UNIVERSITY OF PITTSBURGH LAW REVIEW
Vol. 85 ● Fall 2023

WAYWARD SAMARITANS: "NONPROFIT" HOSPITALS AND THEIR TAX-EXEMPT STATUS

Daniel G. Bird and Eric J. Maier

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

WAYWARD SAMARITANS: "NONPROFIT" HOSPITALS AND THEIR TAX-EXEMPT STATUS

Daniel G. Bird and Eric J. Maier*

ABSTRACT

Modern hospitals have strayed from their purely charitable roots. Many hospitals today function as part of large corporate conglomerate healthcare systems, pay vast sums to executives, and consolidate power through vertical and horizontal mergers and acquisitions, just like commercial businesses do. Yet many hospitals continue to claim the "charitable" mantle and retain valuable tax exemptions. As a result, communities across the country are deprived of billions of dollars in tax revenues every year. This Article contends that tax exemptions for hospitals need a course correction. Hospital tax exemptions originally represented a social bargain: in exchange for vital medical services offered at no charge to the poor and destitute, communities relieved hospitals of their tax burdens. That social bargain has been distorted by the modern sea change in hospital operation and organization. We trace the history of hospital tax exemptions and how the social bargain that once justified those exemptions fell into imbalance. Weak laws and weaker enforcement of tax-exempt status have blurred the line between tax-exempt and tax-paying hospitals. Federal and state governments need new standards with meaningful enforcement to restore balance to communities and the tax-exempt hospitals that serve them.

* Mr. Bird is a partner and Mr. Maier is an associate at Kellogg, Hansen, Todd, Figel & Frederick PLLC, in Washington, D.C. The views herein are those of the authors speaking personally; they do not speak on behalf of their firm or any other entity. The authors are grateful for the valuable input from their colleagues Mary-Charlotte Y. Carroll and Katherine V. Tondrowski. They also thank Marilyn Bartlett, Cynthia Fisher, Carissa Fu, and Judith Garber.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Table of Contents

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

INTRODUCTION

The seal of the Pennsylvania Hospital depicts the Good Samaritan delivering a stranger he had found beaten and robbed into the outstretched arms of an innkeeper. Emblazoned below are the Samaritan's words: "Take care of him and I will repay thee."[1] The Samaritan's deed—washing the stranger's wounds, hoisting him onto his donkey, carrying him to the inn, and paying for his care there—is a model of charity. Upon this model Benjamin Franklin and Dr. Thomas Bond founded the Pennsylvania Hospital in 1753, the first institution of its kind in the colonies. Like the innkeeper, the hospital's volunteer staff provided care to the sick and destitute at no cost, their good works paid for by donations and public funds.[2] Early American hospitals uniformly fit the same mold, and in recognition of the charitable works performed within their walls, hospitals were exempted from taxes of all sorts.

Hospitals today no longer dedicate themselves to healing the poor and destitute. Most hospitals, including tax-exempt hospitals,[3] are now part of multibillion-dollar health systems and their once singular, altruistic purpose has been diminished in favor of the more lucrative provision of care to paying patients. The amount of free or discounted care that tax-exempt hospitals provide to their communities has plummeted when compared to their early American predecessors. Indeed, today tax-*paying* hospitals commit more of their resources to charitable care than their tax-exempt counterparts.[4] Tax-exempt hospital systems boast some of the highest profits

[1] Photograph of Pennsylvania Hospital Seal, *in History of Pennsylvania Hospital*, PENN MED., https://www.uphs.upenn.edu/paharc/collections/gallery/miscellaneous/Seal.html (last visited Nov. 15, 2023).

[2] Tamara R. Coley, *Extreme Pricing of Hospital Care for the Uninsured: New Jersey's Response and the Likely Results*, 34 SETON HALL LEGIS. J. 275, 279 n.23 (2010) (quoting WILLIAM H. WILLIAMS, AMERICA'S FIRST HOSPITAL: THE PENNSYLVANIA HOSPITAL, 1751–1841, at 2 (1976)); *see also The Story of the Creation of the Nation's First Hospital*, PENN MED., https://www.uphs.upenn.edu/paharc/features/creation.html (last visited Nov. 15, 2023) [hereinafter *Story of the Creation*].

[3] Although the phrases "tax-exempt" and "nonprofit" or "not-for-profit" are often treated interchangeably, for reasons that will become clear throughout this Article, the first is most accurate and the latter two misleading. Tax-exempt hospital systems are some of the most profitable healthcare organizations. *See* Ge Bai & Gerard F. Anderson, *A More Detailed Understanding of Factors Associated with Hospital Profitability*, 35 HEALTH AFFS. 889, 893 (2016). For example, seven of the top ten most profitable hospitals in 2013 claimed tax-exempt status. *See id.* For that reason, and because this Article focuses on whether and when hospitals should be relieved of their tax burden, we use the phrase "tax-exempt" throughout.

[4] Anna Wilde Mathews, Tom McGinty & Melanie Evans, *Big Hospitals Provide Skimpy Charity Care—Despite Billions in Tax Breaks*, WALL ST. J. (July 25, 2022, 10:26 AM), https://www.wsj.com/articles/nonprofit-hospitals-vs-for-profit-charity-care-spending-11657936777.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

in the country, with executives paid handsomely for achieving those profits.[5] One major driver of these growing profits is hospital consolidation.[6] For decades, hospital systems have engaged in both vertical and horizontal mergers, making healthcare markets among the most concentrated in the country.[7] Hospital systems leverage the market power that accompanies this concentration to stifle competition and charge supracompetitive prices.[8]

This sea change in hospital organization and operation has distorted Benjamin Franklin and Dr. Bond's chosen motto, shifting the focus of these once-charitable institutions from providing care to pursuing repayment (and then some). Far from relieving poverty, today's hospitals often contribute to it.[9] Americans in great numbers forgo medical care because of the cost.[10] Even before the pandemic, medical debt was the largest source of debt in collections in the nation;[11] today, one in eight Americans has a medical bill in collections.[12] Stories of hospitals pursuing unsavory debt collection practices increasingly fill the headlines, with some hospitals even the target of government investigations and lawsuits.[13] Even when tax-exempt

[5] *See* N.C. STATE HEALTH PLAN FOR TCHRS. & STATE EMPS. ET AL., HOSPITAL EXECUTIVE COMPENSATION: A DECADE OF GROWING WAGE INEQUITY ACROSS NONPROFIT HOSPITALS 2 (2023), https://www.shpnc.org/nonprofit-hospital-executive-pay-report/open (finding that between 2010 and 2021 executives at North Carolina's nine largest hospital systems earned "more than $1.75 billion").

[6] *See* Lovisa Gustafsson & David Blumenthal, *The Pandemic Will Fuel Consolidation in U.S. Health Care*, HARV. BUS. REV. (Mar. 9, 2021), https://hbr.org/2021/03/the-pandemic-will-fuel-consolidation-in-u-s-health-care.

[7] *See id.*

[8] *See id.*

[9] *See* Lunna Lopes, Audrey Kearney, Alex Montero, Liz Hamel & Mollyann Brodie, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, KFF (June 16, 2022), https://www.kff.org/health-costs/report/kff-health-care-debt-survey (explaining that Americans' healthcare debt has seriously negative impacts on their financial health and causes many to skip bill payments and delay college and home buying).

[10] *See, e.g.*, Megan Leonhardt, *Nearly 1 in 4 Americans Are Skipping Medical Care Because of the Cost*, CNBC (Mar. 12, 2020, 10:12 AM), https://www.cnbc.com/2020/03/11/nearly-1-in-4-americans-are-skipping-medical-care-because-of-the-cost.html.

[11] Raymond Kluender, Neale Mahoney, Francis Wong & Wesley Yin, *Medical Debt in the US, 2009–2020*, 326 JAMA 250, 252 (2021).

[12] Jennifer Andre, Miranda Santillo, Kassandra Martinchek, Breno Braga & Signe-Mary McKernan, *Debt in America: National-Level Medical Debt*, URBAN INST. (Oct. 11, 2023), https://datacatalog.urban.org/dataset/debt-america-2023/resource/a1ce4ef2-ccbf-4fbe-af1d-518f95ba7d83.

[13] *See, e.g.*, Jessica Silver-Greenberg & Katie Thomas, *They Were Entitled to Free Care. Hospitals Hounded Them to Pay.*, N.Y. TIMES (Dec. 15, 2022), https://www.nytimes.com/2022/09/24/business/

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

hospitals maintain financial assistance policies, many regularly fail to alert eligible patients that they qualify, meaning those patients often pay for care they can scarcely afford.[14]

This Article examines what the sea change in hospital organization and operation means for hospital tax exemptions. The question matters because hospitals are exempt from myriad federal, state, and local taxes, including corporate income taxes, sales taxes, and property taxes, and they are permitted to issue tax-exempt bonds.[15] According to one study, those combined tax exemptions totaled $24.6 billion in forgone tax revenue in 2011 alone.[16] That is billions of dollars unavailable for schools, infrastructure, public parks, fire and police departments, public assistance programs like Medicaid and the Supplemental Nutrition Assistance Program, and other public services critical to the well-being and social fabric of communities. As hospital revenues and property values have increased in the past decade, so too has that forgone tax bill.

To be clear, we do not call for the end of hospital tax exemptions. Instead, this Article asks: in light of the modern organization and operation of hospitals—including the proliferation of for-profit hospitals that provide similar levels of free and discounted care—what should communities expect in exchange when they grant hospitals such substantial tax exemptions, and how should those communities ensure that those exemptions are justified?

Pennsylvania offers one potential answer. Pennsylvania's Constitution reserves tax exemptions for "institutions of purely public charity."[17] The Supreme Court of Pennsylvania has, over time, developed a stringent set of standards—crystalized in *Hospital Utilization Project v. Commonwealth*—to ensure that only such institutions

---

nonprofit-hospitals-poor-patients.html; Press Release, Wash. State Off. of the Att'y Gen., AG Ferguson Files Lawsuit Against Swedish, Other Providence-Affiliated Hospitals, for Failing to Make Charity Care Accessible to Thousands of Washingtonians (Feb. 24, 2022) (alleging some tax-exempt hospitals "sen[t] more than 54,000 patient accounts to debt collection").

[14] *See* Sayeh S. Nikpay & John Z. Ayanian, *Hospital Charity Care—Effects of New Community-Benefit Requirements*, 373 NEW ENG. J. MED. 1687, 1689–90 (2015); Silver-Greenberg & Thomas, *supra* note 13.

[15] Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes & Colin O'Laughlin, *The Value of the Nonprofit Hospital Tax Exemption Was $24.6 Billion in 2011*, 34 HEALTH AFFS. 1225, 1225 (2015).

[16] *Id.*

[17] PA. CONST. art. VIII, § 2(a)(v).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

are relieved of their obligation to contribute to community coffers.[18] Riding the coattails of their charitable forebears, a number of Pennsylvania hospitals continue to claim the mantle of "purely public charity" and thus avoid state and local taxes, depriving Pennsylvania and its municipalities of billions of dollars annually.[19] But as Pennsylvania's hospitals have drifted from their charitable origins, the justifications they assert for their enormous tax breaks have grown more and more attenuated. In many cases, those justifications—for instance, that hospitals are underpaid by government programs like Medicare and Medicaid[20]—rest on wrong or dubious math and apply equally to for-profit, tax-paying hospitals.

Pennsylvania law wisely commands that the test for institutions of purely public charity be sensitive to "the continually changing nature of the concept of charity and the many variable circumstances of time, place, and purpose."[21] In that vein, this Article examines whether and, if so, when hospitals may be exempted from taxes under the standard established by Pennsylvania's Constitution, which may serve as a model for other states. Part I traces the development of hospitals from almshouses for the poor and vulnerable into massive profit-generating healthcare systems. Part II discusses the origins and development of hospital tax exemptions throughout the country, particularly focusing on the federal approach. Part III examines Pennsylvania's approach to hospital tax exemptions, analyzing the commonwealth's constitutional test for tax exemptions and how modern hospital operation and organization fares under that test. Part III also discusses Pennsylvania's unique common-law approach to developing tax-exemption law. Pennsylvania law lets taxing districts challenge tax exemptions directly in the commonwealth's courts. Several recent decisions denying tax exemptions to Pennsylvania hospitals show the benefits of this uncommon procedure. Unlike jurisdictions that rely solely on cash-strapped and understaffed administrative bodies to police the boundaries of tax exemptions, Pennsylvania places part of that responsibility in the hands of those with a direct interest in ensuring tax exemptions are justified. And by testing tax exemptions in adversary proceedings, Pennsylvania

[18] Hosp. Utilization Project v. Commonwealth, 487 A.2d 1306, 1317 (Pa. 1985).

[19] *See Fair Share Spending*, LOWN INST. HOSPS. INDEX (Apr. 11, 2023), https://web.archive.org/web/20220427201000/https://lownhospitalsindex.org/2022-fair-share-spending (determining that tax exemptions for Pennsylvania hospitals in 2019 exceeded those hospitals' direct benefits to their communities by over $2 billion).

[20] Letter from America's Essential Hospitals et al. to Sen. Charles Schumer, Sen. Mitchell McConnell, Rep. Kevin McCarthy & Rep. Hakeem Jeffries (Mar. 6, 2023), https://www.aha.org/system/files/media/file/2023/03/hospital-organizations-urge-congress-to-prevent-medicaid-dsh-cuts-letter-3-6-23.pdf.

[21] G.D.L. Plaza Corp. v. Council Rock Sch. Dist., 526 A.2d 1173, 1175 (Pa. 1987).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

law ensures that tax exemptions are justified by actual evidence of an organization's contribution to its community.

Hospital tax exemptions need a course correction. Part IV makes several recommendations. At the federal level, the lack of a clear, enforceable standard for hospital tax exemptions is a well-recognized and longstanding problem. Any solution must begin with clarifying both the standard hospitals must meet and the evidence they can use to do so. But a clearer standard will only solve the problem if it is paired with robust enforcement. Currently, the IRS has neither the resources nor adequate mechanisms to ensure hospitals earn their tax exemptions. Congress and the President should direct the IRS to increase the resources available to the agency's Tax Exempt and Government Entities Division. Federal lawmakers should also create new procedural tools, including *qui tam*-like causes of action, through which tax exemptions can be tested. States must also do their part. Too many states grant tax exemptions to any hospital that qualifies under the federal standard. In light of the inadequate federal standard and the IRS's present underenforcement, such delegation to the federal government is more akin to abdication, robbing states of needed tax revenue. States should create and enforce their own standards, and, like Pennsylvania, put at least part of the enforcement responsibility in the hands of school districts and municipalities with direct and substantial interests in ensuring that tax exemptions are justified.

I. FROM POORHOUSE TO PRIVATE EQUITY: THE TRANSFORMATION OF AMERICAN HOSPITALS

A. From Charitable Origins to Centers of Medicine

Hospitals were once charitable institutions. The earliest English hospitals, for example, were "financed by the clergy and donations from royalty, nobility, and wealthy landowners, [and] were . . . almshouses for society's unwanted."[22] Early American hospitals fit the same mold.[23] What many consider the first American hospital—the Pennsylvania Hospital—was founded by Dr. Thomas Bond and Benjamin Franklin in 1753 to address the "increasing numbers of the poor who were

[22] Mark C. Westenberger, *Tax-Exempt Hospitals and the Community Benefit Standard: A Flawed Standard and a Way Forward*, 17 FLA. TAX REV. 407, 418 (2015); *see also* CHARLES R. MCCONNELL, HOSPITALS AND HEALTH SYSTEMS: WHAT THEY ARE AND HOW THEY WORK 4 (2020).

[23] *See* Eric J. Santos, *Property Tax Exemptions for Hospitals: A Blunt Instrument Where a Scalpel Is Needed*, 8 COLUM. J. TAX. L. 113, 116 (2017); *see also* Kellen McClendon, *Do Hospitals in Pennsylvania Relieve the Government of Some of Its Burden?*, 67 TEMP. L. REV. 517, 540–47 (1994).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

suffering from physical maladies."[24] It was "100[%] charitable," funded by "donations from Pennsylvania's elite along with matching funds from the Pennsylvania Assembly," and staffed by volunteers.[25]

The role of hospitals in American society changed drastically in the first few decades of the twentieth century. Early hospitals were seen as dirty and dangerous; they were a last resort for those in need of medical care.[26] Wealthier Americans received their care in the comparatively clean environments of their homes.[27] But technological advances revolutionized the practice of medicine and made hospitals the locus of care.[28] Not only did it become possible to sterilize hospital exam rooms, but hospitals provided the space necessary for complex machinery needed to perform the most advanced medical procedures. As hospitals became home to the cutting edge of medicine, wealthier Americans turned to hospitals for their health care.[29]

Today, hospitals and the doctors who staff them perform a vital societal function and are a critical part of a healthy community. They provide emergency care to community members, play host to important research, and perform complex procedures that would be unavailable in non-hospital settings. Hospitals provide services to large swaths of the communities in which they operate. In 2018, for instance, over eighteen million Americans had one overnight stay in a hospital and another seven million had two or more.[30] That same year saw nearly 130 million emergency room visits.[31] As described more fully below, this broader patient base has revolutionized hospital financing, allowing hospitals to fund themselves almost

[24] Coley, *supra* note 2; *Story of the Creation*, *supra* note 2.

[25] Coley, *supra* note 2, at 279–80.

[26] *See id.*; Santos, *supra* note 23, at 116; ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY 18 (1989).

[27] Coley, *supra* note 2, at 279–80.

[28] *See* Santos, *supra* note 23, at 117; Bruce McPherson, *Hospital Tax Exemption: How Did We Get Here?*, 49 INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN. 191, 191 (2012).

[29] *See* Coley, *supra* note 2, at 280.

[30] CDC, SUMMARY HEALTH STATISTICS: NATIONAL HEALTH INTERVIEW SURVEY 4 (2018), http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_P-10.pdf.

[31] CDC, NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY: 2018 EMERGENCY DEPARTMENT SUMMARY TABLES 3 (2018), https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.pdf.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

entirely through fee-paying patients.[32] And, beginning in the 1970s, the prospect of revenues from those patients attracted investors and gave rise to for-profit, tax-paying hospitals.[33]

Vital hospital services are now provided by tax-exempt and tax-paying hospitals alike. Little now differentiates them from each other. Both types of hospitals provide nearly identical amounts of charitable care; some studies even suggest that tax-paying hospitals commit more of their resources to charitable care than tax-exempt hospitals do.[34] Although hospitals once exclusively dispensed free care, charity care now represents less than 3% of tax-exempt hospitals' expenses.[35] More generally, the evidence suggests that both tax-paying and tax-exempt hospitals serve similar numbers of low-income individuals.[36] Tax-exempt and tax-paying hospitals charge similar prices.[37] And tax-exempt hospitals structure their business operations just like their tax-paying counterparts. As explained further below, tax-exempt hospitals often enter into joint ventures with for-profit firms, and some hospitals even have their own private equity firms as for-profit subsidiaries.[38]

---

[32] *See* Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 319 (1991).

