

PROPERTY TAX EXEMPTIONS FOR
HOSPITALS:
A BLUNT INSTRUMENT WHERE A SCALPEL IS
NEEDED

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I. INTRODUCTION

The hospital industry in the United States has entered a crucible. Though the financial state of nonprofit hospitals has improved recently, many are still struggling to cope with sweeping regulatory reform and a changing healthcare landscape.¹ They are attempting to accommodate a wave of newly insured patients without sacrificing quality of care.² Nonprofit hospitals largely enjoy tax exemption, but are facing challenges from state governments in both courtrooms and statehouses.³ There is widespread dissatisfaction with the status quo. From a tax perspective, the primary problem is that hospitals no longer fit the mold of traditional charitable institutions. When the tax exemption rules were written, hospitals were places where only the indigent sought care, the providers of last resort. They did not charge for their services and were staffed primarily by volunteers.⁴ Since then, hospitals have become the nexus of the United States healthcare system. They now host the world's best doctors and cutting-edge medical technology. And, they have become larger and more business-oriented.⁵

Despite the increasing complexity of hospitals as institutions, the rules granting them tax exemption have remained relatively general. At the federal level, they have historically been exempt under Internal Revenue Code (I.R.C.) § 501(c)(3), the provision exempting charitable institutions generally, since the late nineteenth century.⁶ The first hospital-specific rules in the I.R.C. were added in 2010 through the Patient Protection and Affordable Care Act (ACA).⁷ The current test, the “community-benefit standard,” has been criticized for awarding nonprofit hospitals de facto exemption.⁸ Every state has rules that allow nonprofit hospitals to gain exemption from property taxes.⁹ Some of

¹ *Moody's Revises US Not-For-Profit Healthcare Outlook to Stable from Negative as Cash Flows Increase*, MOODY'S (Aug. 26, 2015), http://www.moody's.com/research/Moodys-revises-US-not-for-profit-healthcare-outlook-to-stable--PR_333323 [<http://perma.cc/6MSE-R77X>]; Paul Demko, *As Rural Hospitals Struggle, Solutions Sought to Preserve Healthcare Access*, MODERN HEALTHCARE (May 16, 2015), <http://www.modernhealthcare.com/article/20150516/MAGAZINE/305169959> [<http://perma.cc/8A3S-MGYT>].

² *Medicaid and CHIP Enrollment Data*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-enrollment-data.html> [<http://perma.cc/Z85G-WDNH>]; Kathleen O'Brien, *Who Will Treat the Flood of Obamacare Medicaid Patients?*, NJ.COM (Feb. 5, 2015), http://www.nj.com/healthfit/index.ssf/2015/02/where_will_400k_new_nj_medicaid_patients_get_care.html [<http://perma.cc/566G-ZGQG>].

³ See *Provena Covenant Med. Ctr. v. Dep't 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); Stephanie Strom, *States Move to Revoke Charities' Tax Exemptions*, N.Y. TIMES (Feb. 27, 2010), <http://www.nytimes.com/2010/02/28/us/28charity.html> [<http://perma.cc/PEB2-6MND>].

⁴ *AHS Hosp. Corp.*, 28 N.J. Tax at 478-95; Barbara Mann Wall, *History of Hospitals*, U. OF PA. SCH. OF NURSING, <http://www.nursing.upenn.edu/nhhc/Pages/History%20of%20Hospitals.aspx> [<http://perma.cc/PEB2-6MND>]; Mark C. Westenberger, *Tax-Exempt Hospitals and the Community Benefit Standard: A Flawed Standard and a Way Forward*, 17 FLA. TAX REV. 407, 418-20 (2015).

⁵ Wall, *supra* note 4.

⁶ I.R.C. § 501(c)(3); Westenberger, *supra* note 4.

⁷ Patient Protection and Affordable Care Act § 9007, 42 U.S.C. § 18001 (2010); I.R.C. § 501(r).

⁸ M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 300-01 (1995).

⁹ Martha H. Somerville et al., *Hospital Community Benefits After the ACA: The State Law Landscape*, THE HILLTOP INSTITUTE (Mar. 2013), <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-StateLawLandscapeIssueBrief6-March2013.pdf> [<http://perma.cc/R3CC-QHF2>].

these systems are even older than the federal level exemption.¹⁰ Nearly half of the states draw from the federal standard and require hospitals to demonstrate some form of community benefit to receive exemption.¹¹

In this Note, I argue that the state level property tax rules governing tax exemption for hospitals are in dire need of reform. Other commentators have suggested changing the metrics used to determine eligibility for tax exemption, usually focusing on federal level exemptions, but these proposals are insufficient.¹² Hospitals are complex institutions with viable for-profit analogues. Yet, they perform socially beneficial services that are worthy of subsidy through the tax system. An effective system must acknowledge and embrace this complexity. I argue that an all-or-nothing exemption is inadequate in the hospital sector and should be replaced by a more flexible system of tax credits. Credits should be provided to hospitals to offset the cost of performing traditional charity care and providing services that would otherwise be difficult for communities to access. This will allow state governments to focus their subsidies on the socially beneficial functions that hospitals offer and avoid interfering in legitimately competitive markets. While the critiques and proposed reforms I discuss could be applied to all tax exemptions for hospitals at both the state and federal levels, there are compelling reasons to begin with state property tax exemptions.

