

The Rationale for a Nonprofit Health Care Sector

The medical care market differs from the hypothetical competitive market in important ways. Consumers are often poorly equipped to judge the quality of medical services. Patients must rely on the judgment of their doctors regarding appropriate diagnostic measures and medical treatments.¹⁴ In addition, many aspects of health care and related activity--such as medical and pharmaceutical research, immunization, and treatment for contagious diseases--benefit society at large. Most of society today believes that access to health care should not be limited on the basis of income.

If the private market provides insufficient health care services and public provision of care does not adequately compensate for the shortfall, the nonprofit sector may help fill the gap. Many Americans are uninsured and unable to afford medical care. Nonprofit institutions can provide public benefits by supplying charity care, running immunization programs, operating clinics in neighborhoods that have a shortage of medical personnel, providing public health education, or operating emergency rooms that are open to all.

Second, nonprofit organizations may correct for the "contract failure" that can occur when consumers are inadequately informed about the products or services they are buying and high transaction costs inhibit their ability to switch from one supplier to another. When buyers are at such a disadvantage, producers can have an incentive to take advantage of them by selling inferior goods or services at excessive prices or in excessive quantities. Consumers may feel that a nonprofit organization, which has goals other than maximizing profits, may be more likely to act in their interests than would a for-profit organization.¹⁵

In the case of health care institutions, nonprofit hospitals for centuries provided services, such as charity care, that neither the private market nor the government provided. Many still do, but to a lesser extent, largely because the federal government has assumed greater responsibility through the Medicaid program. Conversely, in view of the growing trend toward consolidation of health care institutions and integration of health care services, the role of nonprofit institutions in compensating for contract failure may become more important than it has been.

14. See Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review*, vol. 53, no. 5 (December 1963), pp. 941-973.

15. See Henry B. Hansmann, "The Role of Nonprofit Enterprise," *The Yale Law Journal*, vol. 8, no. 5 (April 1980); Dennis Zimmerman, "Nonprofit Organizations, Social Benefits, and Tax Policy," *National Tax Journal*, vol. XLIV, no. 3 (Fall 1991); and Burton A. Weisbrod, *The Nonprofit Economy* (Cambridge, Mass.: Harvard University Press, 1988).

To date, the role of the nonprofit hospital in compensating for contract failure has probably been small, since physicians typically have served as intermediaries between hospitals and patients. In the forms of medical practice most common during much of this century--and still dominant today--physicians usually have the primary responsibility for admitting and discharging patients from hospitals, ordering tests and medications, and supervising treatments. Typically, the physician is in a private or group practice and bills the patient or the patient's insurer for his or her services, not the hospital. Supervision of treatment by a physician on the staff of a hospital is common only in emergency situations or in academic medical centers, which have multiple missions and in which medical faculty may also hold staff positions.

In short, the role of the physician is much the same in traditional medical practice, whether the hospital is for-profit or not. Hospitals depend on doctors for patient referrals and, in urban areas particularly, physicians commonly have practice privileges at several hospitals.¹⁶ If a physician acts as a patient's agent in assessing and supervising a hospital's services, he or she can advance the patient's interest when the institution's interests differ. Therefore, what matters most from the patient's standpoint is not whether the hospital or clinical facility is for-profit or nonprofit, but whether the physician's economic interests are linked to or independent of the institution.

Medical practices are changing, however. In response to market pressures, physicians, HMOs, and hospitals have been forming joint ventures, mostly on a for-profit basis. In many joint ventures, the economic interests of physician and HMO, HMO and hospital, or physician and hospital may coincide. In some cases, physicians are hospital employees. In others, physicians have special relationships with one hospital and refer patients to it exclusively. And in still others, hospitals and HMOs try to control costs by offering bonus incentives to physicians for keeping costs down or by making profit-sharing arrangements with them. These practices may put physicians in positions of conflict of interest.¹⁷ In such situations, the "nondistribution constraint" (the constraint against distribution of net earnings or assets) on nonprofit institutions may result in higher-quality service and more consumer confidence in nonprofit than in for-profit providers. Although nonprofit institutions must be sensitive to costs like for-profit institutions, they need not provide returns to shareholders and thus might strive harder than for-profit

16. Gray, ed., *For-Profit Enterprise in Health Care*, p. 174.

17. *Ibid.*, pp. 164-165.

institutions to maintain the quality of patient care.¹⁸ In theory, then, the current trend toward joint ventures may make compensation for contract failure a more significant rationale for a nonprofit health care sector than it may have been in the past.