[33] *See* McPherson, *supra* note 28, at 191; *see also* Bradford H. Gray, *An Introduction to the New Health Care for Profit*, *in* THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT 1, 2 (Bradford H. Gray ed., 1983) ("The number of hospitals owned or managed by for-profit hospital chains . . . almost doubled between 1976 and 1982.").

[34] Mathews et al., *supra* note 4; Joseph D. Bruch & David Bellamy, *Charity Care: Do Nonprofit Hospitals Give More than For-Profit Hospitals?*, 36 J. GEN. INTERNAL MED. 3279, 3280 (2020) ("[T]here was no significant difference between for-profit and nonprofit hospitals in charity care as percent of total expenses."); Ge Bai, Farah Yehia & Gerard F. Anderson, *Charity Care Provision by US Nonprofit Hospitals*, 180 JAMA INTERNAL MED. 606, 607 (2020) ("[N]onprofit hospitals with superior financial performance provided disproportionately low levels of charity care.").

[35] Bruch & Bellamy, *supra* note 34, at 3279.

[36] *See* Ge Bai, Hossein Zare & David A. Hyman, *Evaluation of Unreimbursed Medicaid Costs Among Nonprofit and For-Profit US Hospitals*, 5 JAMA NETWORK OPEN 1, 3 (2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789009.

[37] *See* Zack Cooper, Stuart V. Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51, 89 (2019) ("Nonprofit . . . hospitals have slightly lower prices than for-profit hospitals.").

[38] *See, e.g.*, Rachel Cohrs, *How America's Largest Catholic Hospital System Is Moonlighting as a Private Equity Firm*, STAT+ (Nov. 16, 2021), https://www.statnews.com/2021/11/16/ascension-investigation-moonlighting-private-equity-firm.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

B. Changes in Hospital Financing

Modeled on the Good Samaritan's example, care at the Pennsylvania Hospital was initially funded primarily by donations from the wealthy. Indeed, patients at the hospital once required security provided by a benefactor to "indemnify the hospital either from the expense of burial in case they die or to defray the expense of caring them back to their place of abode."[39] But as hospitals shifted away from caring exclusively for the destitute, the kinds and amount of hospital financing transformed. As explained below, as hospital care became more and more central to the U.S. healthcare system, hospitals began to rely for revenue more on fee-paying patients than on donations from the public.[40] That shift has seen hospitals transform from traditional charities into large businesses that look indistinguishable from other large commercial enterprises.

Spending on hospital care is now the single largest source of healthcare spending in the United States. In 2021, 31% of all healthcare spending was for hospital care—over $1.3 trillion.[41] Only an infinitesimal sliver of hospital budgets is supported by donations. Today, hospitals are funded by revenue from fee-paying patients, employers, insurance companies, government programs, and, increasingly, investment income.[42] Tax-exempt hospitals often play host to profit-generating physician practices owned by private equity.[43]

This transformation has made it increasingly difficult to distinguish between the operations of for-profit, tax-paying hospitals and the operations of tax-exempt hospitals. According to a 2013 study, seven of the country's ten most profitable hospitals were tax-exempt institutions.[44] Many of those substantial profits are paid

---

[39] *Pennsylvania Hospital*, BENJAMIN FRANKLIN HIST. SOC'Y, http://www.benjamin-franklin-history.org/pennsylvania-hospital (last visited Nov. 17, 2023).

[40] *See infra* Section I.B.1.

[41] *Trends in Health Care Spending*, AM. MED. ASS'N, https://www.ama-assn.org/about/research/trends-health-care-spending (last visited Nov. 17, 2023).

[42] *Id.*

[43] *See* Marcelo Cerullo, Kelly Kaili Yang, James Roberts, Ryan C. McDevitt & Anaeze C. Offodile II, *Private Equity Acquisition and Responsiveness to Service-Line Profitability at Short-Term Acute Care Hospitals*, 40 HEALTH AFFS. 1697, 1697–98 (2021); Karen Minich-Pourshadi, *Private Equity Interest in Nonprofit Hospitals Growing*, HEALTHLEADERS (Aug. 19, 2011), https://www.healthleadersmedia.com/finance/private-equity-interest-nonprofit-hospitals-growing.

[44] Bai & Anderson, *supra* note 3.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

out to hospital system executives.[45] A study of large tax-exempt hospital systems in North Carolina, for instance, found that in 2020 their CEOs took home $3.4 million on average, with four CEOs each taking home more than eight million dollars in four different years between 2012 and 2021.[46] This Part will explore how hospital financing evolved over the last century to make these exorbitant paychecks possible, focusing on three major changes: (1) the shift away from charity care toward paying patients; (2) the advent of government healthcare programs; and (3) the introduction of investment income and the involvement of private equity.

1. From Charity Care to Fee-Paying Patients

As noted above, early hospitals focused almost exclusively on caring for the poor. But as hospitals became more central to health care in the late nineteenth and early twentieth centuries, self-paying patients became the norm.[47] The rise in complicated surgical treatments meant the wealthy needed to receive treatment outside their homes.[48] Hospitals quickly transformed from institutions "whose use stigmatized patients" to "emblem[s]" of their communities.[49] Donations still played a major role in hospital financing, but instead of paying for patient care, those donations were more often put towards construction projects, like the addition of new buildings to hospital campuses.[50] Patients increasingly funded their own care—by 1903, in many states, patients paying out of their own pockets provided more than 70% of hospitals' operating income.[51]

The rise of self-paying patients soon gave way to the rise of health insurance. The earliest forms of insurance were tied to employment.[52] Worker's compensation, for instance, was one of the earliest forms of insurance[53]—it shifted the responsibility

[45] *See* N.C. STATE HEALTH PLAN FOR TCHRS. & STATE EMPS. ET AL., *supra* note 5, at 2.

[46] *Id.* at 6–7.

[47] *See* Coley, *supra* note 2, at 280.

[48] STEVENS, *supra* note 26, at 30.

[49] Coley, *supra* note 2, at 280 (quoting MORRIS J. VOGEL, THE INVENTION OF THE MODERN HOSPITAL 1 (1980)).

[50] *See id.* at 281.

[51] *Id.* at 280.

[52] *Id.* at 283.

[53] William E. Forbath, *The Long Life of Liberal America: Law and State-Building in the U.S. and England*, 24 L. & HIST. REV. 179, 184 (2006).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

for payment for care from the employee to the employer, at least for those injuries that happened in the workplace. Although accident insurance was available for purchase in the early twentieth century, most workers could not afford it.[54] Instead, workers lobbied for worker's compensation programs through which they agreed to forgo the ability to sue their employers in tort for workplace accidents in exchange for guaranteed (albeit lesser) worker's compensation payments.[55] By 1919, thirty-seven states had worker's compensation programs.[56]

More traditional forms of insurance arose in the 1930s and became the norm after World War II.[57] As the Great Depression ripped through American communities, hospitals created "various 'prepayment' schemes" to help "lessen the impact of health emergencies."[58] These programs eventually became Blue Cross plans. Nonprofit, tax-exempt Blue Cross plans were highly successful, and they soon became the largest private insurance system in the country.[59] By 1938, "1.4 million people were enrolled in 38 statewide Blue Cross plans."[60] The success of "the Blues," as they were known, attracted commercial copycats.[61] When President Roosevelt signed the Stabilization Act of 1942 to freeze wages, employers sought to attract employees with contributions to insurance benefits that did not count as wages under the law.[62] Private insurance was soon cemented as central to healthcare spending in the United States.

---

[54] Price V. Fishback & Shawn Everett Kantor, *The Adoption of Workers' Compensation in the United States, 1900–1930*, 41 J.L. & ECON. 305, 310 (1998).

[55] *Id.* at 309–10.

[56] Coley, *supra* note 2, at 283.

[57] Steven Plitt, Daniel Maldonado, Joshua D. Rogers & Jordan R. Plitt, *§ 144:7. Blue Cross & Blue Shield Plans*, *in* COUCH ON INSURANCE (3d ed. Nov. 2022 update).

[58] *Id.*

[59] Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 9 (1986).

[60] *Id.* Blue Shield plans were developed not long after. While Blue Cross plans were insurance for hospital services, Blue Shield plans were developed by physicians to cover physician services. *Id.* at 10.

[61] Plitt et al., *supra* note 57.

[62] Christopher Limbacher, Comment, *Healthcare Price Transparency: Reintroducing Competition*, 53 HOUS. L. REV. 939, 943–44 (2016).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

2. The Introduction of Medicare, Medicaid, and Other Government Programs

By 1960, private insurance was the primary payer for hospital care.[63] Of the $9 billion spent on hospital care that year, $3.1 billion came from private insurance, while patients paid $1.8 billion out of pocket.[64] Public insurance accounted for only $1.4 billion of hospital spending that year.[65] But midway through the 1960s, the introduction of Medicare and Medicaid changed the face of hospital funding and swiftly began to displace what out-of-pocket payment systems remained.[66] Hopes were high for the programs: the hospital industry even asserted that the advent of Medicare and Medicaid would render terms like "'need' and 'charity' . . . anachronisms" in the healthcare context.[67]

Medicare and Medicaid's importance to spending on hospital care ballooned after their enactment. In 1966, the two programs accounted for only 13% of hospital spending.[68] By 1970, that share had more than doubled—the programs accounted for 30% of hospital spending.[69] In 2020, of the $1.3 trillion spent on hospital care, approximately $540 billion came from Medicare and Medicaid.[70] The programs make a variety of payments to hospitals to cover the costs of caring for the elderly and the poor.

Medicare makes two types of payments to hospitals: payments directly reimbursing for care (fee-for-service payments) and supplemental payments to cover

---

[63] *Infographic—U.S. Health Care Spending: Who Pays?*, CAL. HEALTH CARE FOUND. (June 29, 2022), https://web.archive.org/web/20220714224737/https://www.chcf.org/publication/us-health-care-spending-who-pays/ [hereinafter *Health Care Spending*].

[64] *Id.* For a helpful time lapse depiction of spending on hospital care from 1960 to 2020, *see id.*

[65] *Id.*

[66] Aaron C. Catlin & Cathy A. Cowan, *History of Health Spending in the United States, 1960–2013*, CTRS. FOR MEDICARE & MEDICAID SERVS. 11 (Nov. 19, 2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf.

[67] *Tax Reform, 1969: Hearings Before the H. Comm. on Ways & Means*, 91st Cong. 1427 (1969) (statement of Julius M. Greisman, Att'y, American Hospital Association); *see also* Maxwell Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 306 (1995).

[68] *Health Care Spending*, *supra* note 63.

[69] *Id.*

[70] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

other costs.[71] Medicare's fee-for-service rates start with a base rate specific to a patient's diagnosis and the geographical region and then are adjusted to account for region- and hospital-specific factors, like local labor costs or service to "an unusually high percentage of low-income patients."[72] This fixed-payment system is designed to "give[] hospitals an incentive to provide efficient levels of medical service." That is because, "[i]f the hospital spends anything more" than the fee-for-service rate, "it suffers a financial loss."[73]

On top of these fixed fee-for-service payments, Medicare offers numerous supplemental payments. For example, hospitals that serve a disproportionate number of low-income patients (known as Disproportionate Share Hospitals) receive "uncompensated care payments" to help offset associated costs.[74] These uncompensated care payments are meant to help hospitals pay for traditional charity care (i.e., care delivered to low-income patients for which the hospital does not expect reimbursement) and for non-Medicare bad debts (i.e., debts incurred when non-Medicare patients are billed but do not pay).[75] In 2020, Medicare made $8.3 billion in such payments to 2,700 hospitals.[76] When Medicare patients fail to pay their coinsurance or deductibles, Medicare helps offset those debts, too.[77] Medicare also makes other supplemental payments to offset the costs of certain residency programs, to account for unusually expensive Medicare patients, to support hospitals that serve smaller numbers of patients, and more.[78]

---

[71] *See Medicare Payment Systems*, CTRS. FOR MEDICARE & MEDICAID SERVS.: THE MEDICARE LEARNING NETWORK (Jan. 2023), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html.

[72] Becerra v. Empire Health Found., 142 S. Ct. 2354, 2359 (2022) (quoting Sebelius v. Auburn Reg'l Med. Ctr., 568 U.S. 145, 150 (2013)).

[73] *Id.*

[74] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 73 (2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_v3_SEC.pdf [hereinafter MEDPAC 2022].

[75] *Id.*

[76] *Id.*

[77] *Medicare Payment Systems*, *supra* note 71 (choose "Setting Payment Rates" dropdown under "Acute Care Hospital Inpatient Prospective Payment System").

[78] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Medicaid similarly makes fee-for-service and supplemental payments.[79] Medicaid's fee-for-service rates are set by state Medicaid agencies and vary by state.[80] Medicaid makes five major types of supplemental payments: to support Disproportionate Share Hospitals, to supplement Medicaid's low fee-for-service rates, to offset uncompensated care (e.g., care for the under- or uninsured), to encourage efforts to improve care infrastructure, and to support teaching hospitals.[81] Medicaid supplemental payments are substantial; they account for around half of Medicaid payments to hospitals nationwide and even more in certain states.[82] In Pennsylvania, for instance, they represented almost 80% of Medicaid hospital payments in 2021.[83]

Hospitals often claim that Medicare and Medicaid payments are insufficient to cover the costs of caring for Medicare and Medicaid recipients.[84] However, according to independent congressional agencies and many academic studies, Medicare and Medicaid payments are likely sufficient to cover those costs. The Medicare Payment Advisory Commission (MedPAC) has consistently found that Medicare payments are sufficient to cover a "relatively efficient" hospital's average costs of treating Medicare patients.[85] Indeed, MedPAC has determined that Medicare reimbursements *exceed* the marginal cost of treating Medicare recipients—in 2020, hospitals earned a marginal profit of around 5% on Medicare patients.[86] As for

[79] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID BASE AND SUPPLEMENTAL PAYMENTS TO HOSPITALS 1 (2022), https://www.macpac.gov/wp-content/uploads/2022/05/Base-and-supplemental-payments-to-hospitals.pdf [hereinafter MEDICAID BASE].

[80] *State Medicaid Payment Policies for Inpatient Hospital Services*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N (Dec. 2018), https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes.

[81] MEDICAID BASE, *supra* note 79, at 4–7.

[82] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 38 (2022), https://www.macpac.gov/wp-content/uploads/2022/12/MACSTATS_Dec2022_WEB-508.pdf.

[83] *Id.* at 71. These percentages exclude Medicaid Managed Care programs—private insurance companies that accept fixed, per-member monthly fees from Medicaid and provide Medicaid-like coverage to their members. *Managed Care*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/managed-care/index.html (last visited Nov. 17, 2023).

[84] *See, e.g.*, *Fact Sheet: Underpayment by Medicare and Medicaid*, AM. HOSP. ASS'N 2 (Feb. 2022), https://www.aha.org/system/files/media/file/2022/02/medicare-medicaid-underpayment-fact-sheet-current.pdf.

[85] MEDPAC 2022, *supra* note 74, at 70.

[86] *Id.* at 81.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Medicaid, when both fee-for-service and supplemental payments are considered, studies have determined that Medicaid compensates hospitals at least as well as, if not better than, Medicare.[87] It is thus likely that Medicaid payments, too, are sufficient to cover the marginal costs of caring for Medicaid patients.[88]

The federal government's support for hospitals does not end with Medicare and Medicaid. Beyond those programs, the federal government has developed other ways to compensate hospitals. For example, the 340B Drug Pricing Program was designed to help certain hospitals supplement the federal resources they receive by requiring drug manufacturers to sell medicines to participating hospitals at steeply discounted prices.[89] The hospitals can then charge patients (or their insurer) full price for the medicine, allowing the hospital to pocket significant revenue. One recent study found that, under the program, hospitals charged payers nearly five times what it cost the hospitals to acquire certain cancer medications.[90] Hospitals eligible to participate include Disproportionate Share Hospitals, children's hospitals, sole community hospitals, and others.[91]

The 340B Program—initially designed to prop up the revenues of the neediest hospitals—has become a profit center for some of the country's wealthiest hospital systems. In 2019, the program generated more than $40 billion in profit for its participants.[92] Those profits, however, are not always used to support Disproportionate Share Hospitals. For instance, the tax-exempt Bon Secours Mercy Health System enjoyed profit margins as high as 44% at Richmond Community

[87] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID HOSPITAL PAYMENT: A COMPARISON ACROSS STATES AND TO MEDICARE 8 (2017), https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.

[88] *See* Bradley Herring, Darrell Gaskin, Hossein Zare & Gerard Anderson, *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, 55 INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN. 1, 7 (2018).

[89] *See Drug Pricing Program: HHS Uses Multiple Mechanisms to Help Ensure Compliance with 340B Requirements*, U.S. GOV'T ACCOUNTABILITY OFF. (Dec. 14, 2020), https://www.gao.gov/products/gao-21-107.

[90] CMTY. ONCOLOGY ALL. (COA), EXAMINING 340B HOSPITAL PRICE TRANSPARENCY, DRUG PROFITS, AND INCENTIVES 2 (2022), https://communityoncology.org/wp-content/uploads/2022/09/COA_340B_hospital_transparency_report_2_final.pdf.

[91] *340B Eligibility*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/opa/eligibility-and-registration (June 2022).

