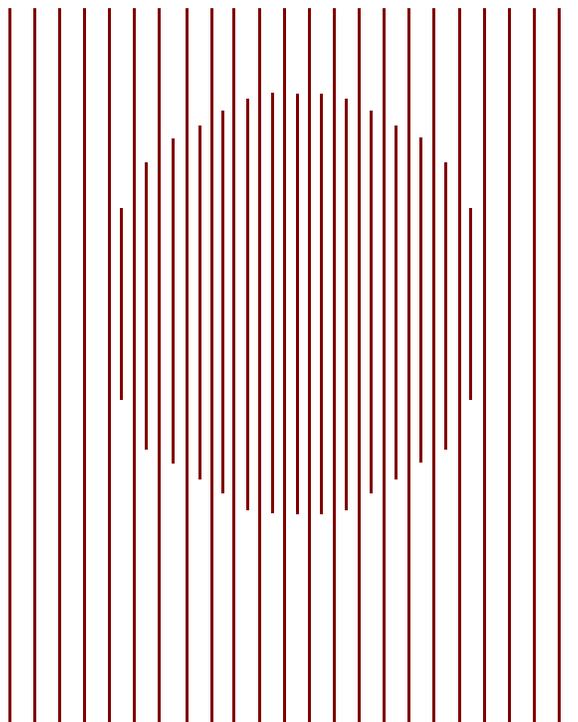


# CBO PAPERS

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

**August 1994**



**CONGRESSIONAL BUDGET OFFICE**



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



## **PREFACE**

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

The paper was written by Pearl Richardson of CBO's Tax Analysis Division, under the direction of Rosemary Marcuss and Frank Sammartino. Mark Booth, James L. Blum, Leonard Burman, Gail Del Balzo, Jon Hakken, Harriet Komisar, Alysa McDaniel, and William Randolph provided valuable comments and suggestions. Harriet Komisar and Eric Guille also provided the data for Tables 2 and 3.

Sherwood D. Kohn edited the paper. Chris Spoor provided editorial assistance. Denise Jordan prepared the manuscript for publication. Questions about the analysis may be addressed to Pearl Richardson at (202) 226-2691.

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Director

August 1994



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## **INTRODUCTION AND SUMMARY**

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

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

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

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

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



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

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

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

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



## BENEFITS AND COSTS OF THE CURRENT TAX TREATMENT

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

### Exemption from Federal Income Taxes

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

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

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

### Tax-Deductible Contributions

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



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

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

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

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

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



### Tax-Exempt Financing

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

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

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

The volume of tax-exempt financing and refunding for health care facilities has risen sharply in the past five years and is likely to continue to do so. It amounted to nearly \$31.7 billion in 1993, compared with an average of \$17.8 billion a year between 1989 and 1992.<sup>6</sup> The bulk (84 percent in 1993) of tax-exempt financing for health care facilities is for nonprofit acute care hospitals.

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

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



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

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

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

### Revenue Losses

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

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

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

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

8. *Ibid.*



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

## HISTORY

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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

## ECONOMIC RATIONALE

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

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

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

