quid pro quo standard of evaluation—they explicitly expect hospitals to provide charitable care to those in need and thereby relieve a state burden.[139] Prescriptive schemes setting spending or cost benchmarks in terms of charitable care hospitals must provide yearly are the antithesis of the totality-of-the-circumstances approach found in the Third and Fifth Circuit cases; prescriptive schemes provide more concrete targets and expectations, rather than leaving a hospital's evaluation to a court weighing a multitude of factors, which can produce ambiguous and inconsistent results.[140]

Third, states are more willing to zealously enforce their tax-exemption policies than the federal government, which is more concerned with the viability of its tax-exemption structure than with enforcing it.[141] According to Mr. Mintz, states are renewing the fight to police tax exemptions against hospitals due to their increasingly profit-driven behavior and their need for revenue.[142] While the federal government also has

137. *Id.* at 420; Swogier, *supra* note 125, at 467. An in-depth explanation of the federal standard was already taken in section II.A of this Article, while state initiatives were sampled in section II.B.

138. *See supra* notes 51–56 and accompanying text. Under the federal standard, other activities such as improving hospital facilities and care capacity, providing medical education, or performing research could qualify as charitable activities under a totality-of-the-circumstances test. *See* St. David's Health Care Sys. v. United States, 349 F.3d 232, 235–36 (5th Cir. 2003); Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1219 (3d Cir. 1993).

139. *See* Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1147–48 (Ill. 2010), *superseded by statute*, 35 ILL. COMP. STAT. 200/15-86 (2015); Utah Cnty. *ex rel*. Cnty. Bd. of Equalization v. Intermountain Health Care, 709 P.2d 265, 269 (Utah 1985); Brody, *supra* note 133, at 622 ("State exemption requirements generally reflect more of a quid-pro-quo rationale [for granting exemption] than does federal exemption.") (quoting Evelyn Brody, *The States' Growing Use of a Quid-Pro-Quo Rationale for the Charity Property Tax Exemption*, 56 EXEMPT ORG. TAX REV. 269, 288 (2007)).

140. *Compare* ORGANIZATION & FINANCE, *supra* note 10, at 651 (noting examples of prescriptive methods among states), *with Geisinger Health Plan*, 985 F.2d at 1219–20 (laying out the totality-of-the-circumstances approach). *See* Mintz, *supra* note 130, at 424 ("Factors used to determine if a nonprofit hospital's use is 'charity' are ambiguous, resulting in arbitrary and inconsistent application. States themselves have acknowledged the confusion and inconsistent application that stems from the use of a multifactor test to determine if a use is 'charity.'").

141. *See* ORGANIZATION & FINANCE, *supra* note 10, at 644.

142. Mintz, *supra* note 130, at 417–18.

stated its intention to enforce against hospitals on a larger scale, no consensus has emerged to rally the federal government to action in the same way that the states have.[143] Also, unlike the states, the federal government worked to *expand* the definition of charity to preserve tax exemption for hospitals; in other words, the federal government has worked to keep exemption alive in contrast to the state governments' more hostile disposition towards it.[144]

These differences can be explained by two underlying causes: (1) good intentions but poor execution by the IRS, and (2) the states' heavy reliance on property taxes to function. As suggested earlier, the advent of the Medicare and Medicaid programs as a social safety net sent the federal government scrambling to justify the hospital tax exemption's existence;[145] because hospitals could now be *paid* for their services, receiving a tax exemption for gratis charitable works did not make sense.[146] The pre-Medicare Revenue Ruling 56-185 actually required free or below-cost care to be provided to the best of the hospital's financial ability.[147] But with Revenue Ruling 69-545, the concept of "charity" was expanded to include using excess revenues to improve healthcare services, education, and research.[148] The idea has substantial merit. Even allowing the exemption to persist without the hospital operating an emergency room makes sense in the right circumstances.[149] To help hospitals adapt to the economic, social, and technological changes of contemporary society, the IRS established a definition of charity that can expand with time.

However, tension remains between the government's desire to require charitable care and its intention to keep the regulations expansive enough to meet the evolving definition of charity. Revenue Ruling 69-545 provided alternate ways for a hospital to earn its exemption while still trying to preserve the community benefit standard.[150] On the one hand, hospitals are required to provide free or below-cost medical care to the best of

143. *See* Rubinstein, *supra* note 6, at 403–04.