[92] NEAL MASIA, 340B DRUG PRICING PROGRAM: ANALYSIS REVEALS $40 BILLION IN PROFITS IN 2019, at 1 (2021), https://340breform.org/wp-content/uploads/2021/05/AIR340B-Neal-Masia-Report.pdf.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Hospital in Virginia, largely thanks to revenue from the 340B Program.[93] Instead of using those profits to provide needed services in the underserved Richmond community, Bon Secours cut the hospital's I.C.U.[94] A broader study of 340B Program found no difference between the amount of charity care provided by participating and non-participating hospitals; both committed around 2.7% of their revenues to charity care.[95]

More recently, the federal government has paid enormous sums to hospitals to cover the loss of revenues associated with the COVID-19 pandemic.[96] These payments helped to keep many smaller hospitals afloat.[97] But some of the largest payments went to tax-exempt hospitals that, by the end of the pandemic's first year, were incredibly profitable. The University of Pittsburgh Medical Center, for instance, accepted $460 million in COVID-19 relief but closed out 2020 with an $836 million operating surplus.[98]

Over the last half century, the involvement of federal and state governments in paying for hospital care has grown exponentially. Today, nearly every hospital in the United States, whether tax-paying or tax-exempt, depends in large part on payments from government programs. According to the American Hospital Association, at the vast majority of hospitals, half of all inpatient stays are paid for by Medicare or Medicaid.[99] There is little dispute that Medicare and Medicaid (along with other federal programs) now play a central role in hospital financing.

---

[93] Katie Thomas & Jessica Silver-Greenberg, *How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits*, N.Y. TIMES (Sept. 27, 2022), https://www.nytimes.com/2022/09/24/health/bon-secours-mercy-health-profit-poor-neighborhood.html.

[94] *Id.*

[95] Anna Wilde Mathews, Paul Overberg, Joseph Walker & Tom McGinty, *Many Hospitals Get Big Drug Discounts. That Doesn't Mean Markdowns for Patients.*, WALL ST. J. (Dec. 20, 2022, 11:33 AM), https://www.wsj.com/articles/340b-drug-discounts-hospitals-low-income-federal-program-11671553899.

[96] Nancy Ochieng, Jeannie Fuglesten Biniek, MaryBeth Musumeci & Tricia Neuman, *Funding for Health Care Providers During the Pandemic: An Update*, KFF (Jan. 27, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update.

[97] *Id.*

[98] Jordan Rau & Christine Spolar, *Some of America's Wealthiest Hospital Systems Ended Up Even Richer, Thanks to Federal Bailouts*, WASH. POST (Apr. 1, 2021), https://www.washingtonpost.com/us-policy/2021/04/01/hospital-systems-cares-act-bailout.

[99] *Fact Sheet: Majority of Hospital Payments Dependent on Medicare or Medicaid; Congress Continues to Cut Hospital Reimbursements for Medicare*, AM. HOSP. ASS'N 1 (May 2022), https://www.aha.org/

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

3. For-Profit Joint Ventures, Investment Income, Private Equity, and Other Sources of Profit

Patient care is no longer the only way that hospitals earn revenue: modern tax-exempt hospitals have myriad ways to earn profits and engage in many of the same tactics as ordinary commercial enterprises. For instance, some tax-exempt hospital systems partner with for-profit entities. Many hospitals now look to investment income to pad their bottom lines. A recent investigation uncovered that one of the nation's largest tax-exempt systems has gone beyond passive investment and operates its own private equity arm. Tax-exempt hospitals also engage in a practice known as "tax arbitrage," in which a hospital issues tax-exempt bonds to pay for its operations even though it has plenty of cash on hand to do so without bond financing. This Section touches only briefly on each of these financing models, leaving for other articles an exploration of their full import. For present purposes, though, it is clear that these tactics make it harder still to differentiate tax-exempt hospitals from tax-paying enterprises.

Under federal tax regulations, tax-exempt hospitals are free to form joint ventures with for-profit entities without risking their exempt status.[100] A 1998 IRS Revenue Ruling explains the circumstances under which a tax-exempt hospital may retain its tax exemption despite receiving financing from a for-profit entity.[101] Specifically, the Ruling considers the following scenario: A tax-exempt hospital and a for-profit entity form an LLC.[102] The hospital contributes all of its assets, including the hospital building, to the LLC and the for-profit entity contributes financing.[103] Both the hospital and the for-profit entity receive interests in the LLC in proportion to their contributions.[104] So long as the LLC is adequately controlled by the tax-exempt hospital and the LLC's governing documents ensure that the hospital's charitable mission takes precedence over any profit imperative, the hospital may retain its tax exemption.[105] These arrangements can be risky for hospitals and, if not

system/files/media/file/2022/05/fact-sheet-majority-hospital-payments-dependent-on-medicare-or-medicaid-congress-continues-to-cut-hospital-reimbursements-for-medicare.pdf.

[100] *See* Rev. Rul. 98-15, 1998-1 C.B. 718.

[101] *Id.*

[102] *Id.*

[103] *Id.*

[104] *Id.*

[105] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

structured properly, can result in the hospital losing its exemption.[106] Nevertheless, these joint ventures permit for-profit entities to draw profit from the operations of tax-exempt hospitals and allow hospitals to earn tax-free revenues from activities funded by for-profit businesses.

Investment income provides another important source of revenue for many tax-exempt hospital systems. Although many hospital systems earn somewhat slim margins on patient care, investment income provides a significant additional profit for some of the largest systems. A 2017 analysis of the eighty-four largest tax-exempt systems showed that while they earned a 2.7% operating margin by caring for patients, those margins more than doubled to 6.7% when accounting for investment income.[107] While many of these systems engage in only passive investment, at least one has gone even further and essentially operates its own private equity arm: Ascension Healthcare, a multibillion-dollar tax-exempt hospital system, has invested in numerous healthcare companies, including at least one medical debt collection company.[108]

Aside from eliminating hospitals' tax bills, tax-exempt status confers other benefits, including the ability to issue tax-exempt bonds. Some hospital systems have used this ability to engage in "tax arbitrage." Large, tax-exempt systems will borrow money using a tax-exempt bond even though their endowments may be large enough to cover the planned expenditure without borrowing anything at all.[109] This strategy is rational for hospitals when their endowment earns a larger return on investments than the interest the hospital would need to pay on the tax-exempt debt.[110] In this way, the hospital can double down on its tax advantage in order to improve its financing—the revenues that created its endowment are tax free, and the tax-exempt bond allows the hospital to secure a low interest rate on its debt.[111]

---

[106] *See also* St. David's Health Care Sys. v. United States, 349 F.3d 232, 239–40 (5th Cir. 2003) (applying Rev. Rul. 98-15).

[107] Bob Herman, *Hospitals Are Making a Fortune on Wall Street*, AXIOS (Dec. 7, 2017), https://www.axios.com/2017/12/16/hospitals-are-making-a-fortune-on-wall-street-1513388345.

[108] Cohrs, *supra* note 38.

[109] Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should it Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 466 (2007).

[110] Michael Fricke, *The Case Against Income Tax Exemption for Nonprofits*, 89 ST. JOHN'S L. REV. 1129, 1160 (2015); KAUFMAN HALL & ASSOCIATES, INC., A GUIDE TO FINANCING STRATEGIES FOR HOSPITALS WITH SPECIAL CONSIDERATION FOR SMALLER HOSPITALS 10 (2010).

[111] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Even though tax-exempt hospitals can issue tax-exempt bonds, they occasionally choose to issue taxable bonds (i.e., bonds in which income earned by the bond's purchaser is taxable). Hospitals use capital raised by taxable bonds to pursue purposes that may not serve the hospital's charitable mission. For instance, hospitals can use the bond proceeds to acquire medical practice groups or competing hospitals.[112] As discussed below, the market consolidation funded by these bonds is often driven by a desire for profits.[113] Alongside the surge in hospital consolidation, the use of such bonds has surged over the last several years.[114]

Hospital financing is now a far cry from hospitals' charitable origins, when donations formed their primary source of revenue. More to the point, hospitals' complex financing arrangements make it hard to draw any clear lines between purportedly charitable hospitals and their for-profit, tax-paying counterparts.

C. Hospital Consolidation

Alongside the change in funding and operation came a change in hospital organization. The individual community hospital has given way to horizontally and vertically integrated conglomerate systems. "The U.S. health care industry in the 21st century has been characterized by consolidation."[115] At least two-thirds of all hospitals are members of a health system.[116] That consolidation has been both horizontal and vertical—hospital systems buy other hospitals (horizontal) and also acquire physician groups (vertical).[117] This consolidation poses significant threats for American consumers.

---

[112] HFA Partners, *Is Taxable Debt a Viable Option for Hospitals?*, BECKER'S HOSP. REV. (July 6, 2011), https://www.beckershospitalreview.com/hospital-management-administration/is-taxable-debt-a-viable-option-for-hospitals.html.

[113] *See infra* Section I.C.

[114] Lorena Hernandez Barcena & David Wessel, *Why the Surge in Taxable Municipal Bonds?*, BROOKINGS (Dec. 21, 2020), https://www.brookings.edu/blog/up-front/2020/12/21/why-the-surge-in-taxable-municipal-bonds.

[115] Claire E. O'Hanlon, *Impacts of Health Care Industry Consolidation in Pittsburgh, Pennsylvania: A Qualitative Study*, 57 INQUIRY: J. HEALTH CARE, ORG., PROVISION, & FIN. 1, 1 (2020).

[116] Karyn Schwartz, Eric Lopez, Matthew Rae & Tricia Neuman, *What We Know About Provider Consolidation*, KFF (Sept. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation.

[117] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Hospital consolidation leads to higher hospital prices. When a hospital system consolidates a market, it can demand higher prices.[118] Hospitals in consolidated markets can charge prices as much as 65% higher than prices in competitive markets.[119] Even when hospital systems acquire hospitals in different geographical markets, prices tend to rise.[120] Vertical acquisitions have the same effect.[121] This phenomenon is not limited to for-profit hospitals—studies show that tax-exempt hospitals, in fact, exercise their market power to raise prices.[122] These higher prices are borne by employers and the tax-paying public in the form of higher health care prices, insurance premiums, and out-of-pocket payments. Government programs also pay the price of reduced hospital competition. MedPAC has found that hospitals facing competitive pressures are more likely to control their costs than are hospitals facing little or no competitive pressure.[123] Over time, if Medicare is to keep pace

[118] Gregory Curfman, *Everywhere, Hospitals Are Merging—But Why Should You Care?*, HARV. HEALTH PUBL'G: HARV. HEALTH BLOG (Apr. 1, 2015), https://www.health.harvard.edu/blog/everywhere-hospitals-are-merging-but-why-should-you-care-201504017844.

[119] *Antitrust Applied: Hospital Consolidation Concerns and Solutions: Statement Before the S. Subcomm. on Competition Policy, Antitrust, & Consumer Rights of the S. Comm. on the Judiciary*, 117th Cong. 9 (2021) (statement of Martin Gaynor, Professor of Economics & Public Policy, Heinz College, Carnegie Mellon University); *see also* Melissa Quintana, Note, *Measuring Hospital Post-Merger Effects: Developing a Standard for Antitrust Analysis*, 21 N.Y.U. J. LEGIS. & PUB. POL'Y 957, 970 (2019) ("A vast majority of literature shows that hospital consolidation results in price increases.").

[120] Thaddeus J. Lopatka, *Cross-Market Mergers in Healthcare: Adapting Antitrust Regulation to Address a Growing Concern*, 102 CORNELL L. REV. 821, 834 (2017).

[121] *See* NICHOLAS C. PETRIS CTR. ON HEALTH CARE MARKETS & CONSUMER WELFARE, CONSOLIDATION IN CALIFORNIA'S HEALTH CARE MARKET 2010–2016: IMPACT ON PRICES AND ACA PREMIUMS 32–36 (2018), http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf (demonstrating that in regions where a higher percentage of physicians work for foundations owned by hospitals or healthcare systems, outpatient procedure prices are higher).

[122] John Simpson & Richard Shin, *Do Nonprofit Hospitals Exercise Market Power?*, 5 INT'L J. ECON. BUS. 141, 154 (1998); *see also* Press Release, Dep't of Just., Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions (Nov. 15, 2018), https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering; Press Release, Cal. Dep't of Just., Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices (Aug. 27, 2021), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-final-approval-575-million-settlement-sutter.

[123] MedPAC Staff, *Meeting Highlight: Hospital Consolidation and its Implications for Medicare*, MEDPAC (Nov. 15, 2016), https://www.medpac.gov/meeting-highlight-hospital-consolidation-and-its-implications-for-medicare; MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 86–87 (2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf [hereinafter MedPAC

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

with the increasing hospital prices that accompany increasing hospital consolidation, the program will have to increase hospital payments—at the expense of taxpayers.

The higher prices charged by consolidated hospital systems do not correlate to higher quality care. The "strong consensus of researchers" is that hospital consolidation "leads to . . . lower quality for US patients."[124] Numerous studies have concluded that "competition [is] associated with improved quality, particularly lower patient mortality."[125] For example, one recent study determined that hospital acquisition "was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates."[126]

As a result of these detrimental effects of hospital consolidation, the hospital industry has long been a focus of state and local antitrust enforcers, but only recently have enforcement actions begun to see significant success.[127] In the first two years of President Biden's administration, the FTC blocked four hospital mergers and is expected to continue vigorous enforcement.[128] Tax-exempt hospitals are not immune from this scrutiny. For example, in 2021, Sutter Health, a tax-exempt hospital system in California, finalized a settlement of a lawsuit brought by the California Attorney General and private parties that challenged Sutter's use of anticompetitive contract

---

2019]; *accord* Emily Gee, *The High Price of Hospital Care*, CTR. FOR AM. PROGRESS (June 26, 2019), https://www.americanprogress.org/article/high-price-hospital-care.

[124] Dylan Scott, *What Biden Should Do If He's Serious About Bringing Down US Health Care Costs*, VOX (Feb. 1, 2021, 4:30 PM), https://www.vox.com/policy-and-politics/2021/2/1/22250286/joe-biden-health-care-plan-hospital-monopolies.

[125] Tim Xu, Albert W. Wu & Martin A. Makary, *The Potential Hazards of Hospital Consolidation: Implications for Quality, Access, and Price*, 314 JAMA 1337, 1337 (2015); WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 11 (2006), https://folio.iupui.edu/bitstream/handle/10244/520/no9researchreport.pdf (finding that hospital consolidation is more likely to reduce quality of care than improve it).

[126] Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care After Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51, 51 (2020); *see also* MARTIN GAYNOR & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE, at 3 (2012), https://www.researchgate.net/publication/283910115_The_Impact_of_Hospital_Consolidation_-_Update.

[127] *See* Cory Capps, Laura Kmitch, Zenon Zabinski & Slava Zayats, *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L.J. 441, 441 (2019).

[128] Harris Meyer, *Biden's FTC Has Blocked 4 Hospital Mergers and Is Poised to Thwart More Consolidation Attempts*, KFF HEALTH NEWS (July 18, 2022), https://khn.org/news/article/biden-ftc-block-hospital-mergers-antitrust.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

terms.[129] Tax-exempt hospitals' aggressive pursuit of horizontal and vertical acquisitions poses significant risks for consumers, and the higher prices that consolidation permits hospitals to charge call into question the propriety of extending tax exemptions to these growing conglomerates.

II. FEDERAL AND STATE APPROACHES TO HOSPITAL TAX EXEMPTIONS

Hospitals are among America's earliest charitable institutions. In his visit to the young nation, Alexis de Tocqueville marveled at the myriad forms of "public associations" Americans had created to take on burdens that, in France, fell to the government.[130] Early Americans, he observed, made "associations to give entertainments, to found establishments for education, to build inns, to construct churches, to diffuse books," and in the same "manner they found[ed] hospitals, prisons, and schools."[131] Hospitals' federal and state tax exemptions grow from these charitable roots.[132] But federal and state law have failed to keep pace with the change in hospital operation and organization. This Part provides a brief overview of federal and state approaches to hospital tax exemptions and describes the periodic efforts to apply antiquated tax policy to modern hospitals.

A. Federal Misadventures

The earliest federal taxes exempted "charitable organizations."[133] For instance, the earliest corporate income tax excluded "associations organized and conducted solely for charitable . . . purposes."[134] Later federal income taxes contained similar exemptions but added the requirement that "no part of the net income" of a charitable organization could "inure[] to the benefit of any private stockholder or individual."[135]

---

[129] Cal. Dep't of Just., *supra* note 122.

[130] 2 ALEXIS DE TOCQUEVILLE, DEMOCRACY IN AMERICA 114 (Henry Reeve trans., Colonial Press rev. ed. 1899) (1840).

[131] *Id.*

[132] *See supra* Section I.A.

[133] Santos, *supra* note 23, at 117.

[134] Paul Arnsberger, Melissa Ludlum, Margarey Riley & Mark Stanton, *A History of the Tax Exempt Sector: An SOI Perspective*, 27 STAT. OF INCOME BULL. 105, 106–07 (2008), https://www.irs.gov/pub/irs-soi/tehistory.pdf.

[135] *Id.* at 107.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

The modern tax code includes nearly identical language.[136] Given hospitals' charitable origins, their tax-exempt status "was rarely challenged" under early tax laws.[137]

It was not until 1956 that the IRS first reckoned with the changing nature of American hospitals. That year, in Revenue Ruling 56-185, the IRS recognized that by the mid-twentieth century, it had become "normal for hospitals to charge those able to pay for services rendered."[138] Although the IRS determined that charging for some hospital services would not preclude a federal tax exemption, it declared that a hospital's charitable exemption was warranted only if it "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."[139] The Ruling also suggested important limitations on tax-exempt hospitals. Hospitals could not purport to "dispense charity merely because some of its patients fail to pay for the services rendered."[140] Hospitals that "operate[d] with the expectation of full payment from all" patients were ineligible for tax exemption.[141] Tax-exempt hospitals' earnings could not "inure directly or indirectly to the benefit of any private shareholder or individual" including through "the payment of excessive rents or excessive salaries, or the use of its facilities to serve [the] private interests" of the hospitals' members.[142]

Under the IRS's 1956 Revenue Ruling, hospitals thus could not qualify for a tax exemption without providing some form of charity care. The precise amount of charity care required, however, was left for the Tax Court and other federal courts to determine.[143] Following the advent of Medicare and Medicaid in the 1960s, hospital administrators purportedly feared they would no longer be able to find patients

[136] *See* 26 U.S.C. § 501(c)(3).

[137] Santos, *supra* note 23, at 118.

[138] Rev. Rul. 56-185, 1956-1 C.B. 202.

