

**TENTH ANNIVERSARY OF THE HEALTH  
LAW CERTIFICATE PROGRAM  
FEBRUARY 5, 2007  
THE ROLE OF THE MODERN  
CHARITABLE HOSPITAL**

*Thomas K. Hyatt, Esquire*\*

**Tom Hyatt:** Thank you, Alan, very much and hello everyone. It's good to see all of you. I think the last time I was here, in this courtroom, the podium was facing the other direction and I was arguing in our moot court finals in front of Judge Weis, Judge Edwards, and Justice Flaherty. I can tell you it's a whole lot easier facing this way and talking to all of you than it was to the three of them. It's very exciting to be back here, 25 years this May since I graduated from Pitt law, and I'm happy to see some of my good friends from our class in the audience as well. It's also very exciting to be here for the Tenth Anniversary of the Health Law Certificate Program. Pitt and the City of Pittsburgh have had a prominent role in the development of health care law throughout the years. Nat Hershey with the School of Public Health was one of the first law professors and practitioners in the area of health law. John Harty and Eric Springer wrote the very influential Hospital Law Manual and created one of the first, if not the first law firms specializing in the practice of health care law. Also there was, of course, Alan Meisel and his seminal work on the right to die and care at the end of life and medical ethics. Alan was doing that when pretty much the only course any law school offered was one on Law and Medicine and it covered just about everything on the waterfront. Alan was one of the early practitioners to drill down into areas that were not just important legally but important to all of us in our lives and in our families. I have always been very impressed with the work that Alan has done in that regard.

Alan mentioned that when I was here, I was the Editor-in-Chief of the *Journal of Law and Commerce*. To offer you a quick illustration of how health law has changed since those years, after my second year I clerked with a health care law firm in Washington and got very excited about this area of law. Professor Ed Symons was our faculty advisor then and I sat down with

---

\* Shareholder, Ober Kaler Grimes & Shriver, P.C.; B.A., Boston College, 1979; J.D., University of Pittsburgh, 1982.

him, and I said, “Professor Symons, I think it would be great if we did a symposium issue for the *Journal* on health law.” And he looked at me paternalistically and said, “I really don’t think there’s a whole lot to talk about there. I’m really not sure we can fill a whole issue with that.” So we cajoled each other and we compromised and we ended up with one article and one book review on health law topics.

Well that was in 1982. There are now, of course, several entire journals devoted to health law. It tells you a lot about how our practice has evolved over the years. It’s wonderful and gratifying to see the Health Law Certificate Program here at Pitt ten years old and going strong, nationally recognized, and honored. For anyone who practices health care law, it’s terrific to see it being picked up in the law schools in this fashion.

It’s somewhat amazing to me that I’m not here any longer as a student but now as a practitioner of nonprofit tax law. I don’t think Professor Bill Brown is in the audience, I’m kind of hoping he is not, because he would laugh hysterically if he knew if I was a tax law practitioner. I took all of one course in tax law when I was in law school, Federal Income Taxation. It was a required course and that is why I took it. So it was somewhat of a surprise that I ended up in this field of law and I have to confess to you now, and Dean Crossley I have to confess to you, I never did and still don’t understand what all the fuss is about over *Crane*’s footnote 37.<sup>1</sup>

Having said that, this is what I do for a living. And here’s the reason why. I got involved in this area of the law in the early ’80s when we were doing nonprofit reorganizations. We were taking a single hospital operating corporation and growing it into these large multi-corporate systems. In order to do that, you had to understand the tax-exempt organization laws because they drove most of the structural and operational choices. The reason I initially got into it is because no one else in my law office wanted to do the tax work and I was the young buck, the new kid on the block, and so I was assigned that work.

What I learned as I got into it was that this stuff was actually pretty interesting. The reason is that nonprofit tax law has relatively little to do with traditional tax law. It has a lot to do with public policy. If I want to look at the question of whether or not Americans should receive free health care and whether or not hospitals should provide that health care, that is at the end of the day a question of nonprofit tax law. If I want to know who is going to sit on the board of directors of a hospital, if I want to know whether a hospital can joint venture with a group of physicians to build an imaging center rather

---

1. *Crane v. Comm’r of Internal Revenue*, 331 U.S. 1, 14 (1947).

than do it directly, if I want to know if a hospital can have a for-profit business that has nothing to do with providing medical care, those are questions of tax-exempt organization law. I got hooked early on and found that it's really an area of law with a lot of difficult questions to answer. A lot of great questions on public policy.

The question that I bring to you today is one of those questions. I would argue it is one of the most formidable public policy questions of our time. That question is: What is the role of a modern charitable tax-exempt hospital? I would suggest you take note of the date April 28, 2005. That was the date that the following comment was made: "What's the difference between a profit making hospital and a not-for-profit hospital these days? Not a lot."<sup>2</sup> Who do you suppose said that? If it was an executive from the Federation of American Hospital Systems, the for-profit hospital trade association, I'd have said, "to be expected." If it was a grandstanding politician, I'd say, "it's okay, it comes with the territory." Do you know who said that? Mark Everson, the Commissioner of the Internal Revenue Service. The regulator in chief of tax-exempt hospitals. If the IRS Commissioner says he can't really tell you the difference between a for-profit and a nonprofit hospital, you had better be worried. It's a rallying cry if ever I heard one. Clearly, nonprofit hospitals must do a better job of making their case as to why in their current iteration they ought to continue to be recognized as charitable organizations. This is not a new debate. It has been going on for over 50 years. Certainly the health care field has changed a great deal in that period of time. Still, the debate continues.