144. *Compare id.* ("[S]tate and local governments actively have challenged the exemption of hospitals."), *with Provena*, 925 N.E.2d at 1143–45, 56 (noting that the broader federal exemption was allowed, and holding that the state exemption was not).

145. *See supra* note 27 accompanying text.

146. *See* Rubinstein, *supra* note 6, at 396.

147. Rev. Rul. 56-185, 1956-1 C.B. 202, 203.

148. Rubinstein, *supra* note 6, at 396–99 ("[Revenue Ruling 69-545] afforded an alternative method whereby a hospital could qualify for exemption as a charitable institution.").

149. *See* Rev. Rul. 83-157, 1983-2 C.B. 94, 95.

150. *See* E. Ky. Welfare Rts. Org. v. Simon, 506 F.2d 1278, 1288 (D.C. Cir. 1974); Karns, *supra* note 8, at 421.

their financial ability, *but* they may also receive an exemption if they carry on enough charitable functions.[151]

The elements set forth in Revenue Ruling 69-545 "deal more with charitable benefit than community issues, leading to the confused expectations society has of nonprofit hospitals."[152] Examining the tests laid out in both *IHC Health* and *St. David's Health Care System* illustrates the difficulty that the courts have had in identifying the expectations that the federal government intended to impose. Absent from the IRS's guidance are the clear prescriptive benchmarks and operating targets used by states like Illinois; instead, the federal standard still in use today presents hospitals with a variety of options and aspirations, but no clear expectations.[153] In short, an expanded definition of charity protects hospitals' tax exemptions, but it does not set clear expectations of what kind of community benefit or relief a hospital is expected to provide in return for its exemption, nor how that is to be measured.

Second, states are heavily dependent on property tax revenues to provide services for their citizens.[154] Indeed, states collect most of their revenue from property taxes.[155] Unsurprisingly, it has been remarked that "when municipalities run low on funds, they challenge nonprofit hospitals' real property tax exemption status . . . ."[156] Swogier labels these state challenges as "money grabbing," because hospitals often own "large amounts of untaxed real estate" and earn substantial revenue for their services.[157] Accordingly, tax-exempt hospitals are a logical target for untapped revenue.[158] This explains the general hostility states have toward tax exemption—if hospitals are not relieving a sufficient burden on the state, the state would be better off collecting taxes to relieve that burden itself.[159] The federal government has a much bigger tax base and is not as

151. *See* Rev. Rul. 69-545, 1969-2 C.B. 117, 117–18.

152. Rubinstein, *supra* note 6, at 389.

153. *See St. David's Health Care Sys.*, 349 F.3d at 235–36.

154. *See* Mintz, *supra* note 130, at 433–34; Karns, *supra* note 8, at 396–97 ("[L]ocal governments needed the money that would be generated by ad valorem real property taxes that would be available if the tax exemption were revoked, and citizens were quite vocal about this matter.").

155. *See* Mintz, *supra* note 130, at 433–34.

156. Swogier, *supra* note 125, at 462.

157. *Id.*; Mintz, *supra* note 130, at 434.

158. *See* Karns, *supra* note 8, at 396–97; Mintz, *supra* note 130, at 433–34.

159. *See* Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1147–48 (Ill. 2010), *superseded by statute*, 35 ILL COMP. STAT. 200/15-86 (2015).

dependent on specific revenues as the states.[160] Without the dependency, the federal government can better afford to focus on policy rather than on—literally—balancing the budget.

B. Comparisons Among the States

Overall, despite differing approaches to the problem, state policy reaches toward a common goal of requiring hospitals to provide charitable care and thus relieve a burden that the state would otherwise bear.[161] The main differences between the states are how they test whether exempt hospitals are meeting the requirements imposed upon them.[162] For example, one major difference is between states that apply factors-based or elements-based tests versus prescriptive tests that set clearly defined revenue targets. Factors and elements states, such as Utah, New Jersey, Minnesota, and Ohio, leave courts with broader discretion to make determinations about what constitutes fulfilling a charitable mission, at the expense of clear expectations.[163] One possible explanation for these differences is the "degree of vigilance with which the courts guard their authority over constitutional terminology."[164] Factors-test states permit greater judicial discretion and can be explained by a relatively stronger desire by these state's high courts to guard their authority. On the other hand, in absolutist states like Illinois that employ prescriptive statutory tests, courts may be more deferential to a legislative panacea for tax exemption.[165]