[139] *Id.*

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] *See* Sonora Cmty. Hosp. v. Comm'r, 46 T.C. 519, 526 (1966) (denying tax exemption to hospital whose charity care was "less than 1 percent of paid care"); Lorain Ave. Clinic v. Comm'r, 31 T.C. 141, 146, 159 (1958) (determining that when only "2 to 5 [percent]" of patients received free treatment the petitioning medical clinic "was not operated exclusively for charitable purposes" and so should not qualify for exemption).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

unable to pay for care, putting hospitals' tax-exempt status in jeopardy.[144] In testimony before the House Ways and Means Committee, representatives from the American Hospital Association urged Congress to do away with the 1956 Ruling's charity care requirement by amending the Tax Code to explicitly exempt all "nonprofit" hospitals.[145] They explained that "the requirement that in order to be exempt, a hospital must provide some free patient care is unrealistic."[146] Medicare and Medicaid were "so comprehensive" that they rendered terms like "'need' and 'charity' . . . anachronisms" in the hospital context.[147]

The IRS responded to this pressure in 1969 when it issued Revenue Ruling 69-545. That Ruling modified the IRS's previous position by removing the "requirements relating to caring for patients without charge or at rates below cost."[148] Instead, the Ruling emphasized that the "promotion of health" alone "is considered to be a charitable purpose."[149] According to the Ruling, "[t]he promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole."[150] So long as the class of persons benefiting from the hospital's services was "not so small that its relief is not of benefit to the community," a hospital could qualify for a tax exemption even if it "ordinarily limits admissions to those who can pay the cost of their hospitalization."[151] The Ruling's requirement that hospitals serve enough of the public so as to "benefit . . . the community," ushered in the "Community Benefit Standard" that has since governed hospital tax exemptions, at least at the federal level.[152] The creation of the

[144] Santos, *supra* note 23, at 118; *see also* Westenberger, *supra* note 22, at 421 (recounting how, following the advent of Medicare and Medicaid, an IRS attorney was told by hospital administrators that "they couldn't find patients to whom to give free care") (internal quotation marks omitted); Bloche, *supra* note 67, 305–06 ("In the late 1960s . . . the [IRS] encountered growing pressure from the nonprofit hospital industry to abandon the charity care requirement entirely.").

[145] *Tax Reform, 1969: Hearings Before the H. Comm. on Ways & Means*, *supra* note 67, at 1434.

[146] *Id.*

[147] *Id.* at 1427.

[148] Rev. Rul. 69-545, 1969-2 C.B. 117.

[149] *Id.*

[150] *Id.*

[151] *Id.*

[152] *Id.* Welfare rights organizations challenged the constitutionality of the 1969 Revenue Ruling on behalf of the indigent, but the Supreme Court ultimately determined that those organizations did not have

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Community Benefit Standard was a critical moment in the blurring of the line between tax-exempt and tax-paying hospitals, as both types of hospitals promote health and typically provide some level of community benefit.

The Community Benefit Standard remains in place today, though subsequent regulatory and legislative changes have tinkered at the margins.[153] Over time, the IRS has moved away from the most muscular reading of its 1969 Revenue Ruling—that mere provision of health care to the general community was sufficient to meet the standard—to a standard that requires something more.[154] That something more could include providing charity care, or it could take some other form.[155] The Ruling does not identify any minimum level of benefit that hospitals must provide to their communities but in the rare circumstance that the IRS denies a hospital a tax exemption and the hospital appeals the decision, federal courts have held that the benefit must be more than "incidental"—"the magnitude of the community benefit conferred must be sufficient to give rise to a strong inference that the organization operates *primarily for the purpose of benefitting the community*."[156] The ambiguity of the Community Benefit Standard has been a perennial target of criticism.[157]

More recently, lawmakers and the IRS have attempted to bring clarity to the Community Benefit Standard. In 2008, the IRS introduced a new tax form—Schedule H—to "combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care."[158] Schedule H requires tax-exempt hospitals to report certain metrics designed to measure a hospital's community benefit. Those metrics include the amount of charity (i.e., free) care a

---

standing to sue, effectively ending the challenge and leaving the Ruling in place. Simon v. E. Ky. Welfare Rts. Org., 426 U.S. 26, 40–46 (1976).

[153] In 1983, the IRS further clarified that a hospital need not operate an emergency room open to all to qualify for a federal tax exemption. Rev. Rul. 83-157, 1983-2 C.B. 94.

[154] *See* John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX: J. L.-MED. 29, 30–37 (2005); *see also* IHC Health Plans, Inc. v. Comm'r., 325 F.3d 1188, 1197 (10th Cir. 2003) ("[E]ngaging in an activity that promotes health, *standing alone*, offers an insufficient indicium of an organization's purpose. . . . Rather, the organization must provide some additional 'plus'" to qualify for exemption.).

[155] *IHC Health Plans*, 325 F.3d at 1197–98.

[156] *Id.* at 1198; *see also* I.R.S. Priv. Ltr. Rul. 201412018 (Mar. 21, 2014) (adopting *IHC*'s formulation of the Community Benefit Standard).

[157] *See, e.g.*, Theodore J. Patton, *The Calamity of Community Benefit: Redefining the Scope and Increasing the Accountability of Minnesota's Nonprofit Hospitals*, 37 HAMLINE L. REV. 1, 5–6 (2014).

[158] Off. of Exempt Orgs., Tax-Exempt & Gov't Entities Div., *Draft Form 990 Redesign Project—Schedule H*, IRS 1 (June 14, 2007), https://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

hospital provides, the amount a hospital claims its cost of caring for Medicare and Medicaid patients exceeds reimbursements from those programs, bad debt (i.e., bills the hospital intends to but ultimately cannot collect), and donations to community groups.[159] According to a recent report by the U.S. Government Accountability Office (GAO), the IRS does not adequately make use of the information reported by hospitals in Schedule H.[160] Indeed, the GAO concluded that the "IRS does not have a well-documented process to ensure or demonstrate it is consistently reviewing the community benefits hospitals provide."[161]

In 2010, the Affordable Care Act (ACA) added certain requirements for tax-exempt hospitals. First, in order to qualify for a tax-exemption under § 501(c)(3), tax-exempt hospitals must complete a "community health needs assessment" once every three years that "takes into account input from persons who represent the broad interests of the community served by the hospital" and must further "adopt[] an implementation strategy" to meet the needs the assessment identifies.[162] The assessment must be "made widely available to the public."[163] Second, tax-exempt hospitals must develop a "financial assistance policy" that outlines how individuals can qualify and apply for "free or discounted care" and also have in place "measures to widely publicize the policy within the community."[164] Third, when it comes to emergency services, hospitals may not charge individuals who would be eligible for financial assistance "more than the amounts generally billed to [insured] individuals."[165] Finally, tax-exempt hospitals may not "engage in extraordinary collection actions" to collect payment from a patient without first making "reasonable efforts to determine whether the individual is eligible for assistance under the [hospital's] financial assistance policy."[166]

---

[159] *Instructions for Schedule H (Form 990)*, IRS 2, 4–5 (2008), https://www.irs.gov/pub/irs-prior/i990sh--2008.pdf.

[160] U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-679, TAX ADMINISTRATION: OPPORTUNITIES EXIST TO IMPROVE OVERSIGHT OF HOSPITALS' TAX-EXEMPT STATUS 27 (2020) [hereinafter U.S. GOV'T ACCOUNTABILITY OFF.].

[161] *Id.*

[162] I.R.C. § 501(r)(3).

[163] *Id.*

[164] *Id.* § 501(r)(4).

[165] *Id.* § 501(r)(5).

[166] *Id.* § 501(r)(6).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Compliance with the ACA's new requirements, however, has been lacking. One study found that "[o]nly 44% of hospitals regularly notified patients of their potential eligibility for charity care before initiating debt collection, and just 29% reported charging patients who were eligible for charity care the amounts generally billed to insured patients."[167] Failure to comply with the ACA's requirements can lead to revocation of a hospital's tax exemption,[168] but there have been only four instances in which the IRS has revoked a hospital's tax exemption for violating Section 501(r)'s requirements; all were government hospitals independently exempt from taxes by nature of their government status.[169]

These recent efforts create reporting obligations for tax-exempt hospitals, but they do little to clarify the burden that those hospitals must meet to justify their exemptions. Indeed, a decade after implementing the adjustments to hospitals' filing requirements, the GAO issued a report concluding that the obligations for tax-exempt hospitals "lack . . . clarity" and called on Congress to specify hospital activities that warrant tax exemption.[170] Further, even if that standard were clarified, lax enforcement by the IRS continues to permit non-complying hospitals to obtain tax exemptions: the GAO identified hundreds of hospitals reporting that less than 1% of their spending went to community benefits.[171]

B. State Approaches to Hospital Tax Exemptions

All fifty states extend tax exemptions of one kind or another to hospitals.[172] State income tax exemptions (where they exist) are almost uniformly tied to an organization's qualifications for federal tax exemption, meaning federally tax-

[167] Nikpay & Ayanian, *supra* note 14, at 1689–90.

[168] Treas. Reg. § 1.501(r)-2(a) (as amended in 2015).

[169] I.R.S. Priv. Ltr. Rul. 201731014 (Aug. 4, 2017); I.R.S. Priv. Ltr. Rul. 201829017 (July 20, 2018); I.R.S. Priv. Ltr. Rul. 201833020 (Aug. 17, 2018); I.R.S. Priv. Ltr. Rul. 201833021 (Aug. 17, 2018). The hospitals in these rulings put up little fight. In each case the hospital at issue was a government hospital and was thus separately exempt because it was a governmental unit. Because the hospitals would remain tax exempt as governmental units, three of the four accepted the IRS's revocation, and the position of the fourth is not known, but during an investigation, officials at that hospital told the IRS that the hospital "did not need, actually have any use for, or want their tax-exempt status under IRC § 501(c)(3)." I.R.S. Priv. Ltr. Rul. 201731014.

[170] U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 160.

[171] *Id.* at 21.

[172] *See Community Benefit State Law Profiles Comparison*, HILLTOP INST.: UMBC, https://hilltopinstitute.org/our-work/hospital-community-benefit/hcbp-state-comparison (last visited Nov. 18, 2023) (comparing state laws regarding hospital tax exemptions).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

exempt hospitals also enjoy exemption from state income taxes.[173] The same is true for state sales and use taxes.[174] For those taxes, states have outsourced their exemption decisions to the federal government—an ill-conceived practice, given the IRS's poor track record discussed above.

More variation exists among states in how they approach property taxes. As with other state and local taxes, some states tie even their property tax exemptions to federal tax exemptions.[175] For those that do not, however, the major division is between those states that provide specific exemptions for hospitals and those that more generally exempt property owned by "charitable" organizations that is used for "charitable purposes."[176] Thirty-two states specifically exempt hospitals, while the remaining eighteen exempt hospitals under a more general statute.[177] Another distinction among state approaches is between jurisdictions that require the exempt property to be used "exclusively" for either "hospital" or "charitable purposes" and those that do not.[178]

Some states specify the amount of benefit a hospital must provide to its community in order to earn its property tax exemption. Illinois requires tax-exempt hospitals to show that they have provided community benefits in an amount greater than what the hospital would otherwise be required to pay in property taxes.[179] Utah

---

[173] *See Community Benefit State Law Profiles: A 50-State Survey of State Community Benefit Laws Through the Lens of the ACA*, HILLTOP INST.: UMBC (2016), https://hilltopinstitute.org/wp-content/uploads/publications/CommunityBenefitStateLawProfiles-50StateSurveyOfStateCommunityBenefitLawsThroughLensOfACA-June2015.pdf [hereinafter *State Law Profiles*] (demonstrating that state laws typically exempt tax organizations that are exempt from federal income tax from state income tax as well).

[174] *Id.*

[175] *See, e.g.*, S.D. CODIFIED LAWS § 10-4-9.3 (LEXIS through 2023 Legis. Sess.); ME. REV. STAT. ANN. tit. 36, § 652(1)(K) (West, Westlaw through 2023 legislation).

[176] Santos, *supra* note 23, at 120–21. *Compare, e.g.*, KAN. STAT. ANN. § 79-201b (West, Westlaw through 2023 Legis. Sess.) (exempting from tax all real and personal property "actually and regularly used exclusively for hospital purposes by a hospital"), *with* KY. CONST. § 170 (West, Westlaw through laws effective Apr. 4, 2023) (exempting real and personal property owned by "institutions of purely public charity").

[177] Santos, *supra* note 23, at 120–21.

[178] *Id.* at 120; *see, e.g.*, COLO. REV. STAT ANN. § 39-3-108(1) (West, Westlaw through laws effective Apr. 14, 2023); KAN. STAT. ANN. § 79-201b.

[179] 35 ILL. COMP. STAT. ANN. 200/15-86(c) (West, Westlaw through P.A. 103-561 of 2023 Regular Legis. Sess.) Services that qualify as community benefit under Illinois law are statutorily defined and include, among other things, "[f]ree or discounted services provided pursuant to the relevant hospital entity's financial assistance policy" and "unreimbursed costs of the relevant hospital entity for providing without

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

similarly requires tax-exempt hospitals to provide community benefits in an amount that "exceeds on an annual basis its property tax liability for that year."[180] Nevada requires most hospitals (including tax-paying hospitals) to provide "care for indigent inpatients in an amount which represents 0.6% of its net revenue for the hospital's preceding fiscal year."[181]

Even when states do not explicitly require the provision of community benefits, the majority require tax-exempt hospitals to report the community benefits they provide.[182] Thirty-one states require tax-exempt hospitals to make such reports, though the required content of those reports differs state-by-state.[183] Some of the requirements are relatively simple,[184] while others are more involved.[185] What states do with this information varies by state,[186] but enforcement mechanisms typically lack teeth.[187]

C. Procedural and Substantive Limitations on Challenges to Federal and State Hospital Tax Exemptions

Challenges to hospitals' tax exemptions are rare. That owes primarily to the fact that, in most jurisdictions, only a single entity has standing to challenge the exemptions: the relevant jurisdiction's taxing authority. Outside of the taxing regulatory body itself, standing to challenge tax exemptions is highly restricted, if it exists at all. Even where the right to challenge tax exemptions does exist, states'

---

charge, paying for, or subsidizing goods, activities, or services for the purpose of addressing the health of low-income or underserved individuals." *Id.* at 200/15-86(e)(1), (e)(2).

[180] PROP. TAX DIV., UTAH STATE TAX COMM'N, PROPERTY TAX EXEMPTIONS STANDARDS OF PRACTICE, STANDARD 2, at 32 (rev. 2023), https://propertytax.utah.gov/standards/standard02.pdf.

[181] NEV. REV. STAT. ANN. § 439B.320(1) (West, Westlaw through 2023 Regular Legis. Sess.).

[182] *State Law Profiles*, *supra* note 173, at 5–6.

[183] *Id.*

[184] *See, e.g.*, WASH. ADMIN. CODE § 246-453-080 (Westlaw through Sept. 20, 2023) ("Each hospital shall compile and report data . . . with regard to the amount of charity care provided . . . .").

[185] *See, e.g.*, N.Y. PUB. HEALTH LAW §§ 2803-l, 2805-a (McKinney through L.2023, chs. 1–49, 61–123) (requiring an annual report on hospital finances and a different, tri-annual "community service plan").

[186] *See, e.g.*, MINN. STAT. ANN. § 144.699(2)(5)(a) (West, Westlaw through laws effective Mar. 21, 2023) (requiring Commissioner of the Department of Health to "report annually on the hospital's community benefit and community care").

[187] *See, e.g.*, 10 PA. STAT. AND CONS. STAT. § 379(i)(1) (West, Westlaw through 2022 Regular Sess. Act 166) (imposing a penalty up to $500 for "knowingly failing to file" the required report).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

exemption standards may be too weak to allow the challengers to show that a hospital's tax exemption is not justified by the benefit it provides the community.

At the federal level no entity other than the IRS can contest an organization's tax exemptions.[188] The Internal Revenue Code entrusts enforcement of the tax laws exclusively to the Secretary of the Treasury.[189] In the hospital context in particular, there is a bevy of precedent that third parties may not challenge the IRS's exemption decisions.[190] In the early 2000s, a rash of class action lawsuits were filed in numerous federal courts across the country challenging hospitals' tax-exempt status.[191] The suits claimed that indigent individuals were third-party beneficiaries of the "contract" between the United States and tax-exempt hospitals.[192] Although infamous plaintiffs' lawyer Richard "Dickie" Scruggs secured one settlement, courts dismissed all his other suits on a variety of grounds, including that "plaintiffs lacked standing to sue to enforce the federal tax code."[193] At bottom, each of these courts held that "only the IRS can challenge a nonprofit organization's tax status."[194]

Suits intended to force the IRS to better enforce the requirements for tax exemptions have fared no better. For example, in *Simon v. Eastern Kentucky Welfare Rights Organization*, individuals and organizations sought to challenge the IRS's 1969 decision, described in Section II.A, to do away with the requirement that tax-

[188] 26 U.S.C. §§ 7428(a)(1)(A), (b)(1) (creating an avenue to challenge "a determination . . . with respect to the initial qualification or continuing qualification of an organization as an organization described in section 501(c)(3)" but allowing only "the organization the qualification or classification of which is at issue" to file such a challenge).

[189] *Id.* § 7801(a)(1) ("Except as otherwise expressly provided by law, the administration and enforcement of [the Internal Revenue Code] shall be performed by or under the supervision of the Secretary of the Treasury.").

[190] Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 570 (S.D.N.Y. 2005), *vacated in part on other grounds*, 455 F.3d 118 (2d Cir. 2006).

[191] Lisa Kinney Helvin, Note, *Caring for the Uninsured: Are Not-For-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y, L., & ETHICS 421, 425 (2008); *see also* Grant v. Trinity Health-Mich., 390 F. Supp. 2d 643, 648–49 (E.D. Mich. 2005) (reviewing cases holding that alleged third-party beneficiaries of contracts between tax-exempt hospitals and the federal government lack standing).

[192] Helvin, *supra* note 191, at 435.

[193] *Id.*; *see also Kolari*, 382 F. Supp. 2d at 570 ("As a threshold matter, a plaintiff lacks standing to enforce rights allegedly created by another person's tax exemption, either in suits against the federal government or against the exempt entity.").

[194] *Grant*, 390 F. Supp. 2d at 653.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

exempt hospitals provide charity care in order to qualify for a tax exemption.[195] Although the individuals had an "obvious interest" in obtaining "access to hospital services," the Court held that their suit could not go forward.[196] The Court determined that it was "speculative whether the desired exercise of the court's remedial powers"—the reinstatement of the charity care requirement—would "result in the availability" of hospital services to the various plaintiffs and their members.[197] For instance, were the charity care requirement reinstated, hospitals may have chosen to forgo a federal tax exemption and continue in their refusal to provide charity care.[198] Because "[s]peculative inferences [were] necessary to connect their injury to the challenged actions" of the IRS, the plaintiffs lacked standing.[199]

In the states, the only prospect for challenging hospital tax exemptions comes in the realm of state and local property taxes. As discussed above, nearly every state outsources non-property tax exemptions to the federal government, awarding such exemptions to any entity that qualifies for a federal tax exemption.[200] But even with respect to property taxes, challenges to hospital tax exemptions are still quite rare. Standing offers a partial explanation, though it is not the whole story. After all, most state courts permit some form of taxpayer standing.[201] These standing doctrines are typically framed as permitting challenges to allegedly unlawful *expenditures* on the theory that such expenditures increase citizens' tax burdens.[202] It is not clear why similar logic would not permit challenges to unlawful tax *exemptions*, as removing

[195] Simon v. E. Ky. Welfare Rts. Org., 426 U.S. 26, 33–34 (1976).