The Rationale for Tax Exemption

If health care is a merit good and private markets fall short of meeting the needs of all members of society, the case for public assistance becomes compelling. Tax subsidies are one way to provide that assistance.

Tax exemptions, tax-deductible contributions and tax-exempt financing serve the public purpose by subsidizing the availability of health care. Although these subsidies may increase access for those who otherwise could not afford health care, they are not specifically targeted to the low-income population. The federal government directly subsidizes health care for a portion of this population through Medicaid and other programs, although coverage is far from complete. If the main purpose of the special tax treatment of nonprofit institutions is to provide the low-income population with access to health care, direct subsidies may serve this purpose more efficiently.

A significant portion of the tax subsidy is for capital acquisition and construction. Currently, tax-exempt financing for health care facilities is broadly available to 501(c)(3) institutions and is not targeted toward any particular purposes or areas. Thus, the subsidy could stimulate investment where facilities are in short supply but it could lead to overinvestment in other areas. A more direct approach such as providing federal loans at below-market interest rates or federal grants to subsidize interest costs could be used to target investment where needed. Direct subsidies avoid the problem that arises when some of the benefits of tax-exempt financing go to the purchasers of tax-exempt bonds.

The argument for any subsidies as compensation for contract failure is less clear. The nonprofit sector might exist to solve the contract failure problem even without tax exemption and other tax benefits. As economist Kenneth Arrow noted, "medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it." So the relationship has an element of trust. "The physician's behavior is supposed to

18. For example, see Robert A. Boisture, "Maintaining a Strong Nonprofit Health Care System Will Be More--Not Less--Important After Health Care Reform," *The Exempt Organization Tax Review*, vol. 9, no. 4 (April 1994), pp. 785-787.

be governed by a concern for the customer's welfare," said Arrow, and a physician's advice "as to further treatment by himself or others is supposed to be completely divorced from self-interest." Although the reality is surely not as ethically pristine in fact as it is in theory, it probably has some influence over resource allocation. "Departure from the profit motive," said Arrow, "is strikingly manifested by the overwhelming predominance of nonprofit over proprietary hospitals." However nonprofit health care institutions can be explained, their existence implies a preference for them by some group--patients, physicians, or donors.¹⁹

REQUIREMENTS FOR TAX EXEMPTION UNDER CURRENT LAW

The basis for exempting health care institutions from taxes has evolved over the better part of this century in response to changes in the practice of medicine, the financing of medical care, and the nature of health care institutions. The criteria for exemption of hospitals from taxes have largely been in place since 1969, but their history at the federal level goes back to the Civil War. In 1863, the federal government imposed a corporate income tax to finance the war and exempted charitable organizations from its provisions.²⁰ The Revenue Act of 1894 and, later, the Revenue Act of 1913 also provided that organizations operated for charitable purposes would be exempt from tax.²¹ Donations to charitable organizations have been tax deductible since 1917. Until 1968, the availability of tax-exempt bonds to finance the projects of health care institutions depended entirely on state law. The Revenue Act of 1968 placed limits for the first time on the use of tax-exempt bonds to finance projects within the private sector. Section 501(c)(3) institutions were exempted from those limits. The Tax Reform Act of 1986 set the current limits on bonds for 501(c)(3) organizations.

The Concept of "Charitable" Activity

In 1923, an Internal Revenue Service ruling narrowly defined "charitable" as the relief of poverty. The definition remained in force until 1959, when the Treasury's final regulations putting into effect the Internal Revenue Code of

19. Arrow, "Uncertainty and the Welfare Economics of Medical Care," pp. 949-950.

20. David A. Hyman, "The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals," *American Journal of Law and Medicine*, vol. 16, no. 3 (1990), p. 334.

21. The Revenue Act of 1894 was declared unconstitutional in *Pollack v. Farmers' Loan and Trust Company*, 158 U.S. 601 (1895).