My premise today is that the role of a modern charitable hospital is threefold. First, it is nonprofit organization. It is a member of the community of nonprofit organizations and as such has a responsibility to that community. Second, it is a tax-exempt public charity. In exchange for freedom from taxation, it has certain obligations to fulfill. Finally, and let there be no mistake about it, a modern charitable hospital is a business enterprise. There are lines to be drawn, lines not to be crossed, but that business enterprise function is a very real part of what they do every day. So let's look at charitable hospitals' roles through those three prisms and see where that leads us.

Let's first talk for a moment about definition of terms. Sometimes you'll hear the term nonprofit, sometimes you'll hear the term tax-exempt. Those

---

2. Remarks of IRS Commissioner Mark Everson at *Representing and Managing Tax-Exempt Organizations Conference*, Georgetown University Law Center, BNA DAILY TAX REPORT at G-9, Apr. 29, 2005.

two terms are not synonymous. Nonprofit means that you are as a creature of state law organized as a nonprofit organization. In order to accomplish that, you have to file articles of incorporation that contain purposes fairly similar to these you'd have to adopt to convince the IRS that you're tax-exempt. But all that makes you is a nonprofit corporation; not tax-exempt. Now part and parcel of that is you also get regulated by the state. We have Karl Emerson with us today from the Bureau of Charities who will speak to that. The next piece of it then becomes, are you also tax-exempt? Whether or not you are tax-exempt is a function of state law and a function of federal law. I'll be focusing primarily on federal law today. Some of our panelists will look at the state law issues.

Also important when you get to the question of tax exemption is to note the difference between federal income taxation and state property taxation, sometimes called *ad valorem* taxation. The reason that distinction is important is that the IRS and the states often times have very different views of what you need to do in order to be recognized as tax-exempt. In the state of Pennsylvania you have to be what's called a "purely public charity," entirely free of profit motive.<sup>3</sup> If that was also the criterion to be federally tax-exempt, I submit to you that many hospitals would not be federally tax-exempt. So the standards are different depending on which body of tax law we're talking about.

Our talk today is about the modern charitable hospital. Why do we use the term modern here? Well, part of that is understanding that we're in a much different place now than we were in 1969, when the community benefit standard was established. Certainly we are in a different place than we were in the early part of the 1900s. The very first hospital in this country was in Philadelphia: the Philadelphia Hospital. In this country, hospitals started as almshouses. You didn't go to a hospital to get better, you went to a hospital to die. You went to a hospital if you had nowhere else to go. If you were wealthy, if you could afford the cost of your care, you were treated at home. The doctor came to your house and saw to it that you got better there.

Because of that historical basis for hospitals, the reason that hospitals were originally considered to be charitable organizations under federal tax law was the relief of poverty. Under the law of English charitable trusts, the relief of poverty was a primary basis for treatment as a charity. Well, in 1956, the IRS for the first time in guidance explained how an exemption for hospitals is justified under federal tax law. In 1956, the IRS issued Revenue Ruling

---

3. 10 PA. CONS. STAT. ANN. §§ 371-72, 375 (West 1997).

56-185.<sup>4</sup> The Service said if you want to be a charitable hospital, you have to provide care to the extent of your financial ability to do so.<sup>5</sup> Now that didn't mean that you had to go belly up in the process, but it did mean that for the most part all of your revenues over and above your expenses had to go to providing indigent care, because it was through the relief of poverty that you qualified for exempt status.

Subsequently, the IRS recognized a different basis for qualifying as a charitable organization through the promotion of health.<sup>6</sup> Much as the advancement of education, the promotion of religion, and the promotion of science are all bases for qualifying as a charity under federal tax law, so, in the IRS's view, is promotion of health.

In 1969, the IRS did a fairly lengthy and thoughtful study to determine whether or not the financial ability standard was still the most appropriate measure for recognizing exemption for charitable hospitals.<sup>7</sup> As a result of that study, the IRS concluded that it is really not the same situation as it was in 1956 because, among other things, hospitals have modern technology, the cost of patient care is much more than it used to be, philanthropic support of hospitals is not what it used to be, and perhaps most importantly in 1965 Congress established the Medicare and Medicaid programs.<sup>8</sup> For the first time, federal programs paid for the cost of care of the elderly and the poor. As a result, the IRS took the position that it is no longer necessary to base exemption solely on the relief of poverty.<sup>9</sup> That was a pretty important change of position for the IRS and it became quite controversial, as we'll talk about in a moment.

I want to spend just a moment recognizing the gentleman who wrote Revenue Ruling 69-545 which established the community benefit standard. He's a lawyer by the name of Bob Bromberg and he passed away this year. Several of you know him from the American Health Lawyers Association, where he chaired the tax program for 21 years. When Bob was at the Service, he wrote Revenue Ruling 69-545, and he put a lot of time and effort into trying to establish in federal tax law what he later called in a 1970 article in the *Catholic Law Review*, a liberal approach to the taxation of charitable

---

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

5. *Id.*

6. Rev. Rul. 69-545, 1969-2 C.B. 117 (citing RESTATEMENT (SECOND) OF TRUSTS § 368 (1959)).

7. [http://ftp.irs.gov/pub/irs-tege/5-26-05\\_hospital\\_sector\\_testimony.pdf](http://ftp.irs.gov/pub/irs-tege/5-26-05_hospital_sector_testimony.pdf).

8. Social Security Amendments of 1965, Pub. L. No. 89-97, 72 Stat. 286 (1965).

9. Rev. Rul. 69-545, 1969-2 C.B. 117.

hospitals, which recognizes that hospitals now are about so much more than simply the relief of poverty.<sup>10</sup>

The debate continues, however, with regard to whether or not that is the right standard today. Some assert that the relief of poverty should still be the proper standard for recognizing charitable tax-exempt status for hospitals.<sup>11</sup> With that as background, let's take a look at what I suggested are the three roles of a modern charitable hospital today.

