

### Intermediate Sanctions

Currently, when an institution fails to comply with the conditions for tax exemption, the IRS's only option is to revoke the status. The severity of the penalty is a disincentive for vigorous enforcement of the law, especially in cases where the violation may be minor or caused by oversight rather than willful neglect. To remedy the problem, both the Ways and Means and the Senate Finance bills include intermediate sanctions on private inurement. The sanctions would impose taxes on insiders and organization managers who knowingly participate in a transaction involving improper personal gain. The Ways and Means bill also includes intermediate sanctions for failure to comply with the new exemption requirements for health care organizations. The tax would amount to \$25,000 or 5 percent of the organization's net investment income, whichever is greater. The tax would be effective January 1, 1995, for all of the new requirements, except the one for an independent board, which would be effective January 1, 1997.

### Health Insurance Purchasing Cooperatives

Under both bills, health insurance purchasing cooperatives that may be established at the state or local level would be eligible for tax-exempt status, provided they adhered to the restrictions on private inurement, lobbying, and political involvement in present law. Purchasing cooperatives would not be eligible to use financing from the proceeds of tax-exempt bonds.

### Taxable HMOs and Commercial Insurers

Both bills would expand the scope of organizations that are treated as taxable insurance companies in similar ways. In both cases, organizations would be taxed as insurance companies if more than half of their business (measured, for example, by gross revenues) consists of issuing accident and health insurance contracts or reinsuring accident and health risks; if they operate as an HMO; or if they enter into arrangements under which they receive fixed payments for providing health care services and assume the risks associated with their rates of use.

In the case of taxable staff- or dedicated- group-model HMOs, no deduction would be allowed for incurred but unreported losses, because the use of an HMO's services for professional care is or can be known by the end of the HMO's taxable year. If, however, the period during which members are covered extends beyond the end of the taxable year (for example, if premiums are paid not monthly, but quarterly or annually over a period other than the



taxable year), a deduction reflecting the increase in unearned premiums for the year would be appropriate.

**Special Rules for Insurance Companies.** Both bills would retain the special rules that apply to Blue Cross and Blue Shield under Section 833. Both bills would also extend the rules to certain other organizations that meet the requirements of Section 833(c)(2), effective for taxable years beginning December 31, 1986. The special rules would extend to organizations that are not HMOs and are governed by state laws that apply specifically and exclusively to not-for-profit health insurance or health service organizations.

### **Tax-Exempt Financing**

The Finance Committee's bill would repeal the \$150 million tax-exempt bond limit that now applies to facilities of all 501(c)(3) institutions except hospitals. The committee intended the measure to accommodate restructuring and expansion of nonhospital health care facilities. The bill would also remove the classification of 501(c)(3) bonds as private-purpose and raise the limit on the share of proceeds that can be used for other than the exempt purposes of the 501(c)(3) institution from 5 percent to 10 percent--which is the limit that now applies to public-purpose bonds. In addition, the bill would remove the restrictions on bond-financed costs of issuance. (Currently, no more than 2 percent of the proceeds of a bond issue may be used to finance issuance costs, and these funds are not counted in determining whether the bonds satisfy the requirement that at least 95 percent of the net proceeds be used for the exempt activities of the organization.) The Ways and Means bill contains no such provisions.

The Joint Committee on Taxation estimates that revenue lost as a result of lifting the limit on all 501(c)(3) institutions would amount to about \$200 million between 1995 and 1999 and to about \$1 billion between 1995 and 2004. If the limit were lifted for health care institutions only (and continued to apply to nursing homes), revenue losses would amount to about \$100 million over five years and about \$400 million over 10 years.

## **CURRENT TRENDS AND EMERGING ISSUES**

Recent changes in the medical marketplace and the possibility of health care restructuring reopen the issue of the basis for exempting health care institutions from income taxes. The Ways and Means and Senate Finance Committee's bills would stiffen the requirements for tax exemption and strengthen their



enforcement. The Finance Committee's bill would also expand the benefits associated with 501(c)(3) status.

The federal government subsidizes health care institutions through the tax system. The justification for these tax subsidies is that these institutions provide a public benefit. The questions, then, are what benefits do tax-exempt institutions now provide that taxable institutions do not also provide, and what benefits are they likely to provide under some of the proposed changes in the health care system?