1954 changed it to conform to a much broader "generally accepted legal definition."²² The broader definition had its roots in British common law, which recognizes as charitable activities several that go beyond providing relief for the poor, such as advancement of education, religion, or community benefit. The Congress had never provided a statutory definition of the term "charitable." Thus, in writing the new regulations, the Treasury relied on judicial decisions, which echo the British Statute of Charitable Uses of 1601. A British legal decision of 1891, for example, defined "charity" as consisting of "four principal divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community."²³

The "Financial Ability" Standard: The Revenue Ruling of 1956. The 1959 regulations had no immediate effect on an IRS ruling of 1956, which had held that a hospital was charitable only if it was "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."²⁴ With respect to the "financial ability" standard, the IRS noted that a hospital could not refuse to accept patients who needed care and were unable to pay for services, but it did not necessarily have to engage in a high level of charitable activity to qualify for tax exemption. It could, for example, provide charity by furnishing services at rates below cost and by setting aside funds for improvement of hospital facilities.²⁵

In several instances following the Revenue Ruling of 1956, the IRS ruled that private hospitals that provided free treatment for less than 5 percent of their patients were not qualified for tax exemption. The "financial ability" standard nonetheless was typically interpreted broadly enough so that in the absence of local demand a hospital might provide no charity care and still meet the operational test for tax exemption, as long as it did not refuse to admit anyone who was unable to pay.²⁶

22. Treasury Regulations, Section 1.501(c)(3)-1(d)(2).

23. *Commissioners for Special Purpose of Income Tax v. Pemsel* (1891), as cited in 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), p. 331.

24. Revenue Ruling 56-185, 1956-1 C.B. 202,203.

25. Revenue Ruling 56-185, 1956-1 C.B. 202.

26. Note, "Federal Income Tax Exemption for Private Hospitals," *Fordham Law Review*, vol. 36, no. 4 (May 1968), p. 758.

The Switch to a Community Benefit Standard: The Revenue Ruling of 1969. The 1956 ruling remained in place until 1969, when the Internal Revenue Service modified it "to remove . . . the requirements relating to caring for patients without charge or at rates below cost."²⁷ The new ruling, 69-545, defined the charity of nonprofit hospitals as providing benefits to a community as a whole.²⁸

The concept of community benefit also harks back to British common law, and in advancing it the IRS brought the criteria for exempting hospitals from taxation into closer conformity with the regulations issued in 1959. But the 1969 ruling also reflected the (in retrospect, overoptimistic) belief that the earlier standard was archaic because the Medicaid and Medicare programs had sharply reduced the need for charity care.

The new ruling was issued a few months before passage of the Tax Reform Act of 1969. The House version of the act (H.R. 13270) included a measure conferring tax-exempt status on hospitals without regard to care for the indigent. The Senate version had no such provision, and ultimately the change was not enacted. According to the report of the Committee on Ways and Means, the reason for the proposed change was to alleviate the "significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."²⁹

The new ruling was controversial. Less than a year after publication of the ruling, the staff of the Senate Finance Committee issued a report recommending that it be revoked and that the previous ruling be restored until such time as the Congress could "devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital."³⁰ The recommendation was not acted on.

In 1973, the Eastern Kentucky Welfare Rights Organization, representing a group of plaintiffs who had been refused treatment in tax-exempt hospitals because of an inability to pay, challenged the community benefit standard in a class action suit on the grounds that it failed to identify

27. 1956 Internal Revenue Bulletin, no. 44, p. 10, as cited in Bromberg, "The Charitable Hospital," p. 237.

28. Revenue Ruling 69-545, 1969-2 C.B. 117.

29. House Report No. 413, 91st Congress, 1st Session, p. 43, as cited in *Eastern Kentucky Welfare Rights Organization v. Shultz*, 370 F. Supp. 325 at 332.

30. Senate Finance Committee, *Medicare and Medicaid: Problems, Issues, and Alternatives*, Report of the Staff, 91st Congress, 1st Session (1970), as cited in *Eastern Kentucky Welfare Rights Organization v. Shultz*, 370 F. Supp. 325, note 14 at 332.

a charitable class. In *Eastern Kentucky Welfare Rights Organization v. Shultz*, a federal district court upheld the challenge and concluded that the Congress had intended to restrict the term "charitable" to the narrow definition of relief of the poor.³¹ The United States Court of Appeals reversed the district court's decision, however, in *Eastern Kentucky Welfare Rights Organization v. Simon*.³²

The Court of Appeals based its decision on whether the term "charitable" as used in Section 501(c)(3) could be broadly interpreted, as it was in Revenue Ruling 69-545, or whether it was to be restricted to the narrower concept of relief for the poor. Noting that the law of charitable trusts supported the broader concept, the court stated:

We cannot conclude. . . that the Congress intended the . . . [narrower] construction. While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of "charitable" status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society. . . . In summary we conclude that Revenue Ruling 69-545 is founded on a permissible definition of the term 'charitable' and is not contrary to any express Congressional intent.³³

The court also expressed the view that the Medicare and Medicaid programs, "combined with the rapid growth of medical and hospital insurance [had] . . . greatly reduced the number of poor people requiring free or below cost hospital services. . . . Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay. Thus, it appears that the rationale upon which the limited definition of 'charitable' was predicated has largely disappeared."³⁴

On appeal of the Court of Appeal's decision, the Supreme Court ruled that the federal courts lacked power under the Constitution to hear the suit because the plaintiffs lacked standing--that is, a sufficient interest in the legal

31. 370 F. Supp. 325 (U.S. District Court for the District of Columbia, 1973).

32. 506 F. 2d 1278 (D.C. Circuit, 1974); vacated on other grounds, *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976).

33. 506 F. 2d 1278, at 1287-88 and 1290.

34. 506 F. 2d 1278 at 1288.

issue they had raised.³⁵ This nullified the judgments of both the District Court and the Court of Appeals. The 1969 ruling stands.

The Criteria for Tax Exemption

Hospitals, HMOs, and integrated delivery systems may be organized as tax-exempt or taxable entities; with a few exceptions, health insurance companies are fully taxable. All nonprofit health care institutions must satisfy the same basic standards for tax exemption, but the criteria for doing so vary with the type of institution. In particular, although all institutions must satisfy a community benefit standard in order to qualify for tax exemption, the requirements under the standard vary with the institution and with the type of tax exemption it is seeking. For each type of institution, the requirements will be more exacting for Section 501(c)(3) than for 501(c)(4) status. For hospitals, most of which are tax-exempt under Section 501(c)(3), the requirements are relatively fixed and longstanding. For HMOs, the requirements for 501(c)(3) status have evolved more recently. Most HMOs are tax-exempt under Section 501(c)(4). In some cases, however, the requirements for 501(c)(4) status are not entirely clear. For IDSs, the standards are still evolving.

Hospitals

Under current law, a hospital qualifies for charitable exemption if it is organized as a nonprofit corporation and complies with the community benefit standard, the prohibitions on private inurement and private benefit (see below), and nontax federal health statutes, such as the Medicare fraud and abuse rules and the laws prohibiting patient-dumping.

Community Benefit Criteria. In applying the standard of community benefit, the IRS has considered whether the hospital operates an emergency room that is open to all regardless of ability to pay, accepts Medicaid and Medicare patients on a nondiscriminatory basis, has a governing board that represents the community at large, is open to all medical staff who wish to use it, or conducts medical research and education programs. Apart from emergency room care, a nonprofit hospital need admit only those patients who have private insurance or are covered under Medicare or Medicaid and may refer indigent patients to public hospitals.

35. *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976).

In the years following the 1969 IRS ruling, instances of refusals by tax-exempt hospitals to accept nonpaying patients in their emergency rooms were reported, but those hospitals did not lose their tax exemptions.³⁶ In 1985, the Congress wrote into the Consolidated Omnibus Budget Reconciliation Act (COBRA) a requirement that all hospitals participating in Medicare accept nonpaying patients in their emergency rooms and that hospitals with Medicaid agreements admit Medicaid patients without discrimination. And, in 1990, an IRS official testified before the House Select Committee on Aging that the agency would consider the COBRA requirements to be the two most important factors in determining a hospital's tax-exempt status.³⁷ The IRS has ruled that in some circumstances, however, a nonprofit hospital may be able to demonstrate sufficient community benefit to qualify for exemption without operating an emergency room. The circumstances include instances when a state agency has determined that an emergency room would be unnecessary and duplicative and when specialty hospitals do not generally treat emergency medical conditions.³⁸

Prohibitions Against Private Inurement and Private Benefit. The rules regarding private inurement stipulate that no part of an institution's net earnings may benefit members of the board, officers, managers, staff, employees, or other individuals associated with the enterprise. The function of the rules is to assure that income and assets serve a public purpose and to prevent their distribution to physicians or other insiders within the institution. The purpose of the prohibition against private benefit is to assure that a hospital or other exempt organization is organized to serve the community as a whole and not private individuals or groups.