In this Note, I argue that the current system of property tax exemptions in every state is in need of reform. In Part II, I provide background information on the history of United States hospitals; the history of tax exemption for hospitals at the federal and state levels; and an overview of current federal and state tax exemption standards for hospitals. I discuss the federal standards because federal policy currently informs state level exemptions to a significant degree. In Part III, I discuss why reform is needed. Finally, in Part IV, I propose a solution that replaces traditional property tax exemptions with a series of tax credits based on the costs hospitals accrue from performing socially beneficial functions that serve the indigent or extend access to underserved populations.

II. BACKGROUND

A. Hospitals in the United States

Though hospitals have long been exempt from tax at both the state and federal levels, modern hospitals are far different from the institutions that existed at the turn of the twentieth century. Early hospitals were truly charitable institutions. They were places where the poor could go for treatment when better options were not available. They were funded almost entirely by donations and staffed primarily by volunteers.¹³

¹⁰ See, e.g., *AHS Hosp. Corp.*, 28 N.J. Tax at 484-86 (indicates that New Jersey hospitals have been exempt from tax since 1851); KY. CONST. § 170 (provision in Kentucky Constitution used by modern hospitals to secure tax exemption was originally ratified in 1891).

¹¹ Somerville et al., *supra* note 9.

¹² E.g., Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B. C. L. REV. 1, 101-10 (1995);

John D. Colombo, *Health Care and Tax Exemption: The Push and Pull of Tax Exemption Law on the Organization and Delivery of Health Care Services: The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 52-64 (2005); Jessica Berg, *Putting the Community Back into the "Community Benefit" Standard*, 44 GA. L. REV. 375, 391-95 (2010).

¹³ Tamara R. Coley, *Note: Extreme Pricing of Hospital Care for the Uninsured: New Jersey's Response and the Likely Results*, SETON HALL LEGIS. J. 275, 279 (2010).

The best private physicians would generally work by administering care to clients of means through direct home visits or small clinics.¹⁴ This model predominated until the end of the nineteenth century.¹⁵ Between the 1890s and 1920s, technological advancements made it possible for hospitals to offer sophisticated care to certain patients in ways that private physicians could not. Hospitals became the source of the country's best medical care and education.¹⁶ Beginning in the 1930s and throughout World War II, the advent and proliferation of hospital insurance pulled more and more paying customers into hospitals.¹⁷ This was the first period in history in which hospitals became dependent on paying patients and paid staff rather than charitable donations and volunteers.¹⁸ In 1965, the creation of Medicare and Medicaid accelerated this trend even further.¹⁹

Today, nonprofit hospitals rely almost entirely on fees collected from patients; charitable donations constitute a negligible portion of their revenues.²⁰ Modern hospitals, for-profit and nonprofit alike, have facilities, equipment, staff, and specialists at the forefront of medical science. Though no hospital is prepared to treat every possible ailment, it is generally expected that the best care of every kind will take place at some hospital.²¹ Modern hospitals are complex institutions; they occupy huge campuses, contain advanced medical equipment, and employ large full-time staffs of doctors, nurses, administrators, and more.²² Despite these changes, however, nonprofit hospitals have generally retained their tax-exempt status at both the federal and state levels.

B. Federal Tax Exemption for Hospitals

1. History of Federal Tax Exemption for Hospitals

At the federal level, lawmakers have sought to exclude charities from taxation since before the advent of the modern federal income tax. The Wilson-Gorman Tariff Act of 1894 imposed a 2% tax on corporate income, but excluded "corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes."²³ Though the 1894 statute would later be found unconstitutional for other reasons, the Revenue Act of 1909 contained a similar provision that exempted charitable organizations, "no part of the net income of which inures to the benefit of any private stockholder or individual," marking the first requirement that tax-exempt organizations be not for-profit.²⁴ The Revenue Act of 1913, which established the

¹⁴ *Id.*

¹⁵ *Id.* at 279-80; Wall, *supra* note 4 at 2-3; M. Gregg Bloche, *Tax Preferences for Nonprofits: From Per Se Exemption to Pay-For-Performance*, 25 HEALTH AFFAIRS W304 (Jun. 20, 2006), <http://content.healthaffairs.org/content/25/4/W304.full> [<http://perma.cc/QTL7-EFBL>].

¹⁶ Wall, *supra* note 4 at 2-3; Bloche, *supra* note 15.

¹⁷ Bloche, *supra* note 15.

¹⁸ Wall, *supra* note 4 at 2-3.

¹⁹ Bloche, *supra* note 15.

²⁰ Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 319-20 (1991).

²¹ Wall, *supra* note 4 at 4-5.

²² See *Provena Covenant Med. Ctr.*, 925 N.E.2d 1131, 1136-38 (Ill. 2010); *AHS Hosp. Corp.*, 28 N.J. Tax. at 471, 474.

²³ Paul Arnsberger et al., *A History of the Tax Exempt Sector: An SOI Perspective*, INTERNAL REVENUE SERVICE STATISTICS OF INCOME BULLETIN (WINTER 2008) 105, 106, <http://www.irs.gov/pub/irs-soi/tehistory.pdf> [<http://perma.cc/2TWK-89YZ>].