First, a charitable hospital is a nonprofit organization. Those of you that have worked in this field know that this has been a tumultuous time for nonprofits, in the last five or six years especially. There has been scrutiny of nonprofits, and particularly of the healthcare sector, like we haven't seen since 1969 with private foundation reforms. Much of this heightened scrutiny started with the Sarbanes-Oxley Act of 2002.<sup>12</sup> The Sarbanes-Oxley Act was intended to go after for-profit corporate abusers. It applies to publicly traded companies and public accounting firms with the exception of two provisions that were actually changes to the federal criminal code<sup>13</sup> and so they apply to nonprofits as well.<sup>14</sup> Sarbanes-Oxley set a standard for trying to provide for more accountability and more transparency in corporate organizations.

I'd like to tell you a quick story that I love that illustrates the change in thinking effected by Sarbanes-Oxley. Sarbanes-Oxley has become a catch phrase for any kind of governance reform or analysis. A client called me up and they said, "we have an architect on our board of directors and the architect in the past has provided some services to us for free. He'd like to help us on a building project that we've got, and he can't do it for free, but he's willing to do it for below his regular charges. Would that be okay?" I talked her through the conflict of interest process and said it would be fine if the organization followed that process. She said a member of her board was very concerned, and that she was certain that it would be a violation of Sarbanes-Oxley. I said, "well it really isn't." And she said, "well, she's adamant about

---

10. Robert S. Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237 (1970).

11. See, e.g., Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and For Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 332 (2007) ("Imposing minimum charity care standards will increase access to medical care for patients without insurance or with inadequate insurance and the actual provision of medical care to those in need. . . ."); see also Gabriel O. Aitesbaomo, *The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption*, 26 CAMPBELL L. REV. 75 (2004) (arguing that the IRS should require hospitals to provide minimum annual levels of charity care in order to receive tax exemption).

12. Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 745.

13. §§ 802(a), 1107(a) (codified at 18 U.S.C. §§ 1513(e), 1519 (2006)).

14. See generally *The Sarbanes-Oxley Act and Implications for Nonprofit Organizations*, BoardSource/IndependentSector (2004) ([www.boardsource.org](http://www.boardsource.org)).

it and she said she'll get back to us, she wants to go talk to her neighbor first." I said, "okay." So the concerned director came back to the next board meeting and she said, "it's okay. I've talked to my neighbor and he said it's really not a problem under Sarbanes-Oxley." The curious client asked: "well, who is your neighbor?" The director replied: "Oh, it's Paul Sarbanes." I guess sometimes it helps to go right to the source.

But it shows you that Sarbanes-Oxley covers a lot of territory and sometimes it's hard to predict exactly what will come out of that. We know that there are two provisions under Sarbanes-Oxley that apply to nonprofits. One is that you can't destroy documents in the wake of a federal investigation or bankruptcy proceeding.<sup>15</sup> Now if you needed Sarbanes-Oxley to tell you that, you are, as one of my Pitt law professors used to say, "too dumb to live." Hopefully, you didn't need a federal law to tell you that. The other provision is that you can't retaliate against whistle blowers.<sup>16</sup> If someone is cooperating in a law enforcement proceeding in good faith, you cannot punish them in their employment because of that action. Again, those apply to nonprofits because they are a change in the federal criminal code. Now Sarbanes-Oxley has become a kind of high water mark for accountability for nonprofits. In fact, the University of Pittsburgh Medical Center has voluntarily pursued full compliance under Sarbanes-Oxley. According to its Annual Report, UPMC is the only health system in the country that is voluntarily pursuing full compliance under Sarbanes-Oxley.<sup>17</sup>

The next development, one that truly catalyzed the debate in terms of what it means to be a nonprofit organization, was a Senate Finance Committee's discussion draft on nonprofit reforms.<sup>18</sup> In the last two years, the Senate Finance Committee and the House Ways and Means Committee have become quite interested in the operations of nonprofit health care organizations and exempt organizations in general and have held hearings in order to get a better picture.<sup>19</sup> Subsequently, the Senate Finance Committee staff put out a discussion draft recommending various charitable reforms for the sector. Usually when you see these things coming out of Capitol Hill you know they were written with the aid of a lot of Diet Coke and Domino's Pizza. This discussion draft was likely written with the aid of vodka and Domino's

---

15. Sarbanes-Oxley Act of 2002 § 802(a), 18 U.S.C.A. § 1519 (2006).

16. *See id.* §§ 1107(a), 1513(e).

17. University of Pittsburgh Medical Center Annual Report, at 2 (Aug. 31, 2006), *available at* <http://www.upmc.com/pdf/annualreport.pdf>.

18. STAFF OF S. COMM. ON FINANCE, 108th Cong., Exempt Status Reforms (2004).

19. Taking the Pulse of Charitable Care and Community Benefits at Non-profit Hospitals: Hearing Before the S. Comm. on Finance, 109th Cong. (2006); Hearing on the Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means, 109th Cong. (2005).