In applying the private inurement and private benefit rules, the IRS has concentrated on joint ventures between hospitals and physicians and on hospitals' policies for recruiting physicians to assure that the policies do not result in payment of unreasonable compensation or the transfer to physicians of an interest in the net income of a hospital.³⁹ The IRS makes determinations on private inurement and private benefit based on the facts and circumstances in each case.

36. Daniel C. Schaffer and Daniel M. Fox, "Tax Administration as Health Policy: the Tax Exemption of Hospitals, 1969-1990," *Tax Notes* (October 21, 1991), p. 228.

37. *Ibid.*

38. Revenue Ruling 83-157, 1983-2 C.B. 94.

39. IRS General Counsel Memorandum 39862 (1991).

HMOs

Health maintenance organizations provide health benefits at a fixed, prepaid price through physicians and other providers who are affiliated with the organization. In the past 10 years, enrollment in HMOs has more than tripled, and the current emphasis on controlling health care costs makes continued growth likely. At the beginning of 1994, some 45.2 million people were enrolled in 545 HMOs--up from 38.7 million people in 541 HMOs two years earlier.⁴⁰

The four basic types of HMOs are the staff model, which employs physicians and staff at its own facilities; the group model, which contracts with an independently organized medical group to provide services at the HMO's or the group's facilities; the network model, which provides services through two or more independent medical groups; and the individual practice association (IPA) model, which provides services through independent physicians who belong to the association.

Physicians in group and staff model HMOs provide services exclusively to the HMO's enrollees, while physicians in network and IPA models may contract with several HMOs and usually maintain a fee-for-service practice as well.

As of the end of 1991, staff-model HMOs accounted for 12 percent of HMO enrollment; group-model HMOs for 27 percent; network HMOs for 16 percent; and IPAs for 46 percent. This breakdown is based on the predominant model type for each HMO. Many HMOs are mixed-model plans. About half of staff-model HMOs, for example, incorporate components of other model types. So do 13 percent of group models, 28 percent of network models, and 8 percent of IPA models.⁴¹

Criteria for Tax-Exemption. HMOs are eligible for tax exemption under Section 501(c)(3), based on the same community benefit standard that applies to hospitals. In applying the community benefit standard to HMOs, the IRS requires as a minimum condition for tax exemption that the HMO provide health care services directly. Thus, staff and dedicated group models are eligible for 501(c)(3) status; HMOs that fit the network or IPA models are not.

40. Group Health Association of America, *HMO Industry Profile 1993*, p. 310; also Bruce Japsen, "Creation of New HMOs Picks Up Steam, Fueled by Reform, Market Forces," *Modern Healthcare* (June 13, 1994), p. 46.

41. Group Health Association of America, *HMO Industry Profile 1993*, p. vii.

Among the other characteristics that the IRS looks for in determining an HMO's tax status are whether it offers open membership, particularly to individuals and small groups; uses a community rating system and charges individuals and groups similar rates; treats patients, regardless of their ability to pay; has an open emergency room; conducts health education programs; and is open to nonmembers on a fee-for-service basis. An HMO need not have all of these characteristics, however, in order to qualify for 501(c)(3) status. Acceptance of applicants with preexisting conditions is not among the criteria for tax-exemption.⁴²

The exemption of HMOs under 501(c)(4) is based on a community benefit standard "that is less exacting than that under 501(c)(3)."⁴³ In assessing an HMO's eligibility for 501(c)(4) status, the IRS looks at whether premiums are set on a community-rated basis, whether membership is open to individuals and small groups, and whether the HMO serves low-income, high-risk, elderly, or medically underserved people. The IRS has indicated that IPAs may not qualify for tax exemption if they are controlled by member physicians, and it has not granted tax exemption to any IPAs under Section 501(c)(4) since 1986.⁴⁴

Taxable HMOs. The tax treatment of a nonexempt HMO depends on whether it qualifies as an insurance company. If it does, it can deduct additions that it makes to reserves to cover accrued liabilities before the taxpayer's obligation has been determined, and it need not postpone deductions until payment.