States with prescriptive approaches disagree on what the appropriate metrics should be as well as other policy considerations, such as what to do with uncollectible debt.[166] These differences are healthy, a product of

160. *See* Kimberly Amadeo, *U.S. Federal Government Tax Revenue: Who Really Pays the Bills?*, BALANCE (Dec. 12, 2022), https://www.thebalance.com/current-u-s-federal-government-tax-revenue-3305762 [https://perma.cc/LEM6-PPYZ] (noting that in 2021, the federal government collected over 4 trillion dollars from income, payroll, excise taxes; federal reserve revenues; and other sources). States, however, only have the reach of their borders—local municipalities suffer even more with businesses moving outside the cities and their tax jurisdictions. *See id*.; Karns, *supra* note 8, at 399.

161. *See* section II.B, *supra* (discussing, particularly through the lenses of Utah, Illinois, and New Jersey, how each state's test focuses on relieving a government burden and charity care).

162. *See* ORGANIZATION & FINANCE, *supra* note 10, at 651.

163. *See* section II.B, *supra* (discussing the approaches used in Utah, New Jersey, Minnesota, and Ohio).

164. Brody, *supra* note 133, at 626.

165. *Id*.

166. *See* ORGANIZATION & FINANCE, *supra* note 10, at 651.

our dualist system where states carry out policy experiments in response to their constituencies. But romanticization of diversity aside, states do not have much of a choice when faced with budget cuts and decreasing federal oversight.[167] In short, the differences among states are largely due to their courts' posture of jealously guarding their authority, legislative diversity, and a lack of guidance and partnership from the federal government, which forced states to figure out the problem on their own.

III. PROPOSED SOLUTION

To set out a workable framework governing federal hospital tax exemption, one must resolve the tension between the desire for charity care and an expansive definition tailored to help hospitals adapt to new commercial realities.[168] While authors like Professor Nation argue for the death of hospital tax exemption, his frustration, while warranted, can be channeled into a less extreme solution.[169] As Professor Karns points out, "[c]onveniently overlooked is the reality that nonprofits are, in the end, business entities at least to the extent that they must be efficient in order to operate in the contemporary provider market."[170] Thus, any proposed solution must both resolve the tension binding the federal approach in a confused state and recognize the realities of today's market. To do this, it must make room for all healthcare providers who comply with the rules of the game to access tax exemption.

The IRS should amend Revenue Ruling 69-545 to largely return to Revenue Ruling 56-185's guidance.[171] While the "promotion of health" standard in the former Ruling provided the necessary expansion relief needed to adapt charity to the changing marketplace, its combination with Revenue Ruling 83-157—the latter being never repealed—allows hospitals to effectively skirt the requirement to provide charity care and choose among alternatives.[172] Such an amorphous standard necessitates equally

167. Karns, *supra* note 8, at 387 ("In the 1980s there was an important shift in power and responsibility to the states that resulted in federal aid cutbacks. This placed additional responsibility for healthcare policy in the hands of local, city and state officials, along with administrators of the nonprofit hospital."); *Wolves in Sheep's Clothing*, *supra* note 7, at 192–93 (noting that states have generally had responsibility for the health of their citizens).

168. *See* Rev. Rul. 83-157, 1983-2 C.B. 94; Rev. Rul. 69-545, 1969-2 C.B. 117.

169. *See Wolves in Sheep's Clothing*, *supra* note 7, at 148.

170. Karns, *supra* note 8, at 495.

171. This proposal seeks to only change the regulations with respect to hospitals. Other types of nonprofit organizations will still be governed by the current standard.

172. *See* Section II.A (noting the promotion of health includes alternative options to earn tax exemption such as providing education, performing research, and improving fa-

amorphous judicial tests that prompts courts to look for clarity in the murky waters of "the totality of the circumstances."[173]

However, Revenue Ruling 56-185 in its current state presents at least two problems that produce unworkable and inequitable policy results. These problems are explained immediately below and followed by the way in which the proposed solution addresses them.