Pizza. There are clearly ideas in the draft that are well intentioned and others that are just off the chart. They threw everything they wanted in there. The discussion draft created a lot of angst in the nonprofit sector. To their credit, nonprofits realized that they could either be legislated to or they could take the ball and run with it and make a proposal to Congress, which is exactly what they did. The Independent Sector convened a number of blue ribbon task forces and created the Panel on the Nonprofit Sector.<sup>20</sup> It prepared formal responses to the Senate Finance Committee discussion draft with recommendations aimed at the Congress, at the IRS, and at members of the nonprofit community for greater accountability and transparency.<sup>21</sup>

During this period, we have also seen significant development in the nonprofit sector on governance best practices. There has been a wonderful, thoughtful discussion amongst nonprofit leaders. A couple of examples: Maryland put together the Standards for Excellence Institute.<sup>22</sup> Its program has been replicated in five or six states now, including in Pennsylvania.<sup>23</sup> The Institute accredits nonprofit organizations that follow certain well-developed best practices for governing and operating their organization. The idea is that you show a donor that you're doing the right thing. Imagine I'm a donor and I'm looking at two different charities that are serving a mission that I want to serve and that look pretty equal to me. Only one of them has been accredited by a watchdog group that says, "they are well governed, they're efficient, they're a good organization." I am probably going to give my dollar to the accredited organization. In fact, the discussion draft of the Senate Finance Committee took the position that such certification ought to be a condition to being recognized as a 501(c)(3) by the IRS.<sup>24</sup> There's also the Better Business Bureau's Wise Giving Alliance. This organization has developed specific benchmarks, e.g., how big should your board be, how much of your dollar should go to administrative and overhead versus for exempt purposes, how many committees should you have, how often should you meet? The Alliance gives you a seal of approval if you achieve those standards.

---

20. Independent Sector, Panel on the Nonprofit Sector, *available at* <http://www.independentsector.org/panel/main.htm>.

21. Panel on the Nonprofit Sector, Strengthening Transparency, Governance, Accountability of Charitable Organizations, *available at* [http://www.nonprofitpanel.org/final/Panel\\_Final\\_Report.pdf](http://www.nonprofitpanel.org/final/Panel_Final_Report.pdf).

22. Maryland Nonprofit Group, *available at* <http://www.standardsforexcellence.org/>.

23. Pennsylvania Nonprofit Group, *available at* <http://www.pano.org/STANDARDS/standardscode.php>.

24. Encourage Strong Governance and Best Practices for Exempt Organizations, Government Encouragement of Best Practices: Staff Discussion Draft for S. Comm. on Finance, 109th Cong. 14 (2004).

Finally, just last week the IRS released a draft of what it believes constitute nonprofit governance best practices.<sup>25</sup> They've indicated that it's a work in progress, and it's stated in fairly general terms, but again offering ideas on what a good 501(c)(3) organization looks like.

Another big piece of this discussion has been transparency. Form 990 is the annual information return that all tax-exempt organizations making more than \$25,000 a year have to file with the IRS. There was a change in the law in recent years that requires that Form 990s be publicly available for anyone who requests them in writing.<sup>26</sup> IRS guidance recommends that they be posted on the nonprofit's website. The real initiative in shining a light on organizations through their 990's has been taken by an organization called Philanthropic Resources, which has a service called GuideStar.<sup>27</sup> GuideStar started getting the PDF images of these 990s and putting them on its own website. If you go to [www.guidestar.org](http://www.guidestar.org), and plug in the name of a nonprofit, tax-exempt organization, you can see 990s of that organization typically over about a seven-year period.<sup>28</sup> This simple initiative has achieved transparency in nonprofit operations to an extent we have never seen before. And it is only going to get more transparent. The IRS is right now developing a major change in the questions they ask under the Form 990.<sup>29</sup> We should see the new Form 990 sometime this year. Part of what the IRS is going after is more information about how hospitals satisfy the community benefit standard. The goal, in part, is to enable the public to compare apples to apples in assessing nonprofit operation. We can barely compare it at all right now under the current Form 990.

Another development that I think is truly remarkable, and very little has been said about this, occurred when the Pension Protection Act of 2006 was passed this past August.<sup>30</sup> The law contains a number of charitable reforms that came right out of the Senate Finance Committee discussion draft. One of them is that for returns filed after August 17, 2006, tax-exempt organizations have to publicly disclose their Form 990-T which is the form organizations file if they earned unrelated business income that's taxable.<sup>31</sup> Why is that remarkable? Because the Form 990-T is a *tax* return. It's not an information

---

25. Internal Revenue Service, Good Governance Practice for 501(c)(3) Organizations, <http://www.irs.gov/pub/irs-tege/good-governance-practices.pdf>.

26. Public Disclosure of Material Relating to Tax-Exempt Organizations, Treas. Reg. Sec. 301.6104(d)-1.

27. Guidestar, *available at* <http://www.guidestar.org/index.jsp> (last visited Oct. 9, 2007).

28. *Id.*

29. Proposed Collection; Comment Request for Form 990, 69 Fed. Reg. 8 (Jan. 13, 2004).

30. Pension Protection Act, 29 U.S.C. § 1001 (2006).

31. IRS Notice 2007-45.

return. As a result, there is only one taxpayer under our tax system that is required to publicly disclose its federal tax returns and that is the tax-exempt organization. Now that is transparency!

My view is that the role of a modern charitable hospital is to be a member of the nonprofit community and to lead that community. Hospitals and universities and churches are the big three in the tax-exempt world. They are the ones that have the resources, both human and capital, to be leaders among nonprofits. They need to step up to the plate and do that. Some of them have done better than others.

It's interesting to me to see how exempt hospitals see themselves in this regard. I looked at the UPMC Annual Report for 2005, the one that is currently on the UPMC website, and Board Chair Beckwith offered this perspective: "This report is designed to provide a snapshot of UPMC—its financial and operational performance and its role in the community—as a superb integrated health system, a contributor to medical education and research, and an agent of economic resurgence."<sup>32</sup> So it was not just a narrow question of how can we be the best possible hospital, or how can we improve research and education, but also how can we improve the community that we're in? How can we be a better nonprofit? How can we better serve?