Commercial Insurers

Health insurance companies are fully taxable. Under Section 501(m), enacted in 1986, an organization may be exempt from taxes only insofar as no substantial part of its activities consists of providing commercial-type insurance. Until 1986, Blue Cross and Blue Shield organizations (BC/BS) were exempt

42. The IRS initially held that while HMOs could qualify for tax-exempt status under Section 501(c)(4), they could not qualify as charitable organizations under Section 501(c)(3) because the preferential treatment they provided members did not constitute a public benefit. The United States Tax Court rejected this position in *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978), on the grounds that the association's membership class was so broad that it constituted a community benefit. In 1993, in *Geisinger Health Plan v. Commissioner*, 985 F. 2d 1210 (3rd Circuit 1993), the Court of Appeals applied the criteria set forth in *Sound Health* and ruled that a network-model HMO, which provided no services directly and excluded applicants with poor health histories, did not benefit the community.

43. Internal Revenue Service, *Exempt Organizations, Technical Instruction Program for FY 1994*.

44. See Revenue Ruling 86-98, 1986-2 C.B. 74; also, General Counsel Memorandums 38898 (1982) and 39829 (1990).

from taxes under Section 501(c)(4). When they were established, BC/BS offered insurance based on community ratings. As more insurance companies entered the market, BC/BS responded by becoming more like them and, to keep costs down, many eventually moved to experience ratings. (Community rating is a method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. Experience rating is a method of determining health plan premiums based on the historical use and distinguishing characteristics of a specific subscriber group.)

Recognizing that BC/BS plans essentially were offering commercial-type insurance, the Congress withdrew their tax exemption in the Tax Reform Act of 1986. At the same time, the Congress enacted Section 833, which provided special relief for BC/BS and similar insurers that were in existence on August 16, 1986, and that meet specified community service requirements. These include community rating for at least 35 percent of the health insurance they provide, coverage of preexisting conditions at no extra charge, and maintenance of continuous, full-year, open enrollment for individuals and small groups, who must account for at least 10 percent of the insurance the companies provide. Section 833 exempts eligible organizations from the rule that requires a 20 percent reduction in the amount an insurance company can deduct for any increase in unearned premium reserves. It also permits eligible organizations to claim a special deduction for their health business for 25 percent of claims and expenses incurred during the taxable year, less adjusted surplus at the beginning of the year.

Integrated Delivery Systems

Integrated delivery systems are proliferating. Many hospitals and physicians have established networks for providing comprehensive health care benefits and more seek to do so. Integration ranges from fully integrated delivery systems (IDS) to management services organizations (MSOs) and physician-hospital organizations (PHOs). In the most fully integrated system, a tax-exempt hospital may simply purchase a physicians' group practice and employ the physicians directly. In some states, however, laws prohibiting the corporate practice of medicine make such arrangements impossible. These laws prohibit hospitals and other corporations from employing physicians or directly providing physician services.

The Foundation-Model IDS. The foundation-model IDS has evolved in states such as California and Texas that prohibit the corporate practice of medicine. Under the foundation model, a hospital establishes a new nonprofit organization, which acquires the assets of one or more medical groups.

Typically, the foundation then contracts with the medical group to provide physician services for the IDS. The acquired assets of the foundation can include hospitals, clinics, equipment, and possibly intangibles. Once the IDS has 501(c)(3) status, it is eligible to obtain financing through tax-exempt bonds. Thus, some acquisitions may be financed with tax-exempt bonds. Other acquisitions may be structured as a bargain sale. If the value of the assets is greater than the purchase price, the owners of the medical group may claim a charitable deduction under Section 170 to the extent that the actual sales price (plus any ascertainable value of the benefit of the transaction to the physicians) is less than the fair market value (determined by an independent appraisal) of the practice.

The IRS has granted several foundation-model IDSs tax-exempt status under Section 501(c)(3). As with hospitals, the IRS's recognition of an IDS's Section 501(c)(3) tax-exempt status is based on the community benefit principle. The IRS has required that the board of the IDS be representative of the community and that the number of medical group physicians on the foundation board be limited. In its favorable tax-exemption determinations to date, the IRS has used a 20 percent limit on the medical group physicians' participation on the foundation board as a safe harbor.