²⁴ *Id.* at 107.

modern federal income tax system, included nearly identical language.²⁵ At that time, hospitals were recognized as organizations that generally fit this provision, and though additional requirements have proliferated, nonprofit hospitals have been included among the entities eligible for exemption from the federal income tax ever since.²⁶

Because hospitals were initially purely charitable, their tax-exempt status was rarely challenged.²⁷ As they evolved into more commercial entities, their de facto tax-exempt status came into question. In 1956, the Internal Revenue Service sought to clarify the application of I.R.C. § 501(c)(3) through Revenue Ruling 56-185.²⁸ This created the “charity care” standard. The ruling stated that a hospital must provide care “to the extent of its financial ability” for those unable to pay to retain tax-exempt status.²⁹ The Service conceded that a tax-exempt hospital could charge certain patients for services, but that the exemption would be lost if it operated “with the expectation of full payment from all those to whom it renders service.”³⁰

In 1965, Congress created Medicare and Medicaid through amendments to the Social Security Act.³¹ Hospital administrators worried that the rapid expansion of health insurance coverage to the indigent and elderly would jeopardize their tax-exempt status simply because far fewer people would be unable to pay for their services.³² Under pressure from stakeholders in the healthcare industry, the IRS issued Revenue Ruling 69-545 in 1969. This ruling created the modern “community benefit” standard.³³ The standard was quickly challenged by groups representing indigent persons in need of care.³⁴ The Ruling was struck down by the District Court, but was ultimately upheld by the D.C. Circuit.³⁵ The Supreme Court took the case and held that the plaintiffs had no standing to sue.³⁶ This effectively upheld the Revenue Ruling, and it remains intact today.

2. *Modern Federal Tax Exemption for Hospitals: The Community Benefit Standard*

Understanding the federal standard is important to the analysis of state property tax exemptions because the federal standard has influenced state law. In addition to the four states that predicate property tax exemption on the maintenance of federal tax-exempt status, twenty-five states utilize some form of the community benefit standard.³⁷

Formally, nonprofit hospitals are granted federal tax exemption under I.R.C. § 501(c)(3). That section provides an exemption from the federal income tax for entities

²⁵ *Id.*

²⁶ See Westenberger, *supra* note 4 at 414-23.

²⁷ *Id.* at 420.

²⁸ Rev. Rul. 56-185, 1956-1 C.B. 202.

²⁹ *Id.*

³⁰ *Id.*

³¹ S.S.R. Cum. Ed., Pub. L. No. 89-97, 79 Stat. 286 (1965).

³² Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL'Y & L. 251, 259-62 (1991).

³³ Rev. Rul. 65-545, 1969-2 C.B. 117.

³⁴ *Eastern Kentucky Welfare Rights Organization v. Schultz*, 370 F. Supp. 325, 326-27 (D.D.C. 1973).

³⁵ *Id.* at 338; *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278 (D.C. Cir. 1974).

³⁶ *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976).

³⁷ Somerville et al., *supra* note 9.

“organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes” that are operated on a nonprofit basis and do not intervene in or attempt to influence the political process.³⁸ Under the community benefit standard, hospitals meet these requirements because they promote the health of a significant portion of their community, not necessarily because they provide services to the indigent. Rev. Rul. 69-545 suggests that nonprofit hospitals should be exempt from tax by virtue of the fact that they provide medical services alone,³⁹ but some courts have interpreted the standard to require some proof that benefiting the public is the primary aim of the hospital.⁴⁰ While certain activities listed on Schedule H of Form 990 – including providing charity care, conducting health education programs, and health advocacy efforts – have been accepted as indications that a hospital provides community benefits, no single activity is necessary or sufficient to meet the standard.⁴¹

The most significant change to the community benefit standard since 1969 was the addition of I.R.C. § 501(r) through the Patient Protection and Affordable Care Act passed in 2010.⁴² Section 501(r) creates two new major requirements that hospitals must meet to qualify for tax exemption under § 501(c)(3). First, hospitals must prepare a Community Health Needs Assessment (CHNA) every three years.⁴³ A CHNA is a report based on data collected from the community served by a hospital identifying the major health challenges facing that community and laying out a plan for the hospital to better address them in the coming years.⁴⁴ Second, hospitals must create a Financial Assistance Plan (FAP) that delineates how the hospital will determine whether a patient is eligible for free or reduced-cost care and make the plan freely accessible for the public.⁴⁵ Section 501(r) also requires that individuals that qualify for assistance under the FAP cannot be charged more for the services they use than an individual with insurance coverage and that hospitals take reasonable steps to determine whether a patient is covered by the FAP before initiating extraordinary collections actions.⁴⁶ These requirements force hospitals to more clearly demonstrate the benefits they confer on their communities.⁴⁷

C. State Property Tax Exemption for Hospitals

I. *Overview of the History of State Property Tax Exemptions for Hospitals*

³⁸ I.R.C. § 501(c)(3).