### Distinctions Between Taxable and Tax-Exempt Institutions

In 1992, nearly 60 percent of all short-term nonfederal hospitals, accounting for more than 70 percent of hospital beds, were nonprofit tax-exempt institutions.<sup>54</sup> These include teaching hospitals and academic medical centers, which qualify for 501(c)(3) status as educational institutions. Approximately one-third of all hospital beds and nearly one-half of the beds in nonprofit hospitals are in teaching hospitals. Nonpublic teaching hospitals represent slightly less than one-fifth of all hospitals and close to one-third of all nonprofit hospitals.<sup>55</sup> Less than 14 percent of all short-term, nonfederal hospitals, representing about 10 percent of beds, are for-profit, investor-owned organizations. The remainder are government-owned.<sup>56</sup> Most HMOs are organized as for-profit operations, but some of the largest are nonprofit and tax-exempt. Tax-exempt HMOs account for only one-third of the total number of organizations, but represent more than half of all HMO enrollees.<sup>57</sup>

The differences in the way for-profit and nonprofit health care institutions behave are difficult to measure. The most comprehensive attempt to study the issues involved in for-profit health care was undertaken in 1981 by the Institute of Medicine, which set up a Committee on Implications of For-Profit Enterprise in Health Care. The committee published its report in 1986. Most of the data that it gathered related to hospitals. And much of the data about costs, quality, and access to care in for-profit and nonprofit hospitals was gathered in the early 1980s, a period dominated by cost-based reimbursement from Medicare and other third-party payers, which provided little incentive for

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54. American Hospital Association, *AHA Hospital Statistics 93/94*, p. 7.

55. Congressional Budget Office, based on analysis of data from the Health Care Financing Administration.

56. American Hospital Association, *Hospital Statistics 93/94*, p. 7.

57. Group Health Association of America, *HMO Industry Profile 1993*, p. 310.



price competition among providers. The committee was aware that Medicare's prospective payment system and other emerging developments could affect its conclusions and therefore regarded its findings as tentative.

The committee found that investor-owned hospitals did not produce the same services at lower cost than their nonprofit counterparts; prices and expenses were higher in investor-owned hospitals.<sup>58</sup> Another study that appeared about the same time found that differences in costs were insignificant, but charges by for-profit hospitals were about 10 percent higher after netting out taxes paid by for-profit hospitals and contributions received by nonprofit hospitals.<sup>59</sup> The committee reported that overall quality of care --based on such limited indicators as accreditation, board certification of staff physicians, and amount of nursing personnel--did not seem to vary between for-profit and nonprofit hospitals. Occupancy rates were higher in nonprofit hospitals, and commitment to research and education was greater. The amount of uncompensated care also was greater at nonprofit hospitals, particularly where for-profit hospitals were most heavily concentrated.

The committee also found that regardless of the form of ownership, debt and retained earnings were the source of almost all capital financing for hospitals. Thus, nonprofit institutions shared with for-profit institutions the need to generate surpluses in order to build reserves for use as working capital and for future renovation or expansion. The surpluses affect credit ratings and, thus, access to capital. On a national basis, the margins of surplus of nonprofit and for-profit hospitals were similar. The comparison was based on the inclusion of gifts and investment income in hospital revenues and involved subtracting from revenues the accrued taxes of investor-owned hospitals.<sup>60</sup>

More recent information is available. Data for 1992 indicate that, as a percentage of total costs, nonprofit hospitals provided somewhat more uncompensated care (charity care and bad debts) net of subsidies from state and local governments than for-profit hospitals (see Table 1). The data also indicate that, on average, for-profit hospitals charge private payers higher fees in relation to their costs than do nonprofits. Nonpatient revenues (which include interest on investments, nonoperating revenues from such facilities as cafeterias and parking garages, federal grants, gifts, and donations) make up

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58. Gray, ed., *For-Profit Enterprise in Health Care*, pp. 185-186.

59. J.M. Watt, Robert A. Derzon, and others, "The Comparative Economic Performance of Investor-Owned Chain and Not-for-Profit Hospitals," *New England Journal of Medicine* (January 9, 1986), pp. 89-96.