The second role of the modern charitable hospital is that of a tax-exempt public charity. Perhaps the central question about this role should be what is the compact that we have with charitable hospitals? What is it that is expected or required of them in exchange for their tax exemption? As I said earlier, in 1969, Revenue Ruling 69-545 was issued in which the IRS established the community benefit standard.<sup>33</sup> It took the position that it's no longer the case that a hospital has to provide charity care throughout the hospital to the extent of its financial ability to do so.<sup>34</sup> Instead, a hospital must provide unlimited charity care in its emergency room. It must treat all that show up in its emergency room without regard to their ability to pay. Under another body of law called the Emergency Medical Treatment and Active Labor Act, for treating people in an urgent medical condition and women in active labor, a hospital must screen these patients for their emergency condition and must stabilize them, but it is not required as a charitable hospital to admit them as a patient and to treat all of their injuries and all their illnesses.<sup>35</sup> The charity care requirement is limited to the emergency room.

---

32. 2005 UPMC Annual Report 2 (2005).

33. Rev. Rul. 69-545, 1969-2 C.B. 117.

34. *Id.*

35. 42 U.S.C. § 1395dd(a)-(b) (2006).

Is that all? No. The IRS then develops this notion of promotion of health, of community benefit.<sup>36</sup> A charitable hospital must have a board of directors comprised of independent civic leaders, and must have an open medical staff not restricted to just a few physicians. It must treat Medicare and Medicaid patients without regard to what those programs pay, and it cannot discriminate against Medicare and Medicaid patients in the provision of care. The hospital's excess revenue must be funneled back into fulfilling its charitable mission. A permitted use could be indigent care, but it could also be building a new building, buying the latest diagnostic imaging unit, undertaking joint ventures to improve access to care in different parts of the city. All of those uses of revenues would be consistent the community benefit standard.

The IRS' new community benefit standard was criticized immediately. A lawsuit was brought, by a welfare rights organization in federal court challenging the standard.<sup>37</sup> The organization argued that the correct basis for recognizing tax-exempt status is the adequate provision of charity care under the financial ability test.<sup>38</sup> The challenge failed and the community benefit standard has stood the test of time. The federal appellate courts that have looked at the issue have essentially concluded that, while it is not perfect, the community benefit standard is still the right standard to use in measuring the ability to qualify as a charitable organization.<sup>39</sup>

Just to demonstrate that not everyone agrees with that conclusion, I want to read to you from a press release that was put out by Senator Charles Grassley, who was until recently the chair of the Senate Finance Committee, and is now the ranking minority member. He said, "I'm engaged in an ongoing review of charity hospitals and it's clear that these hospitals are all over the map when it comes to providing charity care, community benefit and charges to the uninsured. Some charity hospitals are doing a little, some a lot and some nothing. These charity hospitals are receiving billions of dollars each in tax benefits and the public has a right to expect real public benefits in return. It's important to remember that the reason for this is that the IRS changed the rules. There was no change in the law. The IRS in 1969 changed

---

36. Rev. Rul. 69-545, 1969-2 C.B. 117.

37. *E. Kentucky Welfare Rights Org. v. Simon*, 370 F. Supp. 325 (D.D.C. 1973), *rev'd*, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26 (1976).

38. *Id.* at 326-27.

39. *See, e.g.*, *St. David Health Care Sys. v. United States*, 349 F.3d 232, 235 (5th Cir. 2003), *vacated*, No. A01CV046JN, 2004 WL 555095 (W.D. Tex. Mar. 18, 1994); *IHC Health Plans, Inc. v. Comm'r of Internal Revenue*, 325 F.3d 1188, 1197 (10th Cir. 2003); *Geisinger Health Plan v. Comm'r of Internal Revenue*, 985 F.2d 1210, 1217 (3d Cir. 1993), *rev'd*, 30 F.3d 494 (3d Cir. 1994); *Harding Hosp. v. United States*, 505 F.2d 1068, 1075 (6th Cir. 1974).

the rules because they listened to the lobbyists who hoodwinked the IRS and the Treasury that inability to afford medical care was a problem of the past. Well, we are all well aware that the inability to afford medical care is very much a problem of the present.”<sup>40</sup> This was in connection with a hearing to confirm Eric Solomon as Deputy Secretary of the Treasury. Mr. Grassley continued, “[Mr. Solomon], I want your commitment that the Treasury and the IRS are going to look at the real facts . . . and the Treasury and IRS are going [to] put out new guidance during this administration that puts real teeth to charity care, community benefit [and] charges to the uninsured and other important issues in this area. . . . People shouldn’t have to suffer because Treasury and the IRS got the facts wrong in 1969.”<sup>41</sup>

I respectfully submit to you that it wasn’t the IRS that got the facts wrong in 1969, it was the Senator and his staffers that got the facts wrong in 2006. There were no lobbyists hoodwinking the Treasury and the IRS. They didn’t get the facts wrong. If you do the research in this area, if you look at Bob Bromberg’s article on this,<sup>42</sup> if you look at the study that the IRS did at the time, they didn’t say that we no longer have indigent care problems in this country. The development of the community benefit standard was a result of a thoughtful examination of whether or not relying only on the relief of poverty as the basis for recognizing charitable status remained appropriate for modern charitable for hospitals. It is inaccurate to suggest that the IRS got the facts wrong, or that the IRS was somehow bamboozled by lobbyists. You may agree with the standard or you may not but it is an unfair criticism of those involved.