³⁹ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁴⁰ See, e.g. *Geisinger Health Plan v. Comm’r of Internal Revenue*, 985 F.2d 1210 (3rd Cir. 1993) (holding that a health maintenance organization did not qualify for exemption because it created benefits only for its paid subscribers); *IHC Health Plans, Inc. v. Comm’r of Internal Revenue*, 325 F.3d 1188 (10th Cir. 2003) (holding that “not every activity that promotes health supports tax exemption” and that HMOs do not create benefits for their communities beyond their paying customers).

⁴¹ 2015 FORM 990: SCHEDULE H, HOSPITALS, <http://www.irs.gov/pub/irs-pdf/f990sh.pdf> [<http://perma.cc/P76R-PNZ3>].

⁴² Patient Protection and Affordable Care Act § 9007, 42 U.S.C. § 18001 (2010).

⁴³ I.R.C. § 501(r)(3).

⁴⁴ *Id.*

⁴⁵ *Id.* § 501(r)(4).

⁴⁶ *Id.* § 501(r)(5)-(6).

⁴⁷ See Susannah Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33 (2015).

In many states, hospitals have been exempt from property taxes for even longer than they have been exempt from the federal income tax. In New Jersey, for example, many hospitals qualified under the state's first property tax exemption statute, passed through the Laws of 1851, which exempted charitable and religious organizations generally.⁴⁸ The first specific exemption for hospitals was created in 1913 and has remained essentially unchanged through the modern day.⁴⁹ In 1898, Kentucky added a section to its constitution exempting charitable organizations from state taxes, a provision that to this day serves as the basis by which nonprofit hospitals claim tax exemption in that state.⁵⁰ Currently, all fifty states contain some provision by which hospitals can claim exemption from property taxes.⁵¹ Some states have altered their standards over time, either statutorily or through case law. Others have continued to grant hospitals per se tax-exempt status with no significant challenges.

2. *Overview of Modern Standards of State Property Tax Exemptions for Hospitals*

Hospitals are eligible for exemption from property taxes in all fifty states. While no two states have identical property tax rules, some commonalities do exist. No state extends full property tax exemption to for-profit hospitals; each one contains a limitation prohibiting hospitals from generating revenue that inures to private interests.⁵² Each state also imposes some other limitation that hospitals must meet to gain tax-exempt status.

Hospitals can most commonly claim exemption from state property taxes through a provision of the state's law that applies specifically to hospitals. Thirty-two different states have exemptions that apply only to hospitals or health care centers, but even within this group, significant variations exist.⁵³ Some of these states, like Washington, Kansas, and New York, require that the property for which exemption is sought is used primarily or exclusively for hospital purposes.⁵⁴ Others, including Indiana and Colorado, require that the property be owned by a hospital and used for charitable purposes.⁵⁵ In certain states, hospital-specific exemptions are constrained. For example, Nevada specifically exempts the land and buildings owned by hospitals, but the provision does not cover personal property like equipment and supplies.⁵⁶ This property can only be granted exemption under a statute that applies to charitable organizations generally.⁵⁷ Alabama

⁴⁸ *AHS Hospital Corp.*, 28 N.J. Tax at 485.

⁴⁹ *Id.* at 491.

⁵⁰ KY. CONST. § 170.

⁵¹ Somerville et al., *supra* note 9.

⁵² *Id.*

⁵³ States: AL, AK, AZ, CA, CO, FL, GA, HI, ID, IL, IN, KS, CT, MD, MS, MT, NV, NJ, NY, NC, ND, OK, RI, SC, SD, TX, UT, VA, WA, WV, WI, WY. See *A 50-State Survey of State Community Benefit Laws through the Lens of the ACA*, THE HILLTOP INSTITUTE, http://www.hilltopinstitute.org/hcbp_cbl.cfm [<http://perma.cc/28P2-ZY3X>] [hereinafter "*A 50 State Survey*"].

⁵⁴ WASH. REV. CODE § 84.36.040 (West 2010); KAN. STAT. ANN. § 79-201b (2015); N.Y. Real Prop. Tax Law § 420-a.

⁵⁵ IND. CODE § 6-1.1-10-16 (2016); COLO. REV. STAT. § 39-3-108 (2016).

⁵⁶ NEV. REV. STAT. § 361.083 (2010) (exempts real property owned by a nonprofit hospital that treats orphans or the indigent).

⁵⁷ NEV. REV. STAT. § 361.140 (2010) (exempts all property owned by a nonprofit public charity and used for the charity's purpose).

exempts all property used for hospital purposes, but only up to an amount of \$75,000.⁵⁸ Beyond that, hospitals must rely on a more general statute.⁵⁹

The other eighteen states do not have a property tax exemption that applies specifically to hospitals. In each of these states, hospitals must rely on a statute that exempts charitable institutions in general.⁶⁰ Usually, these provisions require that the property in question be used and the organization owning it be organized exclusively or primarily for charitable purposes.⁶¹ Most of these states apply a test similar to the federal charity-care standard.⁶² Some states in this category also impose additional restrictions. Iowa, for example, only allows an exemption for a maximum of 320 acres of real property held by charitable institutions and used for tax-exempt purposes.⁶³

A majority of states have adopted some measure of community benefit as a requirement for property tax exemption. In one way or another, twenty-nine states require hospitals to qualify as tax-exempt organizations under I.R.C. § 501(c)(3) to be eligible for exemption from property taxes.⁶⁴ Eighteen states impose an independent community benefit requirement on hospitals seeking exemption from property taxes.⁶⁵ These often deviate significantly from the federal standard. For example, California accepts a wide variety of activities as evidence of community benefit, including educational programs, child care programs, and the sponsorship of charitable activities that promote health in some way, like food drives.⁶⁶ Florida, by contrast, conditions property tax exemption on qualification under I.R.C. § 501(c)(3), but also requires all nonprofit hospitals to provide a separate, state-level community benefit, which is defined solely as the provision of charity care and participation in the Medicaid program.⁶⁷

To summarize, state standards vary considerably. Some states generally exempt hospitals from property taxes as long as the hospital operates on a nonprofit basis and works primarily to benefit the community, much like the current federal standard. Others have narrower requirements and hew more closely to the old federal charity care standard.