[196] *Id.* at 40–41.

[197] *Id.* at 43.

[198] *Id.*

[199] *Id.* at 45. Similar suits outside of the hospital context have failed for similar reasons. *See, e.g.*, Allen v. Wright, 468 U.S. 737, 744 (1984) (dismissing on standing grounds a suit by parents of Black children who claimed that "despite the IRS policy of denying tax-exempt status to racially discriminatory private schools . . . some of the tax-exempt racially segregated private schools" nonetheless had "racially discriminatory policies").

[200] *See supra* Section II.B.

[201] Joshua G. Urquhart, *Disfavored Constitution, Passive Virtues? Linking State Constitutional Fiscal Limitations and Permissive Taxpayer Standing Doctrines*, 81 FORDHAM L. REV. 1263, 1274–83 (2012). The precise contours of state taxpayer standing doctrines varies, and a catalogue of those regimes is beyond this Article's scope. For a helpful guide, *see id.* at 1313–14.

[202] *Id.* at 1281.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

an entity from the tax rolls likewise increases the tax burden on those who remain.[203] Nevertheless, even in states that permit some form of taxpayer standing, the ability to bring suit is often restricted to challenging government expenditures rather than exemption decisions.[204]

Absent enforcement by taxpayers, states might also empower taxing districts—the municipalities, school districts, and special-purpose districts that rely on property tax revenues—to challenge tax exemptions. Pennsylvania, for example, chose this route,[205] and Texas also extends to taxing districts the right to challenge tax exemptions.[206] Alternatively, states may organize their property tax regime to empower such taxing districts to approve or deny tax exemption applications themselves rather than relying on a centralized administrative agency.[207] The lack of state level challenges thus does not owe (or at least does not owe entirely) to the centralization of exemption decisions in a single agency.

Another obvious reason for the lack of state-level challenges to hospital tax exemptions is that many state laws would make such challenges futile. Again, several states outsource even their property tax exemption decisions to the IRS by making such exemptions coterminous with qualification for federal tax exemptions.[208] Other states exempt "nonprofit" hospitals, full stop.[209] In some states, courts have

[203] William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-Profit Hospitals*, *in* THE CHANGING HOSPITAL INDUSTRY: COMPARING FOR-PROFIT AND NOT-FOR-PROFIT INSTITUTIONS 285, 320 (David M. Cutler ed., 2000).

[204] *See, e.g.*, McClellan v. Bd. of Equalization, 748 N.W.2d 66, 74–75 (Neb. 2008) ("[U]nder common law, taxpayers do not have standing to seek direct review of the tax-exempt status of someone else's property.").

[205] *See infra* Part III.

[206] *See, e.g.*, Atascosa Cnty. v. Atascosa Cnty. Appraisal Dist., 990 S.W.2d 255, 259 (Tex. 1999) ("[The Texas] Tax Code allow[s] a taxing unit to challenge appraisal district decisions that affect appraisal records. . . . [T]he taxing unit may challenge 'an exclusion of property from the appraisal records' or 'a grant in whole or in part of a partial exemption.'") (quoting TEX. TAX CODE §§ 41.03(2), (3)).

[207] *See, e.g.*, WIS. STAT. ANN. § 70.11 (West, Westlaw through 2021 Act 267) (requiring entities seeking exemption to file an application "with the assessor of the taxation district where the property is located").

[208] *See, e.g.*, ARIZ. REV. STAT. ANN. § 42-11105(D) (Westlaw through 2023 First Regular Legis. Sess.) ("Property that is owned by a health care provider recognized under section 501(c)(3) of the internal revenue code and organized as a nonprofit corporation is exempt from taxation . . . .").

[209] *See, e.g.*, WIS. STAT. ANN. § 70.11(4m) (exempting all "[r]eal property owned and used . . . exclusively for the purposes of any hospital of 10 beds or more devoted primarily to the diagnosis, treatment or care of the sick, injured, or disabled . . . no part of the net earnings of which inures to the benefit of any shareholder, member, director or officer.").

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

interpreted broadly worded exemptions for "charitable" organizations to afford hospitals automatic, or near-automatic, relief from taxes so long as they are nominally "nonprofit."[210] For example, in North Carolina, hospitals are exempt from taxation if they are "operated as . . . charitable institution[s]" with "humane and philanthropic objectives . . . [that] benefit[] humanity . . . without expectation of pecuniary profit or reward."[211] But the North Carolina courts have set a low bar to qualify for that exemption. The North Carolina Court of Appeals has held that a hospital is a "charitable" entity so long as it is "organized as a North Carolina nonstock, nonprofit" entity, is "licensed as a general acute care hospital," is "open to all citizens" of the community in which it sits, and "do[es] not deny emergency treatment to patients on the basis of their immediate need [sic] to pay for their care."[212]

Finally, still another reason for the paucity of state-level challenges, albeit one that is more difficult to measure, is inertia: owing to hospitals' charitable origins, the concept of the tax-exempt hospital is hard to dislodge from the American psyche. Generally, the public tends to expect that entities claiming to be "not-for-profit" do more good for their communities than other kinds of organizations.[213] For hospitals in particular, being labeled a tax-exempt charitable entity increases the public's "trust and favorable perception of the hospital."[214] Thus, despite media attention on the issue, public perception may cool the desire of private and public entities to more closely scrutinize hospital tax exemptions.

To say that state-level challenges to hospital tax exemptions are rare is not to say they do not exist. For the reasons described above, however, they most often reach state courts after a hospital appeals the denial of its tax exemption by the relevant administrative body or taxing district. A few high-profile cases fall into this category outside of Pennsylvania, most notably in Utah, Illinois, and New Jersey.[215]

---

[210] *See, e.g.*, N.C. GEN. STAT. ANN. § 105-278.8(c) (2022).

[211] *Id.* §§ 105-278.8(a), (c).

[212] *In re* Moses H. Cone Mem'l Hosp., 439 S.E.2d 778, 784 (N.C. Ct. App. 1994).

[213] *See* Andrew C. Papa, *Not-for-Profit Hospitals and Managed Care Organizations: Why the 501(c)(3) Tax-Exempt Status Should Be Revised*, 22 DEPAUL J. HEALTH CARE L. 93, 111–12 (2021).

[214] Rachel Weisblatt, *Uncharitable Hospitals: Why the IRS Needs Intermediate Sanctions to Regulate Tax-Exempt Hospitals*, 55 B.C. L. REV. 687, 699 (2014).

[215] Utah Cnty. v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985); Provena Covenant Med. Ctr. v. Dept. of Revenue, 925 N.E.2d 1131 (Ill. 2010); AHS Hosp. Corp. v. Town of Morristown, 28 N.J. Tax 456 (N.J. Tax Ct. 2015).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

In each case, the courts grappled with the transformation of hospitals from almshouses to their modern form, and in each case, the courts determined that the past justifications for hospital tax exemptions did not stand up to scrutiny.[216] But for the reasons outlined above, the ability of additional state courts to address the intersection of modern hospital operations and tax exemptions is constricted. We now look more closely at Pennsylvania, which serves as a model for robust enforcement (at least for property taxes) and for the development of tax exemption standards that are sensitive to the changing nature of hospital operation and organization.

III. TENDING THE BOUNDARIES OF CHARITABLE EXEMPTIONS UNDER THE PENNSYLVANIA CONSTITUTION

Unlike other states, Pennsylvania has been a hotbed for challenges to hospitals' tax-exempt status. This is likely in large part due to a Pennsylvania procedure that allows any taxing district with an interest in exempt property to challenge that tax exemption.[217] As a result of this procedure, Pennsylvania courts are routinely called upon to review the propriety of tax exemptions for hospitals and related institutions. Indeed, the commonwealth court recently issued two important decisions further elucidating the circumstances under which hospital tax exemptions are and are not justified.[218] This Part traces the development of hospital tax exemptions in Pennsylvania, including the standard for testing whether such tax exemptions are permitted under the Pennsylvania Constitution, and concludes by discussing the procedural mechanism through which Pennsylvania taxing districts are permitted to challenge tax exemptions.

---

[216] *Intermountain Health Care*, 709 P.2d at 270 (scrutinizing "the contemporary social and economic context of" hospital care and determining that "traditional assumptions" about hospitals' charitable nature "bear little relationship to the economics of the medical-industrial complex"); *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1145 (refusing to recognize a "blanket exemption . . . for hospitals or health-care providers" and instead engaging in a detailed analysis of whether modern hospital activities justified tax exemptions); *AHS Hosp. Corp.*, 28 N.J. Tax at 494, 536 (engaging in "exhaustive review of the evolution of the property tax exemption for hospitals" before determining that "modern non-profit hospitals are essentially *legal fictions* . . . [whose] operation and function . . . do not meet the current criteria for property tax exemption").

[217] *See* 72 PA. STAT. AND CONS. STAT. § 5020-520 (West, Westlaw through 2023 Regular Sess. Act 29); 53 PA. STAT. AND CONS. STAT. § 8844(c)(1) (West, Westlaw through 2023 Regular Sess. Act 29).

[218] *See infra* Section III.E.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

A. Early Understandings of Charities and Charitable Hospitals

In the eighteenth and nineteenth centuries, Pennsylvania hospitals, like hospitals in other jurisdictions, enjoyed presumptive exemptions from state and local taxes. In an early decision regarding a municipal almshouse and hospital, the Pennsylvania Supreme Court called the notion that the "poor-house" would be taxed "absurd."[219] That notion began to change with the Commonwealth's adoption of its 1873 constitution.

Prior to the enactment of the 1873 Pennsylvania Constitution, the Pennsylvania legislature haphazardly handed out tax exemptions through special legislative grants. Although many of these special legislative grants went to charitable institutions, many were also handed out as matters of personal favoritism to "mere trading corporations for private and individual profit."[220] As a result, when the Commonwealth ratified its new constitution, it included a provision requiring that tax exemptions be granted by general laws rather than special legislation.[221] The constitution further defined the kinds of institutions that the General Assembly could choose to exempt from taxation. One of those categories was "[i]nstitutions of purely public charity."[222] The following year, the General Assembly passed a law announcing that "all hospitals . . . founded, endowed or maintained by public or private charity, shall be exempt from taxation."[223]

For a century, Pennsylvania courts worked to define the meaning of a "purely public charity." The first attempt came in *Donohugh v. The Library Co. of Philadelphia*, 86 Pa. 306, 311 (1878), a case discussing the charitable status of a library founded by Benjamin Franklin and others.[224] The Pennsylvania Supreme Court adopted the Court of Common Pleas' definition of a "purely public charity."[225] "Charity," the court explained, included "almsgiving" but also more general acts of "good-will" and "benevolence," like the planting of trees in public spaces or donating

[219] Dirs. of Poor v. Sch. Dirs. of N. Manheim Twp., 42 Pa. 21, 24–25 (1862).

[220] Donohugh v. Libr. Co. of Phila. (Donohugh's Appeal), 86 Pa. 306, 311 (1878).

[221] PA. CONST. art. VIII, § 2(b)(ii) (amended 1968).

[222] *Id.* § 2(a)(v).

[223] *Donohugh's Appeal*, 86 Pa. at 306 (citation omitted).

[224] *Id.*

[225] *Id.* at 314. *Donohugh's Appeal* largely consists of the trial court's analysis and decision, which the Pennsylvania Supreme Court adopted in full. *Id.* at 318.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

to a volunteer fire department.[226] "Public," the court explained, meant that the institution must "not [be] confined to privileged individuals," and instead must be open to an "indefinite or unrestricted" class of persons.[227] And the Court determined that the word "purely" called for an examination of whether the institution was operated "entirely for the accomplishment of the public purpose" or had "some intermixture of private or individual gain."[228]

The definition began to accrete additional facets as courts applied the phrase "purely public charity" to new subjects. For instance, in 1888 the Pennsylvania Supreme Court commented that an institution of purely public charity should "lessen[] the burdens of government."[229] That same year, the court denied a tax exemption to the Academy of the Protestant Episcopal Church because the organization was "mainly dependent on tuition fees."[230]

The Pennsylvania Supreme Court erected a more concrete boundary around institutions of purely public charity in *YMCA of Germantown v. City of Philadelphia*.[231] In considering whether a local YMCA ought to be exempt from taxes, the court explained that "charity" had two requirements: (1) services must be "free of charge, or at least so nearly free of charge as to make the charges nominal or negligible"; and (2) the services must be provided to "legitimate subjects of charity," namely "those who are unable to provide themselves with what the institution provides for them."[232] This absolute requirement that charities provide free services was not so absolute in practice and eventually gave way to a softer rule. In *West Allegheny Hospital v. Board of Property Assessment, Appeals and Review of Allegheny County*, the court clarified that an institution need not charge only "nominal" fees to its beneficiaries or give its services away entirely for free.[233]

---

[226] *Id.* at 312.

[227] *Id.* at 313.

[228] *Id.* at 314.

[229] Fire Ins. Patrol v. Boyd, 15 A. 553, 555 (Pa. 1888).

[230] Trs. of the Acad. of the Protestant Episcopal Church v. Hunter, 15 A. 683, 684 (Pa. 1888).

[231] 187 A. 204, 208 (Pa. 1936).

[232] *See id.* at 209.

[233] 455 A.2d 1170, 1173 (Pa. 1982).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

B. *The Rise and Primacy of* Hospital Utilization Project v. Commonwealth

In 1985 the Pennsylvania Supreme Court decided *Hospital Utilization Project v. Commonwealth* ("*HUP*"), in which it conceded that its previous precedents had not defined the meaning of a purely public charity "with exactness" and attempted to synthesize its past decisions into a set of criteria that could be applied more consistently.[234] Before doing so, the court reiterated what it saw as the "underlying philosophy" of extending tax exemptions to charitable institutions.[235] "Taxes," the court explained, "are not penalties but are contributions which all inhabitants are expected to make" in order to fund essential governmental operations.[236] When one inhabitant "fails to contribute his share" of taxes, "some other inhabitant must contribute more than his fair share."[237] Exemptions should thus only be given to those institutions that "relieve[] the government of part of [its] burden"—the exemption is a "quid pro quo" for the institutions' services "in providing something which otherwise the government would have to provide."[238]

After reviewing the case law, the court announced a five-factor test. In the words of the court, a purely public charity:

(a) Advances a charitable purpose;

(b) Donates or renders gratuitously a substantial portion of its services;

(c) Benefits a substantial and indefinite class of persons who are legitimate subjects of charity;

(d) Relieves the government of some of its burden; and

(e) Operates entirely free from private profit motive.[239]

---

[234] 487 A.2d 1306, 1312 (Pa. 1985).

[235] *Id.* at 1314.

[236] *Id.* (quoting *YMCA*, 187 A. at 210).

[237] *Id.*

[238] *Id.*

[239] *Id.* at 1317.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

The court also clarified that being "a nonprofit corporation does not mandate" an exemption and that whether the organization is exempt from federal taxation is "immaterial" to the analysis under the Pennsylvania Constitution.[240]

Although the court had set out to provide clarity to the lower courts on the meaning of "purely public charity," the intervening decade gave rise to new ambiguities in the *HUP* framework. As a result, the General Assembly passed the Institutions of Purely Public Charity Act in 1997, popularly known as Act 55.[241] In its preamble, Act 55 explains that the "[l]ack of specific legislative standards defining the term 'institutions of purely public charity' has led to increasing confusion and confrontation among traditionally tax-exempt institutions and political subdivisions to the detriment of the public."[242] The General Assembly declared its "intent . . . to eliminate inconsistent application of eligibility standards for charitable tax exemptions [and] reduce confusion . . . by providing standards to be applied uniformly in all proceedings throughout this Commonwealth."[243]

Act 55 provides five criteria necessary for an institution to qualify as a purely public charity that roughly track the *HUP* factors.[244] But Act 55 also provides precise rules for how institutions can meet each factor. For instance, it lists six approved "charitable purpose[s]" and provides several somewhat complicated formulas for determining whether an institution donates or renders gratuitously a substantial portion of its services.[245]

Despite the legislature's evident intent to settle the question of what constitutes a purely public charity, the Pennsylvania Supreme Court was unwilling to delegate that authority to the General Assembly. Instead, in *Mesivtah Eitz Chaim of Bobov, Inc. v. Pike County Board of Assessment Appeals*, the court reasserted itself as the branch of Pennsylvania government charged with enforcing the constitution's reservation of tax exemptions for purely public charities.[246] The court explained that

---

[240] *Id.* at 1316, 1317.

[241] Institutions of Purely Public Charity Act, 1997 Pa. Laws 508 (codified at 10 PA. CONS. STAT. §§ 371–85).

[242] 10 PA. STAT. AND CONS. STAT. § 372(a)(4) (West, Westlaw through 2023 Regular Sess. Act 29).

[243] *Id.* § 372(b).

[244] *Id.* § 375.

[245] *Id.* § 375(b)–(c).

[246] 44 A.3d 3, 8 (Pa. 2012).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

the constitutional provision from which such tax exemptions sprang "was designed not to grant, but limit, legislative authority to create tax exemptions" and that the General Assembly's attempt to "eliminate judicial review of the constitutionality" of exemptions "would defeat this purpose."[247]

As a result, the *HUP* test remains paramount—if an institution does not qualify for an exemption "under the *HUP* test, you never get to the statute."[248] Only after determining the *HUP* factors have been satisfied should a court analyze whether the institution also meets the various tests in Act 55.[249]

C. HUP *Applied to Hospitals and Related Entities: Are Pennsylvania Courts on the Right Track?*

Over the decades since the Pennsylvania Supreme Court announced the *HUP* test, Pennsylvania courts have had several occasions to apply that test to hospitals and related entities. This Section catalogues how the five prongs of the test have been applied and how those applications have changed over time. It also identifies where the *HUP* test, as developed by the courts, may fall short.