There is another catalyst in this area and that is a series of class action lawsuits brought by Dicky Scruggs. You may remember Dicky Scruggs, he’s the fellow who brought the class action suits in the tobacco litigation. When Dicky filed suit in over 50 federal courts across the country, the complaint was as follows: hospitals are charging indigent and uninsured patients full sticker price for their care in the emergency room. It is not what they charge private pay patients.<sup>43</sup> That is not what hospitals charge insurers, not even what they charge Medicare and Medicaid. Charitable hospitals are charging the full sticker price for these patients and then they try to collect it using humiliating and embarrassing collection practices. Clearly, there is evidence that these

---

40. Press Release, Senator Chuck Grassley, Charity Hospitals, U.S. Senate Comm. on Finance (July 14, 2006) (on file with author), *available at* <http://www.senate.gov/~finance/sitepages/grassley2006.htm>.

41. *Id.* at 29.

42. *See supra* note 10.

43. *Ellis v. Phoebe Putney Health Sys. Inc.*, No. 1:04 CV 80 (M.D. Ga. Apr. 8, 2005).

claims are valid. But the legal basis for his challenge was proven to be bankrupt.<sup>44</sup>

The legal argument advanced in these lawsuits was as follows: charitable hospitals have a contract with the IRS, by virtue of being 501(c)(3) organizations, to provide reasonable amounts of charity care across the board at reasonable prices. The tax law has effectively created a charitable trust for the indigent and the uninsured to receive hospital care and accordingly the hospitals ought to be providing this care. Well, every federal court that considered these cases—there were two here in Pittsburgh, against West Penn Allegheny and UPMC—rejected the plaintiffs' claims.<sup>45</sup> They concluded that they failed to state a claim upon which relief could be granted; and there is no contract with the IRS under a well-settled principle of law that unless a legislative action specifically creates a contract right, no inherent contract right exists.<sup>46</sup> The courts concluded that no charitable trust was created imputably, by design, or by wish. Finally, the courts found that these individuals do not have standing to bring these suits. There is no third-party right to challenge the IRS, in that regard.<sup>47</sup> As a result, those suits have fallen by the wayside, although some have been refiled in state courts pursuing state court claims. I'm not aware that there has been great success in that regard.

Nevertheless, those lawsuits achieved something very important. They got people thinking about the indigent care issue more critically. They made charitable hospitals start playing not only defense, but offense on what their charity care responsibilities were. We have recently seen major settlements, *Sutter Healthcare*<sup>48</sup> and *Catholic Health Care West*,<sup>49</sup> to name a couple, with hospitals agreeing to provide specific amounts of charity care above and beyond their emergency room obligations as tax-exempt hospitals. Indigent care remains a major problem in the United States. This past summer we saw the latest report from the Bureau of Census and it was sobering. In 2005, 46.6 million Americans were without health insurance coverage.<sup>50</sup> The historical record is marked by a 12-year period from 1987 to 1998 when the uninsured rate either increased or was not statistically different from one year to the next. The percentage of children without health insurance in 2004 and 2005

---

44. *Id.*

45. *Id.*; Amato v. Allegheny Gen. Hosp., 2004 U.S. Dist. LEXIS 28214 at \*16 (W.D. Pa. 2004); Amato v. UPMC, 371 F. Supp. 2d 752, 759 (W.D. Pa. 2004).

46. *UPMC*, 371 F. Supp. 2d at 755.

47. *Id.* at 756.

48. Darr v. Sutter Health, 2004 U.S. Dist. LEXIS 24592 (N.D. Cal. 2004).

49. Lorens v. Catholic Health Care Partners, 356 F. Supp. 2d 827 (N.D. Ohio 2005).

50. Carmen De Navas-Walt, Bernadette D. Proctor & Cheryl Hill Loe, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Census Bureau, Aug. 2006, at 20.

increased from 10.8% to 11.2%.<sup>51</sup> In 2005 37 million people were below the poverty line.<sup>52</sup> The question remains is it the obligation only of charitable hospitals to devote their resources to that problem, or others at the table too?

The House Ways and Means Committee, through Chairman Thomas, recently put forth a bill, the Tax Exempt Responsibility Act of 2006.<sup>53</sup> Under this bill, charitable hospitals would be required to provide more charity care to uninsured individuals. If a patient makes 100 percent or less of the federal poverty level, he pays \$25; between 100 percent and 200 percent he pays no more than the hospital would charge insurers or the government. If the hospital fails to treat those people, or fails to disclose to them its charity care policies, it can be fined \$1,000 per patient.<sup>54</sup> I don't expect that bill to go anywhere; for one thing the congressman is now retired, and I don't see anybody leaping to take up the reins. However, it makes the point that there are now legislative efforts underway to bring us back to a charity care based standard as the primary basis for tax exemption.

A key issue in this debate has been: what constitutes charity care? What constitutes community benefit? Community benefit is the big circle, charity care is a smaller circle within that. So let's start with charity care. What counts? A major area of disagreement has been whether bad debts should count as charity care? The hospital expects payment, tries to collect it and ultimately is unsuccessful. So it is out that amount of money. Is that necessarily any different than the patient who comes in and is never charged because they met the hospital's criteria for charity?

Another critical issue is how do we measure charity care? Do we measure it in costs or charges? Many would say hospital charges are funny money. Like the hammer you buy from the military for \$10,000 that costs two bucks to make, or like buying your car at sticker price; charges are a number that almost nobody pays. Costs are closer to what people pay and are more consistent across the hospital spectrum. It is argued that we should measure charity care in terms of cost, so that we can really compare apples to apples and oranges to oranges. There is now consensus that we should measure charity care in terms of costs. Whether we should include bad debts, however, remains a point of contention. The Catholic Health Association (CHA) has taken the lead in this area, developing a tool for measuring community benefit

---

51. *Id.*

52. *Id.* at 13.