III. THE PROBLEM

A. Challenges Facing Modern Nonprofit Hospitals

1. *Hospitals Face Thin Profit Margins and Struggle to Continue Operations*

Many nonprofit hospitals face difficult financial situations. As a result, many hospitals choose to merge into ever-growing hospital systems or to eschew tax-exempt

⁵⁸ ALA. CODE § 40-9-1(2) (2016) (exempts property used for “hospital purposes” up to \$75,000).

⁵⁹ ALA. CODE § 40-9-1(1) (1975) (exempts all property used “for purposes purely charitable”).

⁶⁰ States: AR, DE, IA, KY, LA, ME, MA, MI, MN, MO, NE, NH, NM, OH, OR, PA, TN, VT. See *A 50-State Survey*, *supra* note 53.

⁶¹ See *A 50-State Survey*, *supra* note 53.

⁶² See Rev. Rul. 56-185, 1956-1 C.B. 202.

⁶³ IOWA CODE § 427.1(8)(a) (2016).

⁶⁴ See *A 50-State Survey*, *supra* note 53.

⁶⁵ Somerville et al., *supra* note 9 at 4.

⁶⁶ CAL. HEALTH & SAFETY CODE § 127345(c) (West 1996).

⁶⁷ FLA. STAT. § 617.2002 (1990).

status altogether and become for-profit.⁶⁸ No two institutions are the same, and struggling hospitals can be plagued by an array of challenges, from incompetent and inefficient management to the lingering specter of malpractice lawsuits.⁶⁹ However, one of the most frequently mentioned problems facing most hospitals and a main driver of the recent trend towards the consolidation of healthcare services is far more banal: low reimbursement rates.

In a survey of hospital CEOs regarding the greatest financial challenges hospitals faced in 2015, the second and third most common responses were Medicaid reimbursement rates and bad debt from uncollectable fees.⁷⁰ Proponents of hospital consolidation argue that mergers are justified by economies of scale; larger hospital systems can more easily coordinate patient care and spread fixed costs, resulting in better care and lower costs for all.⁷¹ However, health economists have generally found little evidence to support this claim.⁷² Waves of hospital mergers, most recently in the 1990s and late 2000s, have been correlated with substantial price increases and no accompanying improvement in care quality.⁷³ Finding that administrators' stated reasons for merging are, at least to a degree, pretextual, many researchers believe that one of the main advantages sought by merging hospitals is bargaining power. In other words, a large hospital system with fewer competitors can more easily negotiate higher reimbursement rates with insurance companies.⁷⁴

The bargaining power narrative is at least facially supported by the fact that both recent waves of mergers coincided with increased access to healthcare for the poor. Between 1990 and 1995, the peak of the merger wave, Medicaid added almost thirteen million enrollees, a significant percentage of whom were children.⁷⁵ More recently, the Affordable Care Act extended the Medicaid program to cover more than thirteen million

⁶⁸ See Leemore Dafny, *Hospital Industry Consolidation – Still More to Come?*, 370 NEW ENG. J. MED. 198 (2014); Karen E. Joynt et al., *Association Between Hospital Conversions to For-Profit Status and Clinical and Economic Outcomes*, 312 JAMA 1644 (2014).

⁶⁹ Eugene Litvak, *Mismanaged Hospital Operations: A Neglected Threat to Reform*, HEALTH AFF. BLOG (Feb. 22, 2011), <http://healthaffairs.org/blog/2011/02/22/mismanaged-hospital-operations-a-neglected-threat-to-reform/> [<http://perma.cc/4JTX-YKVJ>]; Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFFAIRS 1569, (Sept. 2010), <http://content.healthaffairs.org/content/29/9/1569.full.pdf+html> [<http://perma.cc/manage/create?url=http://content.healthaffairs.org/content/29/9/1569.full.pdf+html>].

⁷⁰ *Top Issues Confronting Hospitals in 2015*, AM. C. OF HEALTHCARE EXECUTIVES (Feb. 2016), <http://www.ache.org/pubs/research/ceoissues.cfm> [<http://perma.cc/NGR9-FPWD>].

⁷¹ Kenneth Davis, *Hospital Mergers Can Lower Costs and Improve Medical Care*, WALL ST. J. (Sep. 15, 2014), <http://www.wsj.com/articles/kenneth-l-davis-hospital-mergers-can-lower-costs-and-improve-medical-care-1410823048> [<http://perma.cc/V8FH-H5AM>]; James Ellis & Aaron Razavi, *3 Reasons Why Hospital Mergers are Advantageous*, HEALTHCARE FINANCE (Feb. 8, 2012), <http://www.healthcarefinancenews.com/blog/3-reasons-why-hospital-mergers-are-advantageous> [<http://perma.cc/YM5B-QV9Z>].