1. Advancing a Charitable Purpose

The *HUP* court offered only vague guidance on what constitutes a "charitable purpose" under its newly formed test. The court quoted precedent explaining that "[i]n its broadest meaning" the word charitable "is understood 'to refer to something

---

[247] *Id.* at 8.

[248] *Id.* at 9.

[249] And the tests do not end there. Institutions bidding for tax exemption must also meet the requirements of the relevant county assessment law. The General Assembly has provided real property exemptions in two separate but nearly identical statutory provisions. In Pennsylvania two different statutory schemes control the assessment of real property and exemption from taxation in the various counties: the Consolidated County Assessment law, 53 PA. CONS. STAT. §§ 8801–68, controls the assessment of real property in counties with smaller populations, while the General County Assessment Law, 72 PA. CONS. STAT. §§ 5020-101 to -602, controls the assessment of real property in counties with larger populations. Both laws "exempt from all county, city, borough, town, township, road, poor and school tax[es]" the property of all "hospitals . . . founded, endowed, and maintained by public or private charity." 72 PA. STAT. AND CONS. STAT. § 5020-204(a)(3) (West, Westlaw through 2023 Regular Sess. Act 29); *see also* 53 PA. STAT. AND CONS. STAT. § 8812(a)(3) (West, Westlaw through 2023 Regular Sess. Act 29). Under both laws, however, property is only exempt if "the entire revenue derived" from the hospital is "applied to the support and to increase the efficiency and facilities thereof, the repair and necessary increase of grounds and buildings thereof, and for no other purpose." Tit. 72, § 5020-204(a)(3); *see also* tit. 53, § 8812(a)(3)(i). The law covering assessment of property in counties with smaller populations also makes clear that property is exempt only if it is "actually used for the principal purposes of the institution and not used in such a manner as to compete with commercial enterprise." Tit. 53, § 8812(a)(3)(ii).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

done or given for the benefit of our fellows or the public.'"[250] Despite having only this tautology to go on, for Pennsylvania courts, the first *HUP* factor is the least controversial when it comes to hospitals. Even before *HUP*, Pennsylvania precedent firmly established that "the promotion of health" is a charitable purpose.[251] Since *HUP*, courts have held that if a hospital maintains "open admission and nondiscrimination policies," that is "conclusive evidence that the hospital advanced a charitable purpose."[252]

This first *HUP* criterion is the most nebulous and overlaps significantly with the test's other factors. Even the definition used by the *HUP* court—"something done or given for the benefit of our fellows or the public"—seems almost indistinguishable from the court's own requirement that the organization "[b]enefit[] a substantial and indefinite class of persons who are legitimate subjects of charity."[253] A review of the case law suggests that the unique contribution of the first prong is to identify the *kinds* of organizations or activities that the community has deemed potentially deserving of tax exemption. In other words, this prong asks courts to make a normative judgment about whether an organization's purpose is one that aligns with traditional notions of "charity." Perhaps because courts are reluctant to make these kinds of policy judgments, they have rarely denied a tax exemption on the basis of this factor alone.[254]

Insofar as this prong asks whether the purpose of an organization is in harmony with traditional notions of charity, care for the sick and disabled is undoubtedly a "charitable purpose." As noted above, the work of physicians and nurses employed

[250] Hosp. Utilization Project v. Commonwealth, 487 A.2d 1306, 1315 (Pa. 1985) (quoting *In re* Hill Sch. Tax Exemption Case, 87 A.2d 259, 262 (Pa. 1952)).

[251] W. Allegheny Hosp. v. Bd. of Property Assessment, Appeals and Rev. of Allegheny Cty., 455 A.2d 1170, 1171 (Pa. 1982). The precise kind of "promotion of health" that qualifies as charity is not always crystal clear. *See* Selfspot, Inc. v. Butler Cnty. Fam. YMCA, 818 A.2d 587, 593 (Pa. Commw. Ct. 2003) (explaining that whether the "promotion of health" is a charitable purpose will depend on the circumstances). But there is no reported instance of a hospital failing this prong of the *HUP* test.

[252] Lewistown Hosp. v. Mifflin Cnty. Bd. of Assessment Appeals, 706 A.2d 1269, 1272 (Pa. Commw. Ct. 1998) (citing *W. Allegheny Hosp.*, 455 A.2d).

[253] *Hosp. Utilization Project*, 487 A.2d at 1315, 1317.

[254] Loren D. Prescott, Jr., *Pennsylvania Charities, Tax Exemption, and the Institutions of Purely Public Charity Act*, 73 TEMP. L. REV. 951, 961 (2000) ("While the Pennsylvania Supreme Court has had occasion to consider institutions that it decided were not 'charitable,' the vast majority of cases heard by the court have involved institutions that satisfy this standard. Indeed, the Pennsylvania Supreme Court suggested in a relatively recent case that 'charity' should be interpreted liberally and its meaning should evolve with society.").

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

by or working at hospitals is essential to the health of American citizens and the social fabric and well-being of communities. There is little doubt that hospitals' work is "for the benefit of our fellows or the public."[255] Most hospitals should meet this first prong with little difficulty. It is on the remaining factors that tax-exempt hospitals may founder.

2. Operating Free of a Private Profit Motive

Institutions of purely public charity also must "[o]perate[] entirely free from private profit motive."[256] This requires determining whether the entity is "distinguish[able] . . . from any other commercial enterprise."[257] In searching for a profit motive, courts must not focus on the "form" of the entity, but rather on "the substance of its structure and operation."[258]

This factor is one of the most frequently litigated when it comes to Pennsylvania hospital tax exemptions, and its meaning has evolved over time. Some pre-*HUP* cases suggested that if an organization could operate without donations from the public and could instead rely entirely on payment from its purported beneficiaries, tax exemption was inappropriate.[259] Intervening cases, both before and after *HUP*, have clarified that the realization of surplus revenue and the charging of fees to some beneficiaries are not absolute bars to tax exemption.[260] It is now clear

[255] *Hosp. Utilization Project*, 487 A.2d at 1315 (quoting *In re* Hill Sch. Tax Exemption Case, 87 A.2d 259, 262 (Pa. 1952)).

[256] *Id.* at 1317.

[257] *Id.* at 1318; *see also* Prescott, *supra* note 254, at 1027 ("[A]t some point charitable activities become so commercial—given services and fees comparable to those offered by competing businesses—that [tax] exempt status must be questioned.").

[258] Sch. Dist. of Phila. v. Frankford Grocery Co., 103 A.2d 738, 741 (Pa. 1954).

[259] White v. Smith, 42 A. 125, 127 (Pa. 1899) (cataloging cases demonstrating this proposition).

[260] W. Allegheny Hosp. v. Bd. of Property Assessment, Appeals and Rev. of Allegheny Cty., 455 A.2d 1170, 1173 (Pa. 1982) (permitting tax-exempt institutions to charge more than "nominal" fees to beneficiaries and explaining that to hold otherwise would fail to "accommodate evolving institutional needs in the light of limits to public and private generosity"); Wilson Area Sch. Dist. v. Easton Hosp., 747 A.2d 877, 880 (Pa. 2000) ("As this court made clear, surplus revenue is not synonymous with private profit.").

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

beyond question that surplus revenue is permitted, and the focus instead rests on how that revenue is used.[261]

In determining whether a hospital's use of its profits runs afoul of this prong of the *HUP* test, courts consider whether the hospital uses its profits in "expectation of a reasonable return," whether its revenues "support[] or further[]" the hospital's "eleemosynary nature," and whether those revenues inure to the benefit of "any private individual related to the charitable entity or related organization(s)."[262] Through this inquiry, courts analyze all manner of business activities that hospitals and other tax-exempt institutions undertake, including whether executive compensation is tied to the financial performance of the institution;[263] whether a hospital aggressively pursues patients for outstanding debts;[264] whether a hospital spends a large amount of its revenues on advertising;[265] whether the hospital requires physicians to sign non-compete agreements;[266] and whether the hospital diverts funds to other institutions that themselves have a profit motive.[267]

---

[261] Prescott, *supra* note 254, at 986; *Wilson Area Sch. Dist.*, 747 A.2d at 880 ("[T]ax-exempt charitable institutions will have revenue, including surplus revenue, but . . . it is how such revenue is used that will determine whether it evidences a private profit motive.").

[262] *Wilson Area Sch. Dist.*, 747 A.2d at 880.

[263] *In re* Appeal of Dunwoody Vill., 52 A.3d 408, 422–23 (Pa. Commw. Ct. 2012) (denying tax exemption to nursing home in part because "a substantial percentage of" its "officers' and executives' compensation [was] based on . . . financial or marketplace performance").

[264] Sch. Dist. of Erie v. Hamot Med. Ctr., 602 A.2d 407, 414 (Pa. Commw. Ct. 1992) (denying tax exemption in part because, in the trial court's opinion, the hospital "accept[ed] defeat only after collection and execution processes fail to yield fruit" and the hospital "fully anticipate[d] payment at the time of admittance").

[265] *Id.* at 411 (noting that the hospital had "spent in excess of one million dollars in advertising in the 1987 fiscal year" alone).

[266] Pinnacle Health Hosps. v. Dauphin Cnty. Bd. of Assessment Appeals, 708 A.2d 1284, 1295 (Pa. Commw. Ct. 1998) ("[N]on-competition clauses . . . enhance the profit making potential of the Hospital, because it [sic] keeps patients within the System by preventing physicians from leaving their employment and moving patients to new private practices, thereby protecting the System's market share. . . . [N]on-competition clauses do not enhance the Hospital's ability to provide charity care."). *But cf.* Cmty. Gen. Osteopathic Hosp. v. Dauphin Cnty. Bd. of Assessment Appeals, 706 A.2d 383, 391–92 (Pa. Commw. Ct. 1998) ("Although such covenants [not to compete] are at odds with the mission of a charitable hospital and may suggest a profit motive, we do not believe that such covenants, by themselves, are sufficient to demonstrate that a hospital is not entirely free of the profit motive.").

[267] Phoebe Servs., Inc. v. City of Allentown, 262 A.3d 660, 670 (Pa. Commw. Ct. 2021) ("[T]he diversion of surplus monies into other entities that have a profit motive is evidence of a profit motive."); Saint Joseph Hosp. v. Berks Cnty. Bd. of Assessment Appeals, 709 A.2d 928, 936 (Pa. Commw. Ct. 1998) ("A

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

In the main, Pennsylvania courts have shown admirable sensitivity to the ways in which modern hospitals' profit-generating activities have become indistinguishable from those undertaken by tax-paying businesses. But an analysis of one method by which hospitals and healthcare systems reveal a profit motive remains underdeveloped. As noted above, the hospital industry is now synonymous with consolidation.[268] The pursuit of profit is a driving force behind this consolidation craze—a strong market position permits a hospital to charge higher prices than it might in a more competitive environment.

Pennsylvania precedent suggests that courts should be skeptical when the evidence shows a tax-exempt hospital is overly interested in gaining or maintaining market share. As one court put it: "the polestar of a charitable hospital is providing service to persons in need of medical care, and not protecting its market share."[269] Courts have cautioned that "the financial connection between" a purportedly charitable institution "and its sister corporation[]" can be "highly relevant."[270] This prong of the *HUP* test thus appears amenable to an inquiry into whether a healthcare system has sought to gain and exercise market power.

Almost a quarter century ago, the Pennsylvania Supreme Court missed an opportunity to expound on how the systemization of hospital care affects the *HUP* inquiry. In *Wilson Area School District v. Easton Hospital*, the court considered whether a hospital could maintain its tax exemption when it used its surplus revenues to capitalize both not-for-profit and for-profit system affiliates.[271] The trial court had found that so long as the hospital's investment in its parent and sister organizations was made "with either the expectation of repayment or in order to increase the efficiency of its own operations," it was not evidence of a private profit motive.[272] Because the hospital's funding of family medical practices and other outpatient services would "reduce[] or eliminate[] the necessity of more expensive inpatient hospital care," the trial court had concluded that investing in such ventures was

---

charitable institution cannot be the financial engine which pulls for-profit freight and remain an institution of purely public charity.").

[268] *See supra* Section I.C.

[269] *Pinnacle Health Hosps.*, 708 A.2d at 1295.

[270] *Saint Joseph Hosp.*, 709 A.2d at 936.

[271] 747 A.2d 877, 878–79 (Pa. 2000).

[272] *Id.* at 880–81 (footnote omitted).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

consistent with the hospital's charitable purpose.[273] The Pennsylvania Supreme Court ignored the appellant's arguments that the hospitals insisted that physicians sign non-compete agreements when the hospital purchased the physicians' practices.[274]

Wilson is best read as an exercise in deference to the fact finder. The trial court determined that the hospital's vertical acquisitions of outpatient practices were efficiency-enhancing and not undertaken to increase the hospital's profitability. Nevertheless, it is troubling that the Pennsylvania Supreme Court failed to engage seriously with the ramifications of the hospital's vertical acquisitions and its use of non-compete clauses to protect its market position. As described below, however, courts have begun to show at least some sensitivity to system dynamics in their analysis of whether hospitals operate with a private profit motive.[275]

3. Donating or Rendering Gratuitously a Substantial Portion of Services

The *HUP* test requires that a tax-exempt institution "[d]onate[] or render[] gratuitously a substantial portion of its services."[276] No "magical percentage" marks the boundary between substantial and insubstantial donations.[277] Instead, courts determine whether the "organization makes a bona fide effort to service *primarily* those who cannot afford the usual fee."[278] This is "a determination to be made based on the totality of circumstances surrounding the organization."[279] Importantly for hospitals, the acceptance of a partial subsidy for services rendered by the institution is not a bar to tax exemption.[280]

---

[273] *Id.* at 880–81.

[274] *Id.* at 882 n.1 (Nigro, J., dissenting).

[275] *See infra* Section III.E.

[276] Hosp. Utilization Project v. Commonwealth, 487 A.2d 1306, 1317 (Pa. 1985).

[277] *Id.* at 1315 n.9.

[278] *Id.* (emphasis added).

[279] *Id.*

[280] St. Margaret Seneca Place v. Bd. of Prop. Assessment, Appeals & Rev., 640 A.2d 380, 382–83, 384 (Pa. 1994) ("The requirement that an institution donate or render gratuitously a substantial portion of its services does not imply a requirement that the institution forgo available government payments which cover *part* of its costs, or that it provide wholly gratuitous services to some of its residents.").

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

In the hospital context, the Pennsylvania Supreme Court has suggested that donated services can include "bad debt expenses," "traditional uncompensated charity care," and "Medicaid and Medicare shortfalls," which is to say, the difference between a hospital's claimed costs and the reimbursements received from government programs.[281] Other non-healthcare "services rendered to the community" like food programs, "social services, and educational programs" are also a factor.[282]

The method for determining whether a hospital provides "substantial" uncompensated care varies from case to case. Some courts have focused on the raw amount of a hospital's claimed un- or undercompensated care, while others have focused on the proportion of a hospital's patient population receiving discounted care.[283] To our minds, the former seems more likely to arrive at an accurate measure of uncompensated care. If the magnitude of the average discount offered to patients is small, the amount of donated care may be miniscule even when a large proportion of patients are receiving those discounts. Court decisions relying only on the proportion of patients for whom the hospital bears some costs are thus concerning.[284]

More concerning, however, is any suggestion in these cases that certain categories of care are presumptively charitable. Specifically, some court decisions suggest that care delivered to Medicare and Medicaid patients is *always* reimbursed below cost. As explained above in Part I.B.2, government programs provide enormous amounts of funding for hospital operations, both on a per-patient basis as with Medicare and Medicaid fee-for-service payments and as lump-sum funding like Medicaid supplemental payments or, more recently, COVID-19 assistance funds. The hospital industry persistently argues that government programs do not cover

[281] Wilson Area Sch. Dist. v. Easton Hosp., 747 A.2d 877, 878 (Pa. 2000).

[282] *Id.* At least one court has been skeptical of whether these non-healthcare activities are actually charitable. It found that a hospital's "community education programs and giveaways were nothing but 'loss leaders' offered to attract customers for higher paying items." Sch. Dist. of Erie v. Hamot Med. Ctr., 602 A.2d 407, 414 (Pa. Commw. Ct. 1992).

[283] *See, e.g.*, Lehighton Area Sch. Dist. v. Carbon Cnty. Bd. of Assessment, 708 A.2d 1297, 1303–04 (Pa. Commw. Ct. 1998) (engaging in both modes of analysis).

[284] *See, e.g.*, Mt. Macrina Manor, Inc. v. Fayette Cty. Bd. of Assessment Appeals, 683 A.2d 935, 940 (Pa. Commw. Ct. 1996) (finding nursing home met this prong because 69% "of all of [its] patients are Medicaid or Medicare patients" despite the fact that the home bore only "a two-percent cost for Medicare patients, and a ten-percent cost for Medicaid patients"); Couriers-Susquehanna v. County of Dauphin, 645 A.2d 290, 293 (Pa. Commw. Ct. 1994) (holding that a nursing home met this prong because "approximately sixty percent of the facility's residents are Medicaid patients for which government payments do not fully cover the cost of care").

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

hospital costs.[285] But studies by academics and independent congressional agencies suggest that these claims should be approached with skepticism.[286] So too must the claim that a hospital's "bad debts" should be considered gratuitously donated services. For one, federal and state governments offer supplemental payments to offset such bad debts.[287] More to the point, however, it seems anomalous to say that bad debts—that is, bills that hospitals pursue but ultimately cannot recoup—should be counted as "donations." It is unlikely that a patient being hounded to pay the hospital bill she cannot afford would agree that the hospital's relenting is akin to charity.

More broadly, hospitals' non-transparent pricing practices confound a precise measurement of what tax-exempt hospitals actually donate to their communities. Hospital pricing typically begins with a hospital's "chargemaster"—a list of hospital-created prices for hospital products and services.[288] Courts and commentators recognize that "chargemasters have become increasingly arbitrary and, over time, have lost any direct connection to hospitals' actual costs."[289] Instead, chargemaster prices significantly overstate the value of services—they are rack rates charged to virtually no one.[290] Chargemasters represent only hospitals' opening positions in price negotiations with private payers—such as employers and insurance companies—who often negotiate to pay a fixed percent of those charges.[291]

Despite chargemasters being disconnected from actual costs of care, hospitals often measure their donated services by reference to chargemaster prices.[292] For instance, suppose a surgical procedure costs a hospital $70,500, but the chargemaster

---

[285] *Fact Sheet: Underpayment by Medicare and Medicaid*, *supra* note 84.