53. Tax Exempt Hospitals Responsibility Act of 2006, H.R. 6420, 109th Cong. (2d. Sess. 2006).

54. *Id.* § 4968(A).

that clearly takes the position that you don't count bad debts, and you measure charity care in terms of costs.<sup>55</sup>

What about the Medicare and Medicaid program? Any hospital administrator will tell you that Medicare and Medicaid don't pay the cost of care in all instances. Thus, there may be cost shortfalls; a hospital provides a service and it is not even recouping its cost. The CHA argues that we should count Medicaid cost shortfalls but not Medicare.<sup>56</sup> The American Hospital Association takes a broader approach: count everything, measure everything.<sup>57</sup> Then you can make your determination as to what you do with that information. But don't hold back on what you're reporting.

The General Accountability Office and the Congressional Budget Office are two well accepted, neutral organizations that came out with studies on this issue in the past year.<sup>58</sup> They looked at uncompensated care, charity care and community benefit. And they basically said we've got mixed results here. Based on our studies, charitable nonprofit hospitals are providing more charity care and more community benefit than for-profit hospitals, but not by much. Commissioner Everson, when he testified in front of the House Ways and Means Committee, said that with recent changes in the health care industry, certain factors specifically discussed in Revenue Ruling 69-545 appear less relevant in distinguishing tax-exempt hospitals from the for-profit counterparts.<sup>59</sup> Having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to their ability to pay are now common features in tax-exempt and for-profit hospitals rather than distinguishing factors. Where is the distinguishing line drawn?

Finally, I want to talk about nonprofit hospitals and their role as business enterprises. Here is a quick take on the legal framework. According to the IRS regulations in this area, if you want to be a charitable hospital, you have to be operated exclusively in furtherance of charitable purposes. Only they said "exclusively" in this context doesn't mean exclusively; it means

---

55. Catholic Health Association, *available at* <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/whatcounts>.

56. *Id.*

57. American Hospital Association, AHA Guidance on Reporting of Community Benefit, *available at* <http://www.aha.org/aha/content/2006/pdf/061113cbreporting.pdf>.

58. The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means, 109th Cong. Serial 109-17 (2005), *available at* <http://www.gao.gov/cgi-bin/getrpt?GAO-05-743T>; The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means, 109th Cong. Serial 109-17 (2005), *available at* <http://www.cbo.gov/ftpdoc.cfm?index=76953BType=1>.

59. The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways and Means, 109th Cong. Serial 109-17 (2005), *available at* [ftp://irs.gov/pub/irs-tege/5-26-05\\_hospital\\_sector\\_testimony.pdf](ftp://irs.gov/pub/irs-tege/5-26-05_hospital_sector_testimony.pdf) (Statement of Mark W. Everson, Commissioner of IRS).

“primarily” . . . which is why they said “exclusively”!<sup>60</sup> So we’re left with the IRS trying to divine at what point you’ve crossed that line of primarily providing exempt services and begun to operate more like a for-profit enterprise.

The history of IRS regulation of healthcare organizations has been a series of yes and no answers. The IRS started out saying hospitals cannot get involved in joint ventures. That is not in furtherance of their charitable purposes. After the *Plumstead Theatre* case,<sup>61</sup> they came around and said, “[a]ll right. If you do it the right way, you can participate in a joint venture.” The IRS said hospitals cannot have taxable subsidiaries because that is using exempt capital to further a for-profit business enterprise.<sup>62</sup> Over time, the IRS became more comfortable with hospitals participating in for-profit ventures. The IRS also said that if you do it the right way, you may have a taxable subsidiary.

The IRS said a charitable hospital cannot have a joint venture where it sells off the net revenue stream of one department of the hospital to non-exempt parties. A charitable hospital cannot have a net-revenue stream joint venture. And then a couple of years later, the IRS came back and said, “heck, you can put the entire hospital into a joint venture. We will let the joint venture operate the whole thing.”<sup>63</sup> So you see, the IRS has been going from a position of “you can’t do this” to continually moving that line closer to operation as a commercial enterprise.

Remember when our friends at Hamot Medical Center, up the road, had problems with regard to their commercial activity? They caught a lot of grief for that at the time when in reality they were doing what a lot of other healthcare systems were doing.<sup>64</sup> I remember that there was a legislator in the state house waving around this organization chart that had about thirty different boxes symbolizing different corporations on it. He complained that this is a sign of what is wrong with America today, and what is wrong with our nonprofit health systems. When pressed on what was wrong with it, he exclaimed that he was not really sure, but that they do not need this many boxes. It reminded me of the movie *Amadeus*; that famous scene where Mozart premiered a new symphony and the Emperor did not like it. When asked what was wrong with it, the Emperor replied: “too many notes.”

---

60. 26 U.S.C. § 501(c)(3) (2006).

61. *Plumstead Theatre Soc’y, Inc. v. Comm’r of Internal Revenue*, 74 T.C. 1324 (1981).

62. Rev. Rul. 98-15, 1998-1 C.B. 718.

63. I.R.S. Priv. Ltr. Rul. 200325003 (June 20, 2003).

64. Robert Pear, *Tax Exemption of Non-Profit Hospitals Scrutinized*, N.Y. TIMES, Dec. 18, 1990, at A1.

Healthcare reorganizations, however well intentioned, confused not just legislators, but members of Congress, the IRS, and the public.

Make no mistake about it, health care is big business. The University of Pittsburgh Medical Center is a \$5 billion enterprise.<sup>65</sup> We are a long way from the days of charitable healthcare providers being operated primarily by volunteers providing all services at or below cost. That is not how health care systems operate today.