⁷² See Thomas C. Tsai & Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?*, 312 JAMA 29 (2014); Leemore Dafny, *The Good Merger*, 372 NEW ENG. J. MED. 2077 (2015).

⁷³ See Tsai & Jha, *supra* note 72; Dafny, *supra* note 72; William Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price & Quality of Hospital Care?*, THE SYNTHESIS PROJECT (2006).

⁷⁴ See Vogt & Town, *supra* note 73.

⁷⁵ *Medical Enrollment and Spending*, KAISER COMM'N (Sept. 1999), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-enrollment-and-spending-trends-fact-sheet-2.pdf> [<http://perma.cc/8AJF-8ZN8>]; Vogt & Town, *supra* note 73.

new people.⁷⁶ While these expansions have improved access to care for vulnerable populations, Medicaid is notorious for offering very low reimbursement rates to hospitals.⁷⁷ This trend has only gotten worse, and has been exacerbated by growing losses attributable to the Medicare program.⁷⁸ It makes sense that hospitals would want to improve their profit margins in situations where they can bargain to offset an influx of patients covered by Medicaid and growing losses from Medicare.

There is evidence that the factors pushing hospitals to become for-profit are similar. The recent trend towards for-profit conversion geographically mirrors the wave of consolidation; both are most frequent in the South.⁷⁹ And criticisms aside, it is clear that both have beneficial effects on hospitals' financial health.⁸⁰

The hospitals of the nineteenth century were established almost exclusively to care for the poor and the elderly. The realities of modern hospital finance, however, push hospitals to run from that legacy. Medicare and Medicaid reimburse at much lower rates than private insurance.⁸¹ Practices that have a high rate of Medicare and Medicaid patients, like obstetrics, tend to operate at a loss,⁸² but are also vital services that would be extremely difficult to access if not provided by nonprofit hospitals.⁸³ This is especially true in rural areas that tend to have the highest percentages of individuals covered by Medicare or Medicaid.⁸⁴ The result is that hospitals, especially in areas that are poor and rural, have conflicting incentives. They provide services that are necessary to keep their tax exemption, but those same services cost the hospitals money and make it more difficult for them to continue operating at all.

2. *Hospitals' Tenuous Hold on Property Tax Exemptions*

⁷⁶ Table 1A: *Medicaid and CHIP: June and July 2016 Monthly Enrollment Updated September 2016*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid/program-information/downloads/updated-july-2016-enrollment-data.pdf> [<http://perma.cc/6JYB-C4TQ>].

⁷⁷ Stephen Zuckerman et al., *Trends in Medicaid Physician Fees, 2003-2008*, 28 HEALTH AFFAIRS w510, (June 2009), <http://content.healthaffairs.org/content/28/3/w510.full> [<http://perma.cc/5KH5-6S72>].

⁷⁸ See AM. HOSP. ASS'N, *Hospital Payment Shortfall Relative to Costs for Medicare, Medicaid, and Other Government, 1997-2014* (May 12, 2016), <http://www.aha.org/research/reports/tw/chartbook/2016/chart4-7.pdf> [<http://perma.cc/6V8M-7VZA>].

⁷⁹ See Vogt & Town, *supra* note 73; Joynt et al., *supra* note 68.

⁸⁰ See Joynt et al., *supra* note 68; J. Kevin Holloran et al., *U.S. Not-For-Profit Health Care Sector Revised To Stable from Negative, Though Uncertainties Persist*, STANDARD & POOR'S GLOBAL CREDIT PORTAL (Sept. 9, 2015), http://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1448167&SctArtId=339491&from=CM&nsl_code=LIME&sourceObjectId=9325791&sourceRevId=1&fee_ind=N&exp_date=20250908-20:11:39 [<http://perma.cc/T68M-9A9R>] (indicating that improvements in hospital finances attributable to frequent mergers).

⁸¹ See AM. HOSP. ASS'N, *Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare and Medicaid, 1994-2014* (May 12, 2016), <http://www.aha.org/research/reports/tw/chartbook/2016/chart4-6.pdf> [<http://perma.cc/MS3E-MCPJ>].

⁸² See John Commins, *Obstetrics a Money-Losing Challenge for Rural Hospitals*, HEALTH LEADERS MEDIA (Apr. 8, 2015), <http://healthleadersmedia.com/page-2/COM-315108/Obstetrics-a-MoneyLosing-Challenge-for-Rural-Hospitals> [<http://perma.cc/A4GL-CUJ4>].

⁸³ Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-For-Profit Hospitals*, 50 UCLA L. REV. 1345, 1364-76 (2003) (finding that nonprofit hospitals provide undersupplied, unprofitable services at significantly higher rates than for-profits).

⁸⁴ *Id.*; Commins, *supra* note 82.

Though most nonprofit hospitals have traditionally received exemption from property taxes in every state, in recent years, both courts and legislatures around the country have begun to challenge this status quo.