A. The Financial Incentive Problem

First, the requirements of Revenue Ruling 56-185 may create perverse financial incentives that have a deleterious effect on charitable care. It requires that nonprofit hospitals "'be organized as . . . nonprofit, charitable organization[s]'" that are "'operated to the extent of [their] financial ability' . . . to pay for services rendered to those who were unable to pay'" rather than "'exclusively for those who are able and expected to pay.'"[174] But as Professor Rubinstein posits,

> [i]ronically, requiring hospitals to render greater levels of uncompensated care may result in unintended consequences. Currently, competition from for-profits, lower reimbursement from third-party payers, increased bad debt and empty beds, and increased cost control mechanisms from managed care organizations have all resulted in decreased hospital profitability. Financially vulnerable, some nonprofit hospitals have closed, or will be closing, their doors. Other nonprofits are finding salvation in conversions and sales to for-profit corporations.[175]

The concern, in short, is twofold. By requiring free or below-cost care in a competitive economic environment, the rational response is to redeploy to profitable use assets once used in charitable care; but this response ultimately will reduce the availability of that care.[176] The second concern is that the purpose of tax exemption to incentivize charitable care is functionally undermined. And even if the issue is remedied, there is still no clear benchmark that alleviates the tension between a protectively broad definition of charity and the expectation to provide charity care.

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cilities, and Revenue Ruling 83-157 allows hospitals to earn their exemption with enough of these activities—even without operating an emergency room).

173. *See* Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1219 (3d Cir. 1993); *see also Wolves in Sheep's Clothing*, *supra* note 7, at 144–45 (noting the public benefit standard is "amorphous").

174. Rev. Rul. 56-185, 1965-1 C.B. 202, 203–04.

175. Rubinstein, *supra* note 6, at 419–20 (footnotes omitted).

176. Rubinstein, *supra* note 6, at 420 n.196.

B. The Formalism Problem

Revenue Ruling 56-185's organizational test presents the second issue. Where market incentives and dependence on sales revenue are the same for both for-profit and nonprofit hospitals—and for-profit hospitals often engage in the same amount or sometimes more exempt activities—what is the rationale for the two types of hospitals being treated differently based solely on their charters?[177] In this tale of two hospitals, while one receives freedom from income taxes, unemployment taxes, preferred postage rates, and favorable interest rates in the bond market, the other is paying full freight in taxes, unrewarded for the same work.[178]

Third, the prohibition on private inurement categorically bars certain corporate entities from participating in tax exemptions. While the policy rationale for the prohibition is cogent, and the goal of providing charity for the community is concededly different than that of enriching shareholders, the rationale breaks down when one examines the formalism problem.[179] But the intent of the federal and many state legislatures—expressed by statute—that profits should return to the community rather than private owners, need not be disturbed.[180] Instead, the problem lies with the private-inurement prohibition's rigidity when applied to hospitals when there are already tools to make it work more effectively.

For these reasons, at the same time that Revenue Ruling 69-545 is repealed, Revenue Ruling 56-185 also needs to be amended. In its current state, Revenue Ruling 56-185 requires the following of exempt hospitals: that they (1) "'be organized as a nonprofit, charitable organization'"; (2) "'be operated to the extent of its financial ability' . . . to pay for services rendered to those who were unable to pay'" and "'not exclusively for those who are able and expected to pay'"; (3) "have an open staff policy in that its facilities are not restricted to use or access by a particular group of physicians or surgeons"; and (4) "that the net earnings derived from the services provided by the entity 'must not inure directly or indirectly to the

177. *See Wolves in Sheep's Clothing*, *supra* note 7, at 144–45 (noting the lack of rationale) ("As noted, most charitable hospitals do very little to provide health care for the uninsured and underinsured.")

178. *See* ORGANIZATION & FINANCE, *supra* note 10, at 589 (noting these organizations enjoy preferred postal rates and the ability to issue tax-exempt bonds under I.R.C. § 145).

179. *See* Karns, *supra* note 8, at 520 ("Tax law scholars, such as Bittker and Rahdert, argue that the total revenues of charitable organizations should not legitimately be considered part of the tax base since the organization is not one that is contrived or organized to pay dividends or provide capital wealth to investors.").