The challenge is establishing parameters for the role of the modern charitable healthcare provider as a business enterprise. Where does that line get drawn? Mr. Everson said in his testimony that the IRS is looking more now at boards of directors and their ability to assert control over the charitable enterprise. If you look at the guidance in Revenue Ruling 98-15 on whole hospital joint ventures and some of the private letter rulings, you see that control is the key.<sup>66</sup>

Why does control matter? Here is why it matters. If you look in the Internal Revenue Code, if you look at the Treasury Regulations, you will not find a reference to the fact that hospitals are charitable organizations. It is not in there. There is nothing inherently charitable about providing health care. If that were true, HCA and other investor-owned systems would all be free of federal income taxation today. What makes hospitals charitable is the manner in which they provide their services. It is whether they are providing community benefit, whether revenues are coming back into fulfilling the mission of the system and not placed in the pockets of investors. The financial control is the key to the determination of charitable purpose. If control is ceded to a for-profit partner you have just crossed the line into a commercial enterprise and may no longer warrant recognition as a charitable organization.

In that process, hospitals will run square into another doctrine that has made its way through the courts called the Commerciality Doctrine. It is a court-developed doctrine which is not found in the statutes or the regulations. The case that is most interesting in that regard is the *Living Faith* case, a Seventh Circuit case from 1991, which has the most articulate explanation of the commerciality doctrine.<sup>67</sup> In that case, the court was looking at nonprofit health food stores and restaurants that were being operated to further the charitable purposes of their respective organizations. The court wondered

---

65. University of Pittsburgh Medical Center, Unaudited Quarterly Disclosure Statement for the Period Ended June 30, 2007 (2007), available at <http://www.upmc.com/NR/rdonlyres/9CF2F49E-C255-4275-A28D-381B32DF6EBC/0/upmcfy20074QDisclosure.pdf>.

66. Rev. Rul. 98-15, 1998-1 C.B. 718.

67. *Living Faith, Inc. v. Comm'r of Internal Revenue*, 950 F.2d 365 (7th Cir. 1991).

how the nonprofit was any different from health foods stores and restaurants that are operated on a commercial basis. Where you have a commercial counterpart, and you are doing something in a commercial manner, why are you worthy of tax-exempt status?<sup>68</sup>

Here are some of the factors that were of concern to the Seventh Circuit: the organization sold goods and services to the public. The organization was in direct competition with for-profit restaurants and food stores. The prices set by the organization were based on pricing formulas common in the retail food business. The organization advertised its services. The organization's hours of operations were basically the same as those of for-profit enterprises. The guidelines by which the organization operated required that its management have business ability and six months training.<sup>69</sup> These factors were sufficient for the court to conclude that the organization was too commercial to qualify as a charitable organization.<sup>70</sup>

The message from the Seventh Circuit seems to be that if you are completely clueless as to how to run an organization, you should be in charge of a charity. That is their take on the commerciality doctrine. If you are operating in a commercial fashion, you are not worthy of tax-exempt status.

Just listening to those factors, and I did not even read all of them, it is abundantly clear that no modern charitable hospital in the country would satisfy that test. This court-developed doctrine restricting the commerciality of charitable enterprises in practice would largely defeat the ability of the modern charitable hospital to satisfy a community benefit standard or even to provide the levels of charity care contemplated in the debate. Where that tipping point is to be found remains to be seen.

Finally, I want to wrap up with a thought about what our role is as counsel to the modern charitable hospital. I would *submit* to you that all of us in this room, all of us that serve as counsel to charitable hospitals, *we* are the IRS. Why do I say that? As counsel we must offer guidance where none is available. The guidance system in the IRS is broken. The IRS simply does not have the manpower and the resources to provide the guidance that is necessary in this area.

I will give you a quick example from my practice. I had a charitable hospital client last year that wanted to do a joint venture with a for-profit enterprise to run an ambulatory surgical center, and they wanted the governance of the venture to be structured differently than what had been

---

68. *Id.* at 369-71.

69. *Id.* at 373-74.

70. *Id.* at 376-77.

approved by the IRS in prior guidance. We submitted a private letter ruling request and I spent nine months of the year trying to get someone at the IRS to read it. After nine months, I was ecstatic because it ended up in the hands of someone at the IRS whom I had worked with before and whom I knew to be a fair and impartial person who took an interest in these matters. I was thrilled when he got it. He said, "I'll call you back as soon as I've read it." He called me back about three months later and said, "I have some bad news for you. I cannot do this. I'm retiring. I can't take it here any longer. We've got too much to do and I'm not going to get to this." Then more than a year after I filed the request, the IRS issued a revenue procedure stating that it was not going to issue private letter rulings on exempt organization joint ventures any more. It had said what the IRS had to say on that topic. Our request was returned to us.

In the good old days, we had things called General Counsel Memoranda (GCM) that said all kinds of things about what the IRS thought and what we were supposed to do. We had more revenue rulings; we had a lot more private letter rulings; we had wonderful, thoughtful, scholarly articles in something called a Continuing Professional Education text that told us a lot about things that the IRS could not say in an official proclamation. All of that is gone now. The IRS is not issuing GCMs any more because Treasury thinks the IRS is making tax policy in the GCMs and they do not want the IRS to do that any more. The IRS does not publish CPE texts any more because they do not have the manpower to do it. They are putting their efforts into enforcement now. Likewise with private letter rulings.

So what happens when the IRS is not there to tell us what the rules are or how they should apply? That is where we as counsel step in. We must counsel our clients on the appropriate course of action to comply with the law, however vague and obtuse that law may be. Even if the IRS is mostly acting *in terrorem*, we must counsel adherence to the rules: these are the proper ways to structure this transaction; this is the proper way to measure charity care; this is the best way to be accountable and transparent as a nonprofit organization. In effect, *we* are the IRS. It is incumbent upon us to ensure that our clients follow the rules, for their benefit and the benefit of the communities they serve.

To prepare us for that role, I cannot think of a better place than the Health Law Certificate Program at the University of Pittsburgh School of Law.

Thank you very much.