60. Gray, ed., *For-Profit Enterprise in Health Care*, pp. 182-201.



TABLE 1. GAINS OR LOSSES BY PAYER, BY HOSPITAL GROUP, 1992

Hospital Group	Total Gain <sup>a</sup> (Percent)	Gains or Losses as a Percentage of Total Costs <sup>b</sup>					Private Payers	
		Medicare <sup>c</sup>	Medicaid <sup>c</sup>	Uncompensated Care <sup>d</sup>	Private	Nonpatient <sup>e</sup>	Share of Total Costs (Percent)	Payment-to- Cost Ratio
All Hospitals <sup>f</sup>	4.8	-4.4	-1.2	-4.9	11.8	3.3	37.6	1.31
Nonprofit	4.7	-4.4	-1.5	-4.6	11.6	3.5	39.4	1.29
For-Profit	6.3	-6.2	-2.1	-3.9	17.4	1.0	40.6	1.43
Public								
Urban areas	4.3	-2.8	0.9	-6.9	8.8	4.0	26.5	1.33
Rural areas	6.1	-4.4	-0.2	-5.0	11.5	3.2	31.8	1.36
Major Teaching <sup>g</sup>								
Public	2.8	-1.2	1.5	-7.3	5.6	4.3	22.1	1.25
Nonpublic	3.6	-2.9	-1.3	-4.8	8.6	4.0	38.8	1.22

SOURCE: Congressional Budget Office based on data from Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (June 1994), p. 44.

NOTE: Because of reporting inconsistencies, there are significant margins of error for the numbers related to all payers in 1992.

- a. Total gain equals total revenues minus total costs for the hospital group, divided by costs for the hospital group.
- b. The gain or loss is equal to the difference between revenues and cost for each source, expressed as a percentage of hospitals' total costs.
- c. Medicare and Medicaid costs equal all costs, both inpatient and outpatient, attributed to these programs' patients regardless of whether the costs are allowable (and therefore reimbursable) by the programs.
- d. Uncompensated care includes charity care and bad debts. Operating subsidies from state and local governments were considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs.
- e. Nonpatient revenues include charitable donations, federal grants, earnings on investments, and nonoperating revenues from such facilities as cafeterias and parking garages.
- f. The table is based on all hospitals covered by Medicare's prospective payment system.
- g. Major teaching hospitals are hospitals with a graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater.



a greater share of total costs for nonprofits than for for-profit institutions (see Table 1).<sup>61</sup>

As a percentage of total costs, nonpublic major teaching hospitals in 1992 had greater losses from uncompensated care, lower "profit" margins, and smaller losses from treating Medicare and Medicaid patients than either nonprofit hospitals or for-profit hospitals. (Major teaching hospitals are those with a graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater.) In general, for-profit hospitals incur greater losses on Medicare and Medicaid patients as a proportion of total costs than nonprofit hospitals do.<sup>62</sup> The payments of privately insured patients and uninsured patients who pay for their care were lower in relation to total costs in major teaching hospitals than in other nonprofit hospitals.

Measured as a percentage of total inpatient days in 1991, nonprofit hospitals had a slightly heavier Medicaid patient load than for-profit hospitals in urban areas; in rural areas, for-profit hospitals had a significantly heavier Medicaid patient load than nonprofits (see Table 2). Nonpublic teaching hospitals generally carried a heavier Medicaid patient load than nonprofit hospitals in urban areas, and particularly in large urban areas. (Large urban areas are metropolitan statistical areas with a population of 1 million or more or New England County Metropolitan Areas with a population of 970,000 or more.) Among nonpublic hospitals, the Medicaid patient load was greatest in major teaching hospitals in large urban areas; it is about 66 percent heavier than in nonprofit hospitals generally (see Table 3).

The overall Medicare patient load in 1991 was much the same for nonprofit and for-profit hospitals, about 47 percent of inpatient days. Nonprofit hospitals had a slightly heavier Medicare patient load in large urban areas; for-profit hospitals had a slightly heavier Medicare patient load in other urban and rural areas (see Table 2). Nonpublic teaching hospitals generally had a lower Medicare patient load than nonprofits (see Table 3).

Occupancy rates were higher for nonprofit than for for-profit hospitals in 1991, as they have been for the past 20 years (see Table 2).<sup>63</sup> Among nonpublic hospitals--and among all hospitals, public and private--the highest

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61. Prospective Payment Assessment Commission, based on analysis of American Hospital Association data, as reported in *Medicare and the American Health Care System: Report to the Congress* (June 1994), pp. 43-44.

62. Prospective Payment Assessment Commission analysis of data from the American Hospital Association Annual Survey of Hospitals, in *Medicare and the American Health Care System*, p. 44.