180. *See* I.R.C. § 501(c)(3) (prohibiting private inurement); section II.B (demonstrating that states also largely prohibit private inurement in their exempt organizations).

benefit of any private shareholder or individual,' whether or not directly associated with the hospital."[181]

To solve the financial-incentive problem, two steps must be taken. First, some of the language in Revenue Ruling 69-545 should be repurposed and recalibrated into (the modified) 56-185. Second, Revenue Ruling 56-185 should require that to be tax exempt, hospitals must relieve a government burden with prescriptive benchmarks that set clear expectations, like in Illinois. The first step bakes the alternate activities allowed by Revenue Ruling 69-545 into the text of its predecessor. Instead of the requirement that the hospital be operated to the best of its financial ability to care for those who cannot pay, the proposed modification should state that the hospital shall "be operated . . . to pay for services rendered to those who [are] unable to pay and 'not exclusively for those who are able and expected to pay.'"[182]

Following this, amended language could read:

> The hospital's operation for other beneficent purposes, such as using net profits to improve its capacity to provide care, providing education, and conducting research will also be considered for purposes of awarding tax exemption, provided the hospital carries on both sets of activities, and the hospital relieves a significant burden on the government.[183] A hospital is deemed to have relieved a significant burden on the government when [x] percent of its total operating revenues are dedicated to the carrying on of both sets of activities each fiscal year.[184]

Amending Revenue Ruling 56-185's second element in this way addresses each facet of the financial-incentive problem. By including the purposes articulated by 69-545 in the Ruling, reverting to 56-185 accounts

181. Karns, *supra* note 8, at 401–02 (quoting Rev. Rul. 56-185, 1965-1 C.B. 202, 203–04).

182. *Id.*

183. *See* IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188, 1197 n.16 (10th Cir. 2003); St. David's Health Care Sys. v. United States, 349 F.3d 232, 235–36 (5th Cir. 2003) (articulating the acceptable alternate activities); *see also* Utah Cnty. *ex rel.* Cnty. Bd. of Equalization v. Intermountain Health Care, Inc., 709 P.2d 265, 269 (Utah 1985); Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131, 1147–48 (Ill. 2010), *superseded by statute*, 35 ILL. COMP. STAT. 200/15-86 (2015) (noting that exempt hospitals are required to relieve a burden on the government).

184. *See* ORGANIZATION & FINANCE, *supra* note 10, at 651. While this Article calls for the evaluation to be carried out with a prescriptive approach, it does not propose an exact percentage. The calculation and proposal of a workable percentage is beyond the scope of this Article and the author's expertise.

for changing financial realities and a hospital's need to rely on third-party revenues to survive.[185] By preserving the expansion of services considered for an exemption while still providing clear expectations, the added language also resolves the tension between the government's twin desires of defining "charity," and yet requiring charitable care.

By requiring the dedication of a portion of operating revenues to both charity care and one or more of the alternative purposes without mandating how the sum is reached, the hospital can act in its best interest. It can now choose among which beneficent purposes it uses to meet the threshold amount of care, so long as part of the activities includes providing charitable care. Alongside this amendment to 56-185, preserving Revenue Ruling 83-157 also allows hospitals the necessary flexibility to decide how they wish to meet their requirements.[186] While objectors may assert that hospitals can still shy away from providing charitable care, this proposal will not allow them to do so completely.[187]

The formalism problem can be solved by simply deleting the organizational test altogether. If the above amendments are made to the operational test, how the hospital is organized is no longer relevant.[188] For-profit hospitals can and do provide charitable care and other exempt functions.[189] If how the hospital is chartered does not affect the institution's ability to adhere to Revenue Ruling 56-185's second command as modified, then the organizational test merely becomes an inequitable barrier to entry to any for-profit hospital willing to adhere to the Revenue Ruling. Thus, removing the organizational test allows for-profit hospitals to balance the scales and be rewarded equally with their nonprofit brethren.

Finally, the prohibition on private inurement prohibits shareholder dividends because they are part of a company's net profit that benefits private shareholders.[190] What appears at first to be an insurmountable categorical bar to for-profit hospitals partaking in tax exemption is quite easily

185. *See* Karns, *supra* note 8, at 501 ("Therefore, even in the absence of Medicare and Medicaid receipts, both nonprofit and for-profit hospitals rely to the extreme on patient insurance providers as primary sources of revenue.").