Several states' taxing authorities have brought high-profile challenges against various hospitals' exemptions and won. In 2010, the Supreme Court of Illinois decided a case challenging the property tax exemption for much of the property located at the Provena Covenant Medical Center (PCMC), a nonprofit hospital owned and operated by Provena Hospitals.⁸⁵ At the time of the case, property was exempt from taxation in Illinois if it was "owned by an institution of public charity" and "actually and exclusively used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit."⁸⁶

The Illinois Department of Revenue denied Provena Hospitals' application for exemption regarding the PCMC campus in 2002, finding that Provena Hospitals was not a charitable institution and the property was not used for charitable purposes.⁸⁷ An administrative law judge reviewed the Department's decision and recommended that Provena Hospitals receive exemption for most of its property.⁸⁸ The Department disagreed with the recommendation and denied the exemption.⁸⁹ Provena Hospitals brought suit in the state trial court, which concurred with the administrative law judge and granted the exemption.⁹⁰ The appellate court reversed. Provena Hospitals then appealed to the Illinois Supreme Court, which upheld the Department of Revenue's denial of Provena Hospitals' application for property tax exemption for PCMC based on a finding that Provena Hospitals was not a charitable institution and the PCMC campus was not used in a charitable way.⁹¹

The court pointed to two major factors that swayed its decision. The first was the fact that PCMC was funded almost entirely by fees for services; of the hospital's \$118 million of total revenue, less than 4% came from sources other than fees, and less than \$7,000 came from charitable donations.⁹² The second was the fact that neither Provena Hospitals nor PCMC actively promoted PCMC's charity care program.⁹³ The hospital would treat indigent patients but would bill them as a matter of course and force those patients to apply for free or discounted care under the terms of the financial assistance program. The court found that fees waived under this program were treated more like bad debt than charitable work and that this approach led PCMC to provide charity care at a level far below the community's need for it.⁹⁴ Of the more than 110,000 admissions at PCMC in 2002, just 302 received financial assistance.⁹⁵ The court found that this number was slightly misleading; the hospital's charity care program gave patients discounts based on the fee that they would have charged otherwise, rather than the cost of providing the care to the hospital. Many of the discounts were smaller than the hospital's profit margin, so PCMC ended up with a net gain even when treating patients that qualified for

⁸⁵ *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1136.

⁸⁶ *Id.* at 1141; 35 ILL. COMP. STAT. 200/15-65(a) (West 2002).

⁸⁷ *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1141.

⁸⁸ *Id.*

⁸⁹ *Id.* at 1141-42.

⁹⁰ *Id.* at 1142.

⁹¹ *Id.* at 1146-47.

⁹² *Id.* at 1146.

⁹³ *Id.* at 1149.

⁹⁴ *Id.*

⁹⁵ *Id.* at 1150.

financial assistance.⁹⁶ The court also explicitly rejected arguments about other ways that PCMC created community benefit, noting that the state standard differed from the federal one.⁹⁷

In 2012, the Illinois legislature responded to *Provena* by enacting new property tax exemption rules for hospitals. Rather than conforming to the federal standard, the new rules clarified the definition of “charity” in the existing rules.⁹⁸ To receive a tax exemption for real and tangible personal property, an Illinois hospital must provide charity care or reduced-cost services for the indigent at levels at least equivalent to what that hospital would otherwise pay in property taxes.⁹⁹ Additionally, the new rules allow for-profit hospitals to receive limited tax credits against their property tax burden equal to the lesser of the real property taxes on hospital facilities and the amount spent providing free and discounted care.¹⁰⁰ While these new rules clarified the old standard, they are far from the de facto exemption offered by the federal community benefit standard, indicating that hospitals in Illinois with practices similar to those employed by PCMC remain vulnerable to legal challenges. Additionally, an Illinois appellate court recently held that the rules requiring a quantum of charity care and other services for a hospital to receive a property tax exemption (but not those granting tax credits to for-profit hospitals) violate the Illinois Constitution, so the standard applicable in *Provena* may return.¹⁰¹

In 2006, 2007, and 2008, the town of Morristown, New Jersey denied Morristown Medical Center’s (MMC’s) application for property tax exemption. MMC is one of several nonprofit hospitals owned and operated by Atlantic Health System (AHS) in New Jersey.¹⁰² This was the first time that a hospital’s entire property tax exemption was challenged in New Jersey.¹⁰³ After discussing MMC, AHS, and their structure and practices, the court traced the origin of tax exemptions for hospitals in the United States as a whole and in New Jersey. The court emphasized that the rules grew out of a desire to provide tax relief to charitable institutions and that the typical practices of hospitals had changed so drastically that they no longer fit into that label.¹⁰⁴ In New Jersey, as in every other state, taxation is the rule and exemption is the exception. Therefore, the court examined MMC with a critical eye and with a posture that any failure to meet the requirements contained in the statutory rules and clarifying case law would result in a loss of exemption.¹⁰⁵

At the time of the case, New Jersey exempted property “actually used in the work of associations and corporations organized exclusively for hospital purposes” and “not conducted for profit.”¹⁰⁶ In two prior letter opinions, the state tax court concluded that MMC was organized exclusively for hospital purposes and that the vast majority of its property was used for those purposes. The question remaining in this case, therefore, was

⁹⁶ *Id.*

⁹⁷ *Id.* at 1152

⁹⁸ 35 ILL. COMP. STAT. 200/15-86(a).