63. American Hospital Association, *Hospital Statistics 93/94*, p. 7.



**TABLE 2. PATIENT DAYS FOR MEDICARE AND MEDICAID  
AND OCCUPANCY RATES, BY HOSPITAL GROUP, 1991**

Hospital Group	Percentage of Patient Days		Occupancy Rate (Percent)
	Medicare	Medicaid	
<b>All Hospitals</b>	45.3	14.1	57.7
<b>For-Profit</b>			
All	46.9	11.5	46.6
Large urban areas <sup>a</sup>	43.5	11.2	45.6
Other urban areas <sup>b</sup>	49.2	9.9	50.0
Rural areas <sup>c</sup>	53.5	16.7	42.5
<b>Nonprofit</b>			
All	46.7	12.9	60.8
Large urban areas <sup>a</sup>	44.3	13.6	65.7
Other urban areas <sup>b</sup>	48.6	11.7	61.2
Rural areas <sup>c</sup>	52.8	13.2	44.8
<b>Public</b>			
All	37.1	21.9	52.8
Large urban areas <sup>a</sup>	26.6	26.9	66.8
Other urban areas <sup>b</sup>	35.6	22.3	60.8
Rural areas <sup>c</sup>	51.4	15.4	37.5

SOURCE: Congressional Budget Office based on analysis of data from the Health Care Financing Administration.

NOTE: Data correspond to hospitals' cost-reporting periods beginning in fiscal year 1991.

- a. Large urban areas are metropolitan statistical areas (MSAs) with a population of 1 million or more or New England County Metropolitan Areas with a population of 970,000 or more.
- b. Other urban areas are MSAs with a population of less than 1 million or New England County Metropolitan Areas with fewer than 970,000.
- c. Rural areas are outside MSAs.



**TABLE 3. PATIENT DAYS FOR MEDICARE AND MEDICAID  
AND OCCUPANCY RATES IN TEACHING HOSPITALS, 1991**

Hospital Group	Percentage of Patient Days		Occupancy Rate (Percent)
	Medicare	Medicaid	
All Teaching Hospitals	40.6	16.9	69.2
<b>Nonpublic</b>			
All	43.3	14.7	68.6
Large urban areas <sup>a</sup>	41.9	15.7	70.7
Other urban areas <sup>b</sup>	45.8	12.8	65.5
Rural areas <sup>c</sup>	50.0	12.8	59.3
<b>Major Teaching, Nonpublic<sup>d</sup></b>			
All	36.6	21.3	76.6
Large urban areas <sup>a</sup>	37.0	21.4	76.7
Other urban areas <sup>b</sup>	32.7	22.1	75.7
Rural areas <sup>c</sup>	40.3	12.2	75.2
<b>Public</b>			
All	23.8	30.5	72.6
Large urban areas <sup>a</sup>	18.7	33.9	74.8
Other urban areas <sup>b</sup>	28.8	27.0	70.9
Rural areas <sup>c</sup>	44.1	20.1	55.2
<b>Major Teaching, Public<sup>d</sup></b>			
All	20.1	32.3	75.0
Large urban areas <sup>a</sup>	17.5	34.2	75.3
Other urban areas <sup>b</sup>	24.9	28.8	74.4

SOURCE: Congressional Budget Office based on analysis of data from the Health Care Financing Administration.

NOTE: Data correspond to hospitals' cost-reporting periods beginning in fiscal year 1991.

- a. Large urban areas are metropolitan statistical areas (MSAs) with a population of 1 million or more or New England County Metropolitan Areas with a population of 970,000 or more.
- b. Other urban areas are MSAs with a population of less than 1 million or New England County Metropolitan Areas with fewer than 970,000.
- c. Rural areas are outside MSAs.
- d. Major teaching hospitals are hospitals with a graduate medical education program and a ratio of interns and residents to beds of 0.25 or greater. Data for nonpublic hospitals include a few for-profit institutions.



occupancy rates were in major teaching hospitals in large urban areas (see Table 3).

### Charity Care

The primary burden of caring for the medically indigent has fallen on public hospitals. Nonprofit hospitals fill a much smaller share of the need, although some evidence suggests that nonprofit, and particularly teaching, hospitals in large urban areas provide significant amounts of indigent care, especially in their emergency rooms.<sup>64</sup>

The amount of charity care that hospitals provide is difficult to measure. Uncompensated care includes both charity care and bad debts. It does not include any unreimbursed costs of caring for Medicaid or Medicare patients. Charity care and bad debts traditionally have been difficult to separate, although current accounting guidelines make distinctions between them.