186. *See supra* note 32 and accompanying text. For example, a primarily research-based hospital will not be hamstrung for its lack of an emergency room, so long as it provides some charitable care through a clinic or some other avenue.

187. The balance between how much charitable care is provided and how much alternate activity is allowed is another question beyond the scope of this Article and best left with policymakers.

188. *See supra* note 8 and accompanying text.

189. *See Wolves in Sheep's Clothing*, *supra* note 7, at 144.

190. *See supra* note 180 and accompanying text.

solved with the already developed concept of UBTI.[191] Through UBTI, nonprofit hospitals are already taxed on income earned that does not relate to their charitable purpose.[192] As enriching shareholders is not part of a charitable mission, income distributed to shareholders could simply be labeled as unrelated business income. By explicitly defining income distributed to shareholders as UBTI and conditioning tax-exempt status on the reporting and paying of taxes on that income, the IRS could craft an exception to the private-inurement prohibition and be reasonably assured of compliance. Failure to comply with this UBTI-standard could potentially subject the hospital to the "death penalty" of losing its tax-exempt status.[193] Thus, with the final barrier to for-profit hospitals receiving equal treatment to nonprofit hospitals removed, the Revenue Ruling becomes a regulation that demands charity care and community benefit and rewards all hospitals that provide a sufficient amount.

CONCLUSION

In its current state, the federal-tax exemption as applied to hospitals is widely out of balance. Due to the IRS's well-intentioned but misguided efforts to respond to a changing world with Revenue Ruling 69-545, nonprofit hospitals that are exempt from taxes are neither required to provide charitable care to patients nor do more than merely promote health.[194] For-profit hospitals that promote health and go beyond 69-545's amorphous standard are not similarly granted an exemption because of the organizational test and the prohibition on private inurement—features of both 69-545 and its predecessor, 56-185.[195]

On the other hand, state governments largely operate on a quid pro quo framework that requires hospitals to relieve a burden on the state through charitable care in exchange for tax exemption.[196] Their approach is necessitated by their dependence on property-tax revenues to provide services at an ever-growing rate amidst budget cuts and tough economic times.[197] This Article concludes that the states have the clearer, more

191. *See supra* note 22 and accompanying text defining UBTI.

192. *Id.*

193. *See* ORGANIZATION & FINANCE, *supra* note 10, at 638. However, intermediate sanctions are a more likely penalty, given they are "the primary tool" the IRS uses to enforce against offending entities that violate the prescriptions on private inurement and benefit. *Id*.

194. *See supra* note 27 and accompanying text.

195. *See supra* notes 34, 180 and accompanying text.

196. *See* section II.B.

197. *See* Karns, *supra* note 8, at 396–97; *see also* Mintz, *supra* note 130, at 433–34.

manageable standards, and thus the federal government should emulate the states' superior methods of creating and policing hospital tax exemption.

To alleviate the inequity that has resulted from the tension between the requirement to provide charity care and yet establish a workable definition of it, the IRS should first repeal Revenue Ruling 69-545. At the same time, three changes should be made to Revenue Ruling 56-185: first, to alleviate perverse incentives, 56-185 should now require hospitals to dedicate a portion of their operating revenues to both provide charity care *and* to engage in 69-545's alternate activities. While permitting improvement, education, and research, but ultimately leaving the balance of those activities to the hospitals' discretion, hospitals can continue to adapt to today's changing economic landscape yet still relieve a burden on the federal government.

Second, Revenue Ruling 56-185's organizational test should be deleted. If hospitals are given clear standards for what they must provide to their communities, whether the hospital is organized as a charity or corporation becomes irrelevant. So long as they meet the standard for providing charitable services, regardless of for-profit or nonprofit status, hospitals should be similarly rewarded. Finally, the IRS can solve the problem of private inurement by carving out an exception for income distributed as shareholder dividends, classifying such income as UBTI and conditioning the exception's applicability upon the payment of taxes. This exception will remove the final categorical barrier to for-profit entities achieving parity with their nonprofit brethren if they engage in the same charitable work.

These three steps correct the balance. Nonprofit entities should be required to relieve a burden on the government and provide more to the communities they serve, and for-profit entities should not be categorically barred from receiving the same rewards for the same work. By leveling the playing field, the IRS can let hospitals' actions speak louder than their charter by forcing them to either pay their dues through service or join the rest of us and pay their taxes.