[286] *See generally id.*; *Medicare Payment Systems*, *supra* note 71; MEDICAID BASE, *supra* note 79; MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 82.

[287] MEDPAC 2022, *supra* note 74, at 73.

[288] Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL'Y 11, 11 (2014).

[289] French v. Centura Health Corp., 509 P.3d 443, 451 (Colo. 2022); *accord In re* N. Cypress Med. Ctr. Operating Co., 559 S.W.3d 128, 132–35 (Tex. 2018) (collecting authorities on chargemaster prices); *see also* Deb Fournier, Trish Riley & Marilyn Bartlett, *Can We Please Stop Fixating on Hospital Chargemasters?*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Jan. 17, 2020), https://www.nashp.org/can-we-please-stop-fixating-on-hospital-chargemasters.

[290] Fournier et al., *supra* note 289.

[291] *Id.*

[292] Niran Al-Agba, *The Fairy Tale of a Non-Profit Hospital*, HEALTH CARE BLOG (Apr. 25, 2017), https://thehealthcareblog.com/blog/2017/04/25/the-fairy-tale-of-a-non-profit-hospital.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

prices the procedure at $229,112.13.[293] If an uninsured patient receives the procedure but does not pay, the hospital may forgive the debt and claim that it donated the full $229,112.13. Numerous categories of care that hospitals claim are charitable may suffer from the same flaw. Hospitals have used chargemaster prices to value charity care, bad debt expenses, and purported government program shortfalls.[294] These calculations substantially overstate the amount of benefit provided to communities.

Even when hospitals use non-chargemaster rates to value their direct community benefit, their calculations still rely on the chargemaster and are often misleading. Hospitals sometimes employ a "cost-to-charge ratio" to estimate the costs of care. The cost-to-charge ratio is typically calculated by dividing a hospital's aggregated costs by the sum of all (chargemaster) charges associated with care provided at the hospital.[295] Hospitals multiply the resulting ratio by the charges associated with un- or undercompensated care to estimate the cost of those services and then claim the resulting amount as a community benefit.[296]

Using cost-to-charge ratios can be misleading for at least two reasons. First, these ratios are necessarily imprecise—they are the ratio of a hospital's average cost to its average charge.[297] If a particular type of care has a different cost-to-charge ratio than is average for the hospital, a hospital-wide cost-to-charge ratio may overstate the costs of that care. One recent study concluded, for instance, that cost-to-charge ratios calculated on a hospital-wide basis would significantly overstate the cost of surgical care, especially at "not-for-profit facilities."[298] Cost-to-charge ratios are also imprecise in a different way: when determining the cost of providing donated care, what matters is not a hospital's average costs, but the *marginal* cost of caring for the recipients of the purportedly donated care.[299]

Second, cost-to-charge ratios are misleading because a hospital's "costs" may reflect a hospital system's market power as opposed to the actual value of the care

---

[293] As was the case in *French*, 509 P.3d at 446–47.

[294] Fournier et al., *supra* note 289; *see also* Fuse Brown, *supra* note 288, at 36–37.

[295] Christopher P. Childers, Jill Q. Dworsky, Marcia M. Russell & Melinda Maggard-Gibbons, *Comparison of Cost Center-Specific vs Hospital-Wide Cost-to-Charge Ratios for Operating Room Services at Various Hospital Types*, 154 JAMA SURGERY 557, 557 (2019).

[296] *Fact Sheet: Underpayment by Medicare and Medicaid*, *supra* note 84.

[297] Childers et al., *supra* note 295.

[298] *Id.* at 557–58.

[299] Herring et al., *supra* note 88, at 7.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

provided to community members.[300] Dominant hospital systems have little incentive to operate efficiently.[301] If a dominant system wants to increase its costs by, for instance, increasing executive pay, it can simply raise prices for private payers. Indeed, MedPAC has consistently found that hospitals facing competitive pressures are more likely to control their costs than are hospitals facing little or no competitive pressure.[302]

Taxing authorities cannot accurately measure hospitals' claims of donated care unless they have an accurate measure of hospitals' costs. As described below, recent cases have shown that courts are willing to closely scrutinize such claims—a welcome development.[303]

4. Benefitting a Substantial and Indefinite Class of Persons Who Are Legitimate Subjects of Charity

Pennsylvania's requirement that tax-exempt institutions benefit a "substantial and indefinite class of persons" derives from the constitutional requirement that tax exemptions be reserved for purely *public* charities.[304] In early cases, the Pennsylvania Supreme Court framed this requirement as one of access as opposed to an inquiry into the actual segment of the population benefitted by a purported charity's activities.[305] Later cases clarified that, in addition to being open to the public, "a substantial percentage" of the actual beneficiaries of a charity "must be legitimate objects of charity."[306]

This factor is infrequently litigated in cases concerning hospital tax exemptions. Whether the hospital maintains an open admissions policy is often

[300] *See* MEDPAC STAFF, *supra* note 123.

[301] *Id.*

[302] *See id.*; MedPAC 2019, *supra* note 123, at 86–87; *accord* Gee, *supra* note 123.

[303] *See infra* Section III.E.

[304] Prescott, *supra* note 254, at 971–72.

[305] Donohugh v. Libr. Co. of Phila. (Donohugh's Appeal), 86 Pa. 306, 313 (1878) ("The smallest street in the smallest village is a public highway of the Commonwealth, and none the less so because a vast majority of the citizens will certainly never derive any benefit from its use. It is enough that they may do so if they choose.").

[306] Hosp. Utilization Project v. Commonwealth, 487 A.2d 1306, 1317 (Pa. 1985) (citing Ogontz Sch. Tax Exemption Case, 65 A.2d 150, 153 (Pa. 1949); YMCA of Germantown v. Philadelphia, 187 A. 204, 208–09 (Pa. 1936)).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

dispositive of this prong.[307] Without an open admissions policy, a hospital's tax exemption claim would be significantly weakened, if not doomed.[308]

HUP, however, demands more than an open admissions policy—it also requires that a "substantial percentage" of a hospital's beneficiaries be "legitimate objects of charity."[309] The Pennsylvania Supreme Court has held that "people whose costs are only partially covered by Medicaid payments are manifestly legitimate objects of charity."[310] As explained above, however, the degree to which hospitals are actually subsidizing the care of Medicaid patients is uncertain, and it is clear that Medicaid offers numerous pecuniary benefits to participating hospitals beyond fee-for-service reimbursements.[311] An inquiry faithful to *HUP*'s demands would thus look beyond the mere maintenance of an open admissions policy and the treatment of Medicaid patients.

5. Relieving the Government of Some of Its Burden

The fifth and final *HUP* factor—whether a charity relieves the government of some of its burden—derives from what the Pennsylvania Supreme Court has called the "underlying philosophy" of charitable tax exemptions.[312] According to the court, governments award tax exemptions as a quid pro quo for a charity's shouldering a burden that would otherwise fall to the government.[313] In *HUP*, the court suggested that this prong demands an inquiry into whether the charity's activities are "traditionally done by the government" such that in the charity's absence, the government would step in.[314] Also relevant was whether "for-profit corporations" provide similar services, presumably because the existence of for-profit enterprise suggests that the charity's activities are commercial, rather than governmental.[315]

---

[307] St. Margaret Seneca Place v. Bd. of Prop. Assessment, Appeals & Rev., 640 A.2d 380, 384 (Pa. 1994).

[308] *See, e.g.*, Sch. Dist. of Erie v. Hamot Med. Ctr., 602 A.2d 407, 413–14 (Pa. Commw. Ct. 1992) (denying tax exemption to hospital in part because it lacked a comprehensive open admissions policy).

[309] *Hosp. Utilization Project*, 487 A.2d at 1317.

[310] *St. Margaret Seneca Place*, 640 A.2d at 487.

[311] *See supra* Section I.B.2.

[312] *Hospital Utilization Project*, 487 A.2d at 1314.

[313] *Id.* (quoting YMCA of Germantown v. Philadelphia, 187 A. 204, 210 (Pa. 1936)).

[314] *Id.* at 1317 n.10.

[315] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

In *St. Margaret Seneca Place*, however, the Pennsylvania Supreme Court seemed to alter this test. There, the lower court had held that a nursing home failed this prong because Medicare and Medicaid payments accounted for nearly 60% of the home's revenues.[316] The Commonwealth Court of Pennsylvania had had "difficulty seeing how the nursing home [was] relieving the government of" its burden, when in fact the services provided by the home were imposing significant liability on the government.[317] The supreme court held that this rather common sense reasoning was error. It explained that the "test of whether an institution has relieved the government of some of its burden does not require a finding that the institution has fully funded the care of some people who would otherwise be fully funded by the government" but rather "whether the institution bears a substantial burden that would otherwise fall to the government."[318] Covering a "portion of the cost for Medicaid patients" thus "fulfill[ed] the requirement" of the fifth prong.[319]

The Pennsylvania Supreme Court's reasoning in *St. Margaret Seneca Place* is flawed. First, as noted above, the notion that hospitals are not fully compensated for the care they provide to Medicare and Medicaid patients is questionable.[320] Second, studies show that for-profit hospitals often provide the same amount of or more unreimbursed Medicaid care than tax-exempt hospitals do.[321] That fact undermines the notion that such unreimbursed care is a government burden that should be rewarded with tax exemptions rather than a decision that rational economic actors undertake to generate a profit for investors. Third, government health insurance programs are designed to contain hospital costs by incentivizing hospitals to operate efficiently.[322] Granting tax exemptions to hospitals because they spend more than the government reimburses undermines these incentives, frustrating government goals

[316] St. Margaret Seneca Place v. Bd. of Prop. Assessment, Appeals & Rev., 640 A.2d 380, 384 (Pa. 1994).

[317] St. Margaret Seneca Place v. Bd. of Prop. Assessment, Appeals & Rev., 604 A.2d 1119, 1125–26 (Pa. Commw. Ct. 1992).

[318] *St. Margaret Seneca Place*, 640 A.2d at 385.

[319] *Id.*

[320] *See supra* Section I.B.2.

[321] *See, e.g.*, Bai et al., *supra* note 36.

[322] Eric Lopez, Tricia Neuman, Gretchen Jacobson & Larry Levitt, *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, KFF (Apr. 15, 2020), https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature ("[A]s for hospitals, MedPAC maintains that holding Medicare payment rates close to practice costs incentivizes physician practices to become more efficient.").

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

rather than relieving its burdens. Fourth, and relatedly, hospital consolidation is a major driver of increased health care costs. Those cost increases are borne, in large part, by government payers. The Pennsylvania Supreme Court has given short shrift to this factor when it comes to healthcare providers, but it deserves closer scrutiny as it applies to hospitals.[323]

D. Pennsylvania's Procedure Encourages Common-Law Development of Exemption Standard

As made clear by the above discussion, Pennsylvania courts have had ample opportunity to expound on the commonwealth's constitutional standard for tax exemption. That owes in large part to Pennsylvania's procedure for challenging tax exemptions. We contend that neither Pennsylvania's tax exemption standard nor its challenge procedure can alone explain why Pennsylvania is fertile ground for challenges to hospital tax exemptions. Both are necessary. This Section thus briefly describes the procedure through which taxing districts can dispute tax exemptions that deprive them of revenue by removing large parcels of property from their tax rolls.

Because tax assessments in Pennsylvania are relatively decentralized, the precise procedure for challenging a property tax exemption varies from county to county. In general, however, a taxing district—meaning a county, municipality, or school district—may appeal a property assessment.[324] The appeal may be initiated at one of two times: (1) following a reassessment of the property; or (2) annually by taking an appeal of a property's assessment. Reassessments of property in Pennsylvania are infrequent.[325] Instead, the taxable value of a property for a given year is typically calculated by multiplying the value of the property during a base year (i.e., the last year all property in a county was reassessed) by a set ratio that is calculated by analyzing property sales in the county over a given period. A county can go decades without conducting a reassessment necessary to set a new base year—

[323] For an argument that hospitals do not relieve the government of a burden because the government has no obligation to provide health care in the first place, see Kellen McClendon, *Do Hospitals in Pennsylvania Relieve the Government of Some of Its Burden?*, 67 TEMP. L. REV. 517 (1994).

[324] 72 PA. STAT. AND CONS. STAT. § 5020-520 (West, Westlaw through 2023 Regular Sess. Act 29); 53 PA. STAT. AND CONS. STAT. § 8844(c)(1) (West, Westlaw through 2023 Regular Sess. Act 29).

[325] Some counties regularly reassess the value of properties. Philadelphia County (which is coextensive with the City of Philadelphia), for instance, reassesses all properties more frequently. *See* CTR. FOR RURAL PA., PENNSYLVANIA COUNTY PROPERTY REASSESSMENT: IMPACT ON LOCAL GOVERNMENT FINANCES AND THE LOCAL ECONOMY (2010), https://www.rural.pa.gov/getfile.cfm?file=Resources/PDFs/research-report/county_reassessment_2010.pdf&view=true.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Allegheny County, which includes Pittsburgh, last undertook a county-wide reassessment in 2013.[326] Absent a county-wide reassessment, property values for tax purposes cannot be altered unless the property is subdivided or combined, improvements are added or destroyed, or a catastrophic loss occurs on the property.[327]

Given the rarity of a change in a property's assessment, most tax exemption challenges are made during the opportunity for annual appeal. Different counties have different due dates for filing an annual appeal.[328] Appeals are first heard by the relevant county's Board of Property Assessment Appeals and Review.[329] After the Board determines the propriety of a property's exemption, the property owner or an affected taxing district may appeal the decision to the county's Court of Common Pleas—the trial court of general jurisdiction within the Pennsylvania judicial system.[330] The Court of Common Pleas conducts a *de novo* review of the case and is thus "the ultimate finder of fact" in tax assessment appeals.[331] The trial court takes testimony just as it would in any other civil bench trial. Following the trial court's resolution of the issue, the case may be appealed to Pennsylvania's Commonwealth Court and then, ultimately, to the Pennsylvania Supreme Court.

E. Recent Challenges to Hospital Tax Exemptions Illustrate Benefits (and Limitations) of Pennsylvania Standards and Procedure

In February 2023, the Commonwealth Court of Pennsylvania decided four related appeals concerning the tax exemptions of four hospitals owned by the Tower

---

[326] Lou Fabian, *Property Valuation for Tax Purposes*, ALLEGHENY CNTY., https://www.alleghenycounty.us/real-estate/property-assessments/index.aspx (last visited Nov. 21, 2023).

[327] *See, e.g.*, 53 PA. STAT. AND CONS. STAT. §§ 8817(a), 8815(a) (West, Westlaw through 2023 Regular Sess. Act 29).

[328] For example, Allegheny County requires such appeals be filed by March 31st of a given tax year, Philadelphia requires appeals be filed by the first Monday in October, and the remaining counties require appeals be filed sometime between August 1st and September 1st. PENNSYLVANIA TAX HANDBOOK, § 12–1:7.

[329] *See, e.g.*, 53 PA. STAT. AND CONS. STAT. § 8844(e)(1) (West, Westlaw through 2023 Regular Sess. Act 29).

[330] *See, e.g.*, 53 PA. STAT. AND CONS. STAT. § 8854(a)(1) (West, Westlaw through 2023 Regular Sess. Act 29).

[331] Parkview Ct. Assocs. v. Del. Cnty. Bd. of Assessment Appeals, 959 A.2d 515, 520 (Pa. Commw. Ct. 2008).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Health healthcare system.[332] The appeals arose from two separate opinions issued by two separate courts of common pleas—three of the hospitals are located in Chester County (Brandywine, Phoenixville, and Jennersville Hospitals) while the fourth is in Montgomery County (Pottstown Hospital).[333] Prior to Tower Health's acquisitions, all four hospitals were tax-paying entities.[334] But when Tower Health purchased them in 2017, it applied for tax exemptions for all four. The school districts and municipalities that had previously relied on tax revenues from the hospitals appealed, and eventually all four cases found their way to Pennsylvania's trial courts.[335]

Although the hospitals were similarly organized, and although the evidence in all four cases was nearly identical, the Montgomery County and Chester County courts came to opposite conclusions: Pottstown Hospital could keep its exemption, while the other three hospitals lost theirs.[336] In both decisions, the primary *HUP* prongs in dispute were whether the hospitals operated free of a private profit motive and whether they donated a substantial amount of their services.[337] In both cases, the vast majority of the hospitals' claimed donated care came in the form of Medicare and Medicaid shortfalls.[338] As for the hospitals' profit motives, the taxing districts in all four appeals pointed to the enormous salaries paid to Tower Health executives that were funded in part by the hospitals' revenues and argued that the healthcare

[332] Pottstown Sch. Dist. v. Montgomery Cnty. Bd. of Assessment Appeals, 289 A.3d 1142 (Pa. Commw. Ct. 2023); Brandywine Hosp., LLC v. Cnty. of Chester Bd. of Assessment Appeals, 291 A.3d 467 (Pa. Commw. Ct. 2023); Phoenixville Hosp., LLC v. Cnty. of Chester Bd. of Assessment Appeals, Nos. 1281 C.D. 2021, 1285 C.D. 2021, 2023 WL 1871695 (Pa. Commw. Ct. Feb. 10, 2023); Jennersville Hosp., LLC v. Cnty. of Chester Bd. of Assessment Appeals, Nos. 1282 C.D. 2021, 1286 C.D. 2021, 2023 WL 1871705 (Pa. Commw. Ct. Feb. 10, 2023). The authors of this Article submitted amicus briefs in all four appeals on behalf of patientrightsadvocate.org and Families USA, LLC.

[333] *In re* Appeal of Brandywine Hosp., LLC, 70 Ches. Cty. L. Rep. 4 (Pa. Ct. Com. Pl. Civ. Div. 2021); Pottstown Sch. Dist. v. Montgomery Cnty. Bd. of Assessment Appeals, No. 2017-27756, 2022 WL 563076 (Pa. Ct. Com. Pl. Civ. Div. Feb. 23, 2022). Although the tax exemptions of four hospitals were challenged, the Chester County court issued a single decision with respect to the three hospitals under its jurisdiction.

[334] *See Pottstown Sch. Dist.*, 2022 WL 563076, at *2; *Brandywine Hosp.*, 291 A.3d at 472.

[335] Tower Health eventually closed Brandywine and Jennersville Hospitals when the system decided that the hospitals could not generate sufficient revenues. Lisa Scheid, *Tower Expected to Close Brandywine Hospital Months Before Announcement*, READING EAGLE (Dec. 18, 2021, 7:45 PM), https://www.readingeagle.com/2021/12/18/tower-health-close-brandywine-hospital.