In the past few years, the American Institute of Certified Public Accountants and the Hospital Financial Management Association have established criteria for distinguishing between charity care and bad debt. The criteria state that bad debts result from the unwillingness of a patient to pay, while charity service is provided to a patient with demonstrated inability to pay. Nevertheless, the requisites for charity care can vary from state to state, and most analysts caution against attempts to distinguish such care from bad debt. The American Hospital Association, which is the primary source of data on uncompensated care, avoids making distinctions between charity care and bad debt. The General Accounting Office in 1990 also noted inconsistencies in the way hospitals distinguish between the two.<sup>65</sup> A survey by *Modern Healthcare* of more than 150 health care systems suggests that in 1992 and 1993 charity care expenses were substantially higher in relation to net patient revenues for nonprofit than for-profit systems.<sup>66</sup>

A few states have recently enacted legislation requiring hospitals that are exempt from state taxes to provide charity care or meet specific community benefit criteria. For example, in the fall of 1993, the Texas legislature passed a law specifying charity care criteria for exemption from state property taxes.

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64. General Accounting Office, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption*, GAO/HRD-90-84 (May 1990), pp. 2-3.

65. *Ibid.*, p. 18.

66. Jay Greene and Sandy Lutz, "Systems Post Fourth Straight Year of Income Growth," *Modern Healthcare*, vol. 24, no. 21 (May 23, 1994), p. 42.



Under the Texas statute, a hospital must meet either a charity care or a community benefit requirement to qualify for the tax exemption. The charity care requirement is 4 percent of net patient revenues. The community benefit requirement is charity care equal to 3 percent of net patient revenues, plus a community benefit requirement equal to 2 percent of net patient revenues. The unreimbursed costs of caring for financially or medically indigent patients count toward meeting the charity and community benefit requirements. Losses from unreimbursed costs of caring for Medicaid patients count toward the charity care requirement. Losses from Medicare patients count toward the community benefit requirement.

In Massachusetts, the attorney general's office took a different approach, deferring for two years a set of specific targets for nonprofit hospitals to meet in determining the value of the charitable benefits they provide. Current guidelines encourage hospitals to assess community health care needs and to develop plans and budgets for meeting local needs consistent with the hospitals' financial resources and in consultation with local representatives. The guidelines require hospitals to submit annual reports on community benefits to the state attorney general and to make the reports available to the public, but leave it up to the hospitals to delineate which communities to focus on.<sup>67</sup>

If health care restructuring is enacted, the need for charity care may decline but it would not disappear, at least during a period of transition. As health care coverage broadens, the number of people who are insured would increase, thereby removing some of the burden on both public and private hospitals. But the shortfall from reimbursements by government-sponsored and private insurance programs that do not fully cover costs would persist until cost increases are held in check, as would the burden of providing health care for illegal aliens, who (based on proposals to date) would have no required insurance coverage and would probably be free riders on the system. In short, hospitals and other health care providers would continue to care for people who are uninsured and unable to pay for their medical care, although generally to a lesser extent than they do now.

### Mergers, Acquisitions, and the Tax-Exempt Sector

Although the number of hospitals and hospital beds in relation to population has been steadily declining over the past 20 years, the tax-exempt sector of the

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67. John Morrissey, "Massachusetts Community Benefit Guidelines Omit Targets," *Modern Healthcare* (June 27, 1994), p. 14.



health care system is expanding in other ways and is likely to continue to do so with or without the advent of health care restructuring. Much of the expansion has resulted from, and is likely to continue to be caused by, the horizontal merger of hospitals and the vertical integration of health care services. As a by-product of these developments, the variety of institutions under the tax-exempt umbrella is growing.

Horizontal mergers of hospitals generally consolidate existing resources, but in the process hospitals may also add equipment or expand facilities to broaden their range of services. Mergers and the formation of hospital systems have been taking place in both the tax-exempt and taxable sectors. Between 1983 and 1992, the number of hospital systems increased from 249 (representing 2,050 hospitals with 378,000 beds) to 300 (representing 2,826 hospitals with 540,000 beds). At the same time, the total number of nonfederal acute care hospitals declined from 5,788 to 5,292.<sup>68</sup>