More generally, the IRS has indicated that it would expect IDSs to provide benefits to the community beyond operating an open emergency room and treating Medicaid and Medicare patients without discrimination, but the standards for determining whether an IDS is providing a community benefit are still evolving.⁴⁵ Thus, the IRS has indicated that conducting public health education programs may constitute a community benefit. It has also indicated that it believes that integrating hospital and physician services and patient records can benefit a community by eliminating duplication of procedures, thus lowering prices.⁴⁶

In reviewing foundation-model IDSs, the IRS seeks to assure that the hospital did not pay more than fair market value for the medical group's assets and that the intangible assets will contribute to the organization's exempt purposes. The Internal Revenue Service is more likely to grant tax exemption if the foundation has purchased rather than leased the assets of a medical group. The IRS's view is that leasing arrangements can change over time and thus have greater potential for private inurement. The IRS also scrutinizes agreements between medical groups and foundations to assure that physicians do not derive more than incidental private benefit from the relationship and

45. Internal Revenue Service, *Exempt Organizations: Technical Instruction Program for FY 1994*, p. 225.

46. *Ibid.*, pp. 226 and 243.

that physician compensation is based on arm's-length negotiations between medical groups and foundations or their parent hospitals.

Management Services Organizations. MSOs are not as fully integrated as IDSs. MSOs do not provide medical services; rather they purchase the tangible assets of medical groups and then provide support staff, equipment, and facilities necessary for the group to conduct its private practices. Typically, a hospital capitalizes MSOs, which may be organized in several ways: for example, as a subsidiary of a hospital, an operating division of a hospital, or a separately incorporated entity. Under a contractual arrangement, the physician group provides medical services to the hospital, and the hospital provides physical assets, support staff, and administrative and management services necessary to conduct a medical practice. The MSO may be a first step toward fuller integration and offers a hospital stronger ties with a medical group. It offers a medical group the opportunity to realize the cash value of its tangible assets and freedom from administrative responsibilities. And it eases physician recruitment by eliminating "buy-in" requirements.⁴⁷

So far, MSOs have not applied to the IRS for recognition of tax-exempt status, nor has the IRS issued any rulings or guidelines about them. MSOs are unlikely to have a charitable purpose that would support recognition of tax-exempt status. In general, the IRS considers joint ventures between hospitals and physicians to be consistent with 501(c)(3) status only if they advance the hospital's charitable purposes and do not result in private inurement or more than incidental private benefit to the physicians involved. Thus, tax-exempt hospitals involved in creating MSOs must ensure that their payments to a medical group do not jeopardize their tax-exempt status. An MSO could jeopardize a hospital's tax-exempt status if the MSO were capitalized by a hospital and the MSO paid more than fair market value for a medical group's tangible assets or charged less than fair market prices for the services it provides to a physician's group.

Physician-Hospital Organizations. PHOs are collective negotiating entities that enable physicians and hospitals to contract with HMOs and employers. Typically, physicians and hospitals jointly govern in such arrangements, physicians retain substantial autonomy over clinical decisions, and hospitals provide the financial and administrative expertise necessary to manage capitated payments. PHOs serve as delivery systems for HMOs, while HMOs fulfill managerial, administrative, sales, and marketing functions. In some cases, HMOs pay the PHO on a discounted fee-for-service basis; in others, the

47. Robert A. Boisture, "Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs," *The Exempt Organization Tax Review*, vol. 9, no. 2 (February 1994), p. 281.

PHO is paid a per capita fee to provide services to HMO members, and individual physicians' fees are limited by the PHO.⁴⁸ Physician-hospital organizations are generally analogous to independent practice associations with a hospital participant. The IRS has not ruled on the tax-exempt status of PHOs to date, although it has received some applications. The same standards that the IRS has applied to the newly approved IDSs will probably apply to PHOs seeking tax exemption.

As of 1993, about 14 percent of all hospitals had formed PHOs, 7 percent had formed MSOs, and 4 percent had formed joint ventures with physician groups. Joint ventures of all types are more common in urban than in rural areas and among teaching rather than nonteaching hospitals.⁴⁹

PROPOSALS FOR CHANGE

The House Committee on Ways and Means and the Senate Committee on Finance have reported out bills that in some respects would change the current tax treatment of health care providers and codify some of the IRS's practices.⁵⁰ The key provisions of these measures include new requirements for tax exemption and new sanctions when an institution fails to comply with the conditions for tax exemption. Several measures in the two bills are similar; the main difference is that the Ways and Means bill imposes more requirements for tax exemption. In addition, the Senate Finance bill would lift current limits on the use of tax-exempt financing by 501(c)(3) institutions.