[336] *Pottstown Sch. Dist.*, 2022 WL 563076, at *17; *Brandywine Hosp.*, 291 A.3d at 472–73.

[337] *Pottstown Sch. Dist.*, 289 A.3d at 1150, 1149; *Brandywine Hosp.*, 291 A.3d at 477–84.

[338] *Pottstown Sch. Dist.*, 289 A.3d at 1151; *Brandywine Hosp.*, 291 A.3d at 482–83.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

system had improperly tied system executives' bonuses to the hospitals' financial performance.[339] The taxing districts also pointed out that the Tower Health system charged enormous "management fees" to the system's constituent hospitals for which the hospitals received little benefit.[340]

In Montgomery County, where Pottstown Hospital was initially permitted to retain its tax exemption, the court accepted almost without question that Medicare and Medicaid had undercompensated the hospital to the tune of tens of millions of dollars.[341] Although the Montgomery County court found the $2.3 million annual compensation paid to Tower Health's CEO "eye-popping," the court felt constrained by precedent and held that such compensation did not evince an impermissible profit motive.[342]

The Chester County court, considering much the same evidence, took a decidedly different view. That court held that the hospitals failed to prove that Medicare and Medicaid reimbursements were below cost.[343] In particular, the court explained that the hospitals claims were dubious because they were based in part on the hospitals' chargemaster rates, which contained "inflated" prices, rather than on the actual costs of caring for Medicare and Medicaid patients.[344] As for the hospitals' profit motives, the Chester County court held that Tower Health paid its executives unreasonably high salaries and impermissibly tied executive bonuses to the hospital's financial performance.[345] The court further found that the system imposed enormous liabilities on the hospitals in the form of "management fees" and bond interest obligations for which the hospitals received no tangible benefit in return.[346]

[339] *Pottstown Sch. Dist.*, 289 A.3d at 1152–53; *Brandywine Hosp.*, 291 A.3d at 480.

[340] *Brandywine Hosp.*, 291 A.3d at 478–79.

[341] *Pottstown Sch. Dist.*, 2022 WL 563076, at *3–4.

[342] *Id.* at *13–14.

[343] *Brandywine Hosp.*, 291 A.3d at 482.

[344] *Id.*

[345] *Id.* at 479.

[346] *Id.* at 478–79.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

The commonwealth court affirmed the Chester County decision and reversed the Montgomery County decision.[347] In a series of rulings, the court confronted in important ways the question of how the *HUP* test maps onto modern hospital operation. The court agreed with the hospitals that, in some cases, "shortfalls from Medicare and Medicaid may constitute donations of gratuitous services."[348] Importantly, however, the court made clear that trial courts need not take hospitals at their word when they assert that they have been undercompensated by government payers.[349] In affirming the Chester County decision, the court made clear that a hospital must prove that government reimbursements fall below the hospital's actual costs before any purported "shortfalls" will count as donated services.[350]

The commonwealth court also reiterated that the financial relationship between a healthcare system and its constituent hospitals is highly relevant to determining whether those hospitals operate with a private profit motive.[351] First, the court held that tying a substantial portion of compensation for *system* executives to *hospital* financial performance indicated that the hospitals operated with a private profit motive.[352] Specifically, the court held that "tying 40% of [system executives'] bonus incentives to [the] Hospital's financial performance is sufficiently substantial to indicate a private profit motive."[353] The court also found that system executives' compensation was unreasonably high, with the Tower Health CEO's base salary reaching $1.4 million by fiscal year 2020.[354] The court so held notwithstanding the hospitals' argument that their executives were compensated in accordance with industry practice.[355]

---

[347] *Id.* at 481, 484 (affirming Chester County decision); Pottstown Sch. Dist. v. Montgomery Cnty. Bd. of Assessment Appeals, 289 A.3d 1142, 1155 (Pa. Commw. Ct. 2023) (reversing Montgomery County decision).

[348] *Brandywine Hosp.*, 291 A.3d at 482.

[349] *Id.*

[350] *Id.* at 482–84.

[351] *Id.* at 478–79.

[352] *Id.* at 481 (explaining that a nonprofit may not "directly tie[]" compensation "to the financial status of the nonprofit") (quoting Phoebe Services, Inc. v. City of Allentown, 262 A.3d 660, 671 (Pa. Commw. Ct. 2021)).

[353] Pottstown Sch. Dist. v. Montgomery Cnty. Bd. of Assessment Appeals, 289 A.3d 1142, 1154 (Pa. Commw. Ct. 2023); *accord Brandywine Hosp.*, 291 A.3d at 481.

[354] *Pottstown Sch. Dist.*, 289 A.3d at 1153 n.10.

[355] *Id.* at 1153.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

In another important holding, the commonwealth court agreed with the Chester County court that Tower Health charged large "management fees" to its constituent hospitals without providing a commensurate benefit.[356] This holding shows an increasing sensitivity to system dynamics—courts must not blindly accept the reasonableness of financial transactions between entities within a healthcare system and instead should scrutinize those transactions to determine whether they evince an impermissible profit motive.

Finally, although perhaps not legally meaningful, it should be noted that the commonwealth court appeared to endorse some of the more aggressive language from the decisions below. For instance, the court appeared to agree with the Chester County trial court's characterization of Tower Health as "no more tha[n] corporate health care raiders" whose goal was to "drain the juice out of the hospitals until there was nothing left but a dried-out husk."[357] The commonwealth court also acknowledged that although the conclusion that hospitals relieve the government of some of its burden may have been acceptable in 1985 when *HUP* was decided, that may no longer reflect the reality of hospital operations.[358] Instead, with the "government . . . now paying nearly one-half of the population's health care costs," it appears that at least some hospitals' "financial model . . . is to increase [the] burden on the government and reliance on government insurance payments."[359]

These cases highlight both the benefits and limitations of Pennsylvania's tax-exemption standard and challenge procedure. The commonwealth court's decisions show that the *HUP* test permits an inquiry sensitive to the changing nature of hospital operation and financing. For instance, although the commonwealth court permitted the hospitals to claim Medicare and Medicaid shortfalls as donated care,[360] it clarified that such claims must be supported by evidence that government reimbursements are actually below cost.[361] As government insurance programs continue to grow, this

---

[356] *Brandywine Hosp.*, 291 A.3d at 478–79. The court also chided the Montgomery County court for ignoring "evidence regarding the reasonableness of the charges imposed by Tower Health for the management and administrative services it provided to [Pottstown] Hospital." *Pottstown Sch. Dist.*, 289 A.3d at 1154.

[357] *Pottstown Sch. Dist.*, 289 A.3d at 1153 n.10 (quoting *Brandywine Hosp.*, 291 A.3d at 480).

[358] *Brandywine Hosp.*, 291 A.3d at 483.

[359] *Id.*

[360] For a discussion of why claimed Medicare and Medicaid shortfalls are dubious, see *supra* Section III.C.3.

[361] *Brandywine Hosp.*, 291 A.3d at 482–84.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

requirement that hospitals present hard evidence is vital to ensuring that hospital tax exemptions are justified. Similarly, the commonwealth court's clear concern that Tower Health and its executives misused community hospitals to generate systemwide revenues will encourage lower courts to scrutinize the ramifications of the increasing systemization of the healthcare industry.

The *Brandywine* and *Pottstown* cases also illustrate one of the major limitations of Pennsylvania's tax exemption procedure: delay. These tax exemption appeals began in 2018 and have crawled through litigation since.[362] Municipality and school district budgets are stretched thin and years-long litigation is costly. Nevertheless, the ability for taxing districts to have a direct say in the composition of their tax rolls likely justifies this delay. Rather than placing school districts and towns at the mercy of administrative decision-making, those local governments—who likely have the keenest understanding of whether a hospital is benefitting their communities—have the opportunity to ensure that all property owners are paying their fair share.

IV. RECOMMENDATIONS FOR COURSE CORRECTING HOSPITAL TAX EXEMPTIONS

Tax exemptions are a statutory bargain: governments agree to free organizations from contributing to public coffers and in exchange those organizations provide direct benefits to the community. Put differently, tax-paying citizens and entities agree to provide all the funds needed to fill government coffers, in exchange for tax-exempt entities' providing necessary community benefits that others do not supply. Hospitals doubtlessly provide vital benefits to the communities they serve. But, at both the federal and state levels, the current tax exemption regime too often entitles hospitals to avoid taxes without a concrete showing that they in fact provide such benefits on terms beneficial to the community.

This problem is not new. In 1990, the government organization that would become the GAO concluded that congressional action was needed to "encourage [tax-exempt] hospitals to provide charity care and other community services."[363]

---

[362] Indeed, litigation over the tax status of Pottstown Hospital continues. The Pennsylvania Supreme Court recently granted that hospital's petition for allowance of an appeal to the Commonwealth's high court. *See* https://montco.today/2023/10/pottstown-hospital-at-center-of-potential-landmark-pennsylvania-supreme-court-decision/. The Pennsylvania Supreme Court denied similar petitions filed by Brandywine, Jennersville, and Phoenixville hospitals. *See* https://www.law360.com/health/articles/1773694?nl_pk=d83825aa-722e-4e6e-808f-1c18c6dd484a&utm_source=newsletter&utm_medium=email&utm_campaign=health&utm_content=2023-12-06&read_main=1&nlsidx=0&nlaidx=7.

[363] HUM. RES. DIV., U.S. GEN. ACCT. OFF., GAO/HRD-90-84, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION 3 (1990).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

Three decades later, the GAO is still calling for clearer standards for tax-exempt hospitals.[364] Some state courts also raised the alarm about improper hospital tax exemptions decades ago, though the problem persists.[365] Below, we outline several recommendations to address this longstanding problem.

A. Better Federal Standards and Enforcement

The problems of the federal Community Benefit Standard are well-documented.[366] We agree a clearer standard is needed. Without more robust enforcement, however, a clearer standard will be meaningless. Congress's last attempt to ensure hospitals earned their tax exemptions offers a perfect example. In passing the Affordable Care Act, Congress imposed reporting requirements on hospitals that were designed to give the IRS necessary information to enforce the Community Benefits Standard.[367] More than a decade later, the GAO concluded that the IRS is still woefully underenforcing its tax exemption standards.[368] Below, we propose a few improvements to both the federal standard and federal enforcement mechanisms.

The Community Benefit Standard is too nebulous to ensure that hospitals earn their tax exemptions. The current mélange of potential "community benefits" that a hospital may claim to provide does not adequately incentivize hospitals to provide direct aid to communities. To take one example, hospitals often claim that money invested in "research" should count as a community benefit.[369] But counting all research spending as community benefit poses at least two problems. First, hospitals often enjoy a pecuniary benefit from the research they undertake—for example, hospitals typically own any intellectual property developed as a result of their

[364] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 160.

[365] *See, e.g.*, Utah Cnty. *ex rel.* Cnty. Bd. of Equalization v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985) (pointing out that if "nonprofit hospitals, which charge fully for their services," are tax exempt because they relieve the government of a burden, "it might be argued that for-profit hospitals relieve a greater portion of the public 'burden' because they provide medical care without public subsidy.").

[366] *See, e.g.*, Colombo, *supra* 154, at 29 (arguing that the Community Benefit Standard "has failed as a legal test for tax exemption").

[367] *See supra* Section II.A.

[368] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 160, at 21–22.

[369] *See* Rick Pollack, *Lown Institute Report on Hospital Community Benefits Misses Mark*, AM. HOSP. ASS'N BLOG (Apr. 12, 2022, 12:22 PM), https://www.aha.org/news/blog/2022-04-12-lown-institute-report-hospital-community-benefits-misses-mark.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

research, meaning they can profit from any innovations their physicians develop.[370] Second, whether any given research will actually benefit the community that a hospital serves is not clear: for example, a hospital's research may focus on ailments that do not affect its community's citizens. Similarly, for the reasons described above, it would be appropriate for Congress and the IRS to scrutinize the propriety of counting hospitals' bad debts and claimed Medicaid and Medicare shortfalls as community benefits.[371]

We thus agree with the GAO that Congress should revise the Internal Revenue Code to specify which activities should count as community benefits. In doing so, we would advocate for at least a partial return to the pre-Community Benefit Standard requirement that a hospital provide some level of charity care. The IRS's move away from a charity care requirement was based on the (laughably) false premise that the advent of government insurance programs would eliminate the existence of patients in need of free care: no one could question the enormous need for charity care.[372] With both tax-paying and tax-exempt hospitals providing minimal amounts of charity care, Congress should consider setting a clear numerical charity care requirement that tax-exempt hospitals must meet.

In crafting these more concrete changes to how the IRS determines the propriety of a hospital tax exemption, we think Congress should provide more general guideposts regarding the tax-exemption standard. Currently, the only statutory standard is that hospitals must be "organized and operated exclusively for . . . charitable . . . purposes" and meet the additional requirements created by the Affordable Care Act.[373] As shown in the discussion of Pennsylvania's *HUP* test, however, what constitutes a "charitable" organization is a multi-faceted question. We think that the five prongs of the *HUP* test provide appropriate guardrails for making such determinations and properly align exemption decisions with the public policy purpose of providing charitable tax exemptions. We would encourage lawmakers to carefully consider the underlying philosophy of tax exemptions—that is to say, a quid pro quo for a charity's direct benefit to their community—and

---

[370] DELOITTE CTR. FOR HEALTH SOLUTIONS, DELOITTE 2017 SURVEY OF US HEALTH SYSTEM CEOS: MOVING FORWARD IN AN UNCERTAIN ENVIRONMENT 15 (2017) (explaining that hospitals and health systems can "capitalize on their intellectual property," because "[o]nce the hospital has filed for patent or copyright protections, it can sell or license the IP to other industry stakeholders").

[371] *See supra* Section I.B.2.

[372] *See supra* text accompanying notes 5–10.

[373] I.R.C. § 501(c)(3), (r).

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

provide the IRS clear guidance so that its exemption decisions align with that purpose.

Congress should also consider earmarking funding for the IRS's Tax Exempt and Government Entities Division.[374] The recent GAO report on hospital tax exemptions makes clear that the IRS is not allocating adequate resources to scrutinizing hospital exemption applications.[375] For example, the GAO's analysis identifies thirty hospitals that reported *no* spending on community benefits.[376] If Congress is serious about ensuring hospitals earn their tax exemptions, it must ensure that the IRS is committing adequate funding to the IRS division tasked with policing those exemptions.

If Congress is not inclined to require the IRS to allocate more funding to its Tax Exempt Division in order to step up enforcement, Congress could empower citizens to carry the torch by creating a *qui tam* procedure for challenging unjustified hospital exemptions. The False Claims Act[377]—a highly effective law designed to uncover and stop contractors from defrauding federal programs—serves as a model. That Act permits private individuals to challenge fraudulent practices, though the Attorney General's consent is required to dismiss the action.[378] This enables the Department of Justice to enlist private resources to combat such fraud. Congress could develop a similar program for challenging tax exemptions. This would solve the current standing bar to citizen-led tax exemption challenges.[379] It would have the added benefit of encouraging the common-law development of the law surrounding hospital tax exemptions.

With the IRS's limited resources and stunted exemption standard, the federal taxing authority has failed to account for major changes in hospital organization and operation. As a result, the federal government forgoes billions of tax dollars annually[380]—tax dollars that the federal government could use to provide the very

[374] Congress could do this by adding funding to the IRS's budget earmarked for exemption enforcement, or it could direct the IRS to allocate more of its existing budget to that purpose.

[375] *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 160, at 21.

[376] *Id.*

[377] 31 U.S.C. §§ 3729–32.

[378] *Id.* § 3730(b).

[379] *See supra* Section II.A.

[380] EY, ESTIMATES OF THE FEDERAL REVENUE FORGONE DUE TO THE TAX-EXEMPTION OF NON-PROFIT HOSPITALS COMPARED TO THE COMMUNITY BENEFIT THEY PROVIDE, 2019, at 2 (May 2022),

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

healthcare benefits that hospitals currently claim but often fail to provide their communities.

B. Decoupling State and Federal Standards and Empowering Local Taxing Districts

States have their own roles to play in bringing about the needed course correction for hospital tax exemptions. We make two major recommendations in this regard: (1) states should decouple their tax exemption standards from the federal standard; and (2) states should empower local governments to challenge tax exemptions that affect their budgets.

As noted above, when it comes to state income and sales taxes, most states abdicate their exemption decisions to the federal government by granting exemptions to any organization that qualifies for a federal tax exemption.[381] Some states even delegate property tax exemption decisions to the IRS.[382] States should repeal and replace any law that bases state tax exemptions entirely on federal tax exemptions. For the reasons described above, there is currently no reason to believe that federal exemption decisions fulfill the central policy aim of tax exemptions: trading direct benefits to communities for tax relief. In place of those laws, we would encourage state legislatures to consider a standard like the one announced in *HUP*. That standard is flexible enough to account for past and future changes in hospital organization and operation, and it hews closely to the policy aims that hospital tax exemptions are meant to serve.

States should also empower and encourage the common-law development of their tax-exemption standards. As detailed throughout this Article, neither the nature of charity nor the nature of hospital operations is stagnant. As our current conundrum illustrates, standards that are too rigid or are too infrequently revisited risk permitting tax exemptions long after the justification for such exemptions has faded. Pennsylvania's system of permitting taxing districts to challenge exemption decisions and its adaptable legal standard have created a fertile environment for hospital tax exemption decisions to evolve alongside changes in hospital organization and operation. Neither the standard nor the procedure are alone sufficient—states need to implement both better exemption standards and better

---

https://www.aha.org/system/files/media/file/2022/06/E%26Y-Benefit-of-of-Tax-Exemption-Report-FY2019-FINAL-with-links.pdf.

[381] *See supra* Section II.B.

[382] *Id.*

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu

processes for enforcing them. Even Pennsylvania could improve its current process by hastening the speed with which such cases advance through the court system.

CONCLUSION

Hospital tax exemptions are in dire need of a course correction. Multibillion-dollar hospital systems are currently permitted to avoid taxes without having to make a concrete showing that the benefits they provide to their communities in fact justify their exemptions. As a result, modern hospitals seem more like Wayward Samaritans than the Good Samaritan their forebears emulated. Pennsylvania provides at least some answers to the now longstanding question of how communities can restore tax-exempt hospitals to their charitable function and ensure their conduct justifies the wealth of tax benefits that their communities forgo.

ISSN 0041-9915 (print) 1942-8405 (online) ● DOI 10.5195/lawreview.2023.981
http://lawreview.law.pitt.edu