Vertical integration of health care institutions has included a variety of joint ventures between physicians and hospitals. In a recent survey of nearly 1,200 top hospital executives by the accounting firm of Deloitte and Touche, 81 percent of the respondents indicated that they did not believe that in five years their institutions would be operating on a stand-alone basis. Hospitals are linking up with physicians' groups and HMOs to provide a wide variety of services, including routine office visits, diagnostic procedures, inpatient treatment, and even home or nursing home care. The traditional hospital--which provides inpatient services ordered by independent physicians--seems to be losing ground to new forms of health care delivery.<sup>69</sup>

Horizontal mergers and integrated delivery systems could, in theory, constrain the growth in costs by consolidating resources. Survey information, however, indicates that mergers have often entailed acquisition of more equipment, renovation of buildings, and construction of new facilities, which--at least over the short run--have caused operating costs and prices to rise at a faster rate than before the mergers took place. For example, a study by Health Care Investment Analysts of 14 mergers involving 28 hospitals reported that the aftermath included higher occupancy rates, improved profit margins, and price increases at higher annual rates. The rate of price increases began to level off four years after the mergers took place.<sup>70</sup>

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68. American Hospital Association, *Directory of Multihospital Systems (1980-1987)* and the editions of the *AHA Guide* for the years 1988-1993.

69. Deloitte and Touche, *U.S. Hospitals and the Future of Health Care: A Continuing Opinion Survey--Fifth Edition 1994* (Philadelphia: Deloitte and Touche, 1994), p. 1.

70. Jay Greene, "The Costs of Hospital Mergers," *Modern Healthcare* (February 3, 1992), pp. 36-43.



Affiliations can take many forms, ranging from contractual relationships to fully integrated systems. Among tax-exempt institutions, vertical integration has commonly involved the acquisition by tax-exempt hospitals of for-profit physicians' groups to form a tax-exempt provider network or integrated delivery system. As of July 1994, the IRS had issued several rulings for tax-exempt IDSs under Section 501(c)(3) and was considering additional applications. The new rulings have granted tax-exempt status to foundation-model IDSs. According to an IRS spokesperson, IDSs are "the single biggest development" in the tax-exempt health care sector.<sup>71</sup>

The Ways and Means and the Senate Finance Committees' bills would preempt state prohibitions on the corporate practice of medicine and thereby make the formation of tax-exempt, vertically integrated systems a simpler process than it is in several states today. Preempting state laws that prohibit the corporate practice of medicine would make it possible for hospitals to hire physicians as employees and provide medical services directly. This might eliminate the need for hospitals in states with prohibitions against the corporate practice of medicine to use the foundation model in forming an IDS (that is, to establish a new legal entity that must get an exemption from the IRS before moving forward). Tax-exempt hospitals would then be able to acquire physicians' groups or HMOs more quickly and easily, and the growth of tax-exempt vertically integrated delivery systems could accelerate.<sup>72</sup>

These new developments raise the issue of whether tax-exempt hospitals should continue to be able to acquire for-profit medical groups and operate the resulting integrated delivery system as a tax-exempt entity and, if so, on what basis. Tax-exempt IDSs are quite new. Reliable data do not exist to support or refute the view that just integrating hospital and physician services will benefit a community, either by providing services that had been previously unavailable or by eliminating duplication of procedures, thereby constraining the growth in costs.

### The Growth in Tax-Exempt Financing

At the same time that hospital occupancy rates have been declining and hospitals have been reducing the number of their beds, tax-exempt new financing for acute care hospitals has been holding steady. By and large, the

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71. T.J. Sullivan, Special Assistant for Health Care, Office of the Assistant Commissioner, Employee Plans and Exempt Organizations, in *Tax Notes* (April 18, 1994), p. 276.

72. Boisture, "Assessing the Impact of Health Care Reform on the Formation of Tax-Exempt Health Care Providers and HMOs," p. 281.



purpose of new financing is to modernize existing facilities, purchase new equipment, and build new outpatient facilities.

Physicians' groups have also used tax-exempt financing, but to a much lesser extent than hospitals. Among physicians' groups, medical faculty practice plans have enjoyed the most favorable credit ratings. Most nonprofit physicians' groups have difficulty gaining access to the tax-exempt bond market unless they are affiliated with a university medical center or a tax-exempt hospital. If a tax-exempt hospital acquires a physicians' group, however, it may be able to use tax-exempt bonds to finance the expansion of clinical facilities.

The emergence of new forms of health care institutions, in particular integrated delivery systems, is likely to lead to increases in the use of tax-exempt financing. Removal of the per-institution limit on outstanding issues of tax-exempt bonds for facilities not integrally related to acute care could lead to further increases.