New Requirements for Tax Exemption

Both the Ways and Means and Finance Committee bills would impose new requirements for tax exemption to Section 501(c)(3) and 501(c)(4) organizations that provide health care, including hospitals, HMOs, clinics, nursing homes, and old age homes. The new provisions delineate the public benefits that health care providers must furnish in exchange for tax exemption. Some states have enacted similar measures (see below). The Finance Committee's bill exempts from the new requirements institutions that have as

48. *Medical and Health Perspectives* (February 28, 1994), p. 4.

49. Prospective Payment Assessment Commission, *Report and Recommendations to the Congress* (March 1, 1994), p. 24.

50. House Committee on Ways and Means, *Health Security Act*, Report 103-601, Part 1 (July 14, 1994); Senate Committee on Finance, *Health Security Act* (August 2, 1994).

a principal purpose academic training or medical research. Under the Ways and Means bill, an educational or other organization would be exempt from the new provisions only if its predominant activities did not involve delivering health care services to patients. Under the proposals, tax-exempt health care institutions--in addition to satisfying a community benefit standard--would have to:

- o Provide significant "qualified outreach services." The Ways and Means bill defines these as health care services and related education and social service programs that are provided in a medically underserved area or are offered below cost to individuals otherwise unable to afford them. The Finance Committee's bill adds to that definition the option of providing specialty emergency care facilities that normally operate at a loss, such as emergency trauma, emergency psychiatry, or burn centers. Under both bills, an institution would demonstrate that it provides qualified outreach services on a facts-and-circumstances basis. Both bills would permit an institution to provide outreach directly or by making a contribution to another institution that offers it.
- o Annually assess their community's need for health care and for qualified outreach services and prepare a written plan for meeting those needs, with the participation of community representatives.
- o Refrain from discriminating against individuals participating in government-sponsored health plans, such as Medicare or Medicaid, and from discriminating in providing emergency services on the basis of a patient's ability to pay.⁵¹ These two provisions would essentially codify existing IRS rulings pertaining to hospitals.

Additionally:

- o Under the Ways and Means bill, tax-exempt institutions--to the extent of their financial ability--would have to provide nonemergency health care services without regard to the patient's ability to pay.⁵² This provision is similar to the IRS's

51. The latter provision applies only to institutions that operate emergency rooms.

52. This provision would not apply to HMOs that do not directly provide medical services.

1956 ruling with regard to charity care. It would not apply to HMOs that do not directly provide medical services.

- o The Ways and Means bill would require tax-exempt health care providers to maintain an independent board of directors; that is, at least 80 percent of the governing board of a tax-exempt health care organization would have to be composed of individuals who receive no compensation directly or indirectly (a) for medical services performed in connection with the organization or (b) as an officer of the organization. This proposal would codify and apply to health care institutions generally the 20 percent limit on insider or physician board representation that the IRS has applied in recent exemption determinations involving IDSs.
- o Both the Ways and Means and the Finance Committee bills would deny tax-exempt status under Section 501(c)(4) to health care organizations that permit any part of their net earnings to inure to the benefit of any private shareholder or individual.

Provisions Relating to HMOs. Both the Ways and Means and the Finance Committee bills would codify current IRS rulings regarding tax-exemption requirements for HMOs. In order to qualify for 501(c)(3) status, the bills require HMOs to furnish primary health care services at their own facilities by professionals who essentially do not provide such services elsewhere. Thus, as under current regulations, only staff- and dedicated-group-model HMOs would qualify.

In order to qualify for 501(c)(4) status, HMOs would not have to provide services at their own facilities, but would have to furnish primary care through fixed-fee contracts and supply other care only on referral from an HMO. Providers would qualify for 501(c)(4) status by assuming the risk in relation to the rate at which an HMO's members use health care services. Under current law, if the provision of insurance is only "incidental" to an HMO's regular operations, the activity is tax-exempt. But if a tax-exempt HMO expands its operations by arranging to provide medical care through a network of physicians on a fee-for-service basis, present law considers it to be providing commercial-type insurance. As under present law, depending on its extent, the insurance activity might be taxed as an unrelated business, or the HMO might lose its tax-exempt status.⁵³

53. For more detail, see House Committee on Ways and Means, *Health Security Act*, pp. 590-592; and Senate Committee on Finance, *Health Security Act*, pp. 203-204.