⁹⁹ *Id.* 15-86(c).

¹⁰⁰ 35 ILL. COMP. STAT. 5/223(a).

¹⁰¹ *Carle Foundation v. Cunningham Township*, 45 N.E.3d, 1173, 1180 (January 2016).

¹⁰² *AHS Hospital Corp.*, 28 N.J. Tax at 462, 470-71.

¹⁰³ *Id.* at 464.

¹⁰⁴ *Id.* at 478-95.

¹⁰⁵ *Id.* at 496 (quoting *Princeton University Press v. Borough of Princeton*, 172 A.2d 420 (N.J. 1961)).

¹⁰⁶ *Id.* at 495; N.J. STAT. ANN. § 54:4-3.6.

whether the property was used to generate profit.¹⁰⁷ The court held that, except for the parking lot, fitness center, and auditorium, every portion of the MMC campus used for hospital purposes was also used to generate profit and was therefore ineligible for tax exemption.¹⁰⁸

The court came to this conclusion through an exhaustive examination of the hospital's practices. It found that almost every worker in the hospital, from the majority of its physicians to its food and laundry service providers, was actually a for-profit contractor.¹⁰⁹ Though the association with for-profit service providers would not jeopardize AHS's nonprofit status, the same for-profit companies and individuals had access to and regularly used all of the property for which the hospital was claiming exemption.¹¹⁰ Both the identity of the taxpayer and the actual use of the property were essential components of the analysis. The court acknowledged that hospital employees had access to all of the same facilities and equipment, but noted that property used for a mix of exempt and non-exempt purposes is ineligible for exemption unless the two uses can be clearly separated.¹¹¹ In this instance, there was no distinction; for-profit physicians and staff could and did use every area of the hospital.¹¹²

In addition to the use of the property by certain for-profit entities, the court noted that AHS had direct control of various for-profit entities. The hospital group owned five separate for-profit physician practices that operated out of the MMC, an arrangement typically referred to as "captive P.C.'s."¹¹³ The court also highlighted a Cayman-based for-profit corporation that was a subsidiary of MMC. This corporation was presented as an insurance company, but the court concluded that it was functionally a reserve fund to cover unexpected liabilities. In other words, it was a way for the hospital to retain profits without formally retaining profits.¹¹⁴ The court also took issue with AHS's and MMC's extremely generous compensation of their top executives.¹¹⁵ All of these factors together showed that, despite its technical nonprofit status and the careful planning that sustained it, the MMC and AHS functionally operated with for-profit interests.

In November of 2015, AHS reached a settlement with the Town of Morristown.¹¹⁶ Months later, the New Jersey legislature passed a bill that would have allowed nonprofit hospitals with some profit-generating functions to retain their exemption, but make payments to the municipalities where they were located.¹¹⁷ The bill was ultimately pocket-vetoed by Governor Christie, but its passage suggests that the

¹⁰⁷ *AHS Hospital Corp.*, 28 N.J. Tax at 468.

¹⁰⁸ *Id.* at 536.

¹⁰⁹ *Id.* at 529-30.

¹¹⁰ *Id.* at 501.

¹¹¹ *Id.* at 500.

¹¹² *Id.* at 501-02.

¹¹³ *Id.* at 507-08.

¹¹⁴ *Id.* at 510-12.

¹¹⁵ *Id.* at 515-22.

¹¹⁶ Andrew Kitchenman, *Deal Strips Morristown Medical Center of Some of Its Tax-Exempt Status*, N.J. SPOTLIGHT (Nov. 12, 2015), <http://www.njspotlight.com/stories/15/11/11/agreement-strips-morristown-medical-center-of-some-of-its-tax-exempt-status/#> [<http://perma.cc/XR29-7W4Z>].

¹¹⁷ *Tax Court Rules Against Hospital in Morristown Property Tax Case*, CENTER FOR NON-PROFITS (Oct. 17, 2016), http://www.njnonprofits.org/PropertyTax_MorristownMedical.html [<http://perma.cc/K9GY-5KEF>].

legislature is unwilling to continue to extend full exemption to institutions that engage in activities similar to those of MMC.¹¹⁸

Both *Provena* and *AHS* show the fragility of the property tax exemption currently held by the majority of nonprofit hospitals across the United States. In addition to the threat of litigation under current law, as recently as 2010, legislatures in states as far-flung as Pennsylvania, Hawaii, Kansas, and Connecticut have introduced legislation to scale back or repeal tax exemptions for nonprofits, including hospitals.¹¹⁹ The problem is not simply that state and local taxing authorities have become more zealous; it is that hospitals have evolved so much since the creation of the current standards that the law has become unmoored from reality. In concluding its lengthy opinion, the New Jersey tax court acknowledged, “[i]f it is true that *all* non-profit hospitals operate like the Hospital in this case, as was the testimony here, then for purposes of the property tax exemption, modern non-profit hospitals are essentially *legal fictions*.”¹²⁰ This has left hospitals in every state in a vulnerable, uncertain position.

3. *Coerced PILOTs Add to Some Hospitals’ Financial Burdens*

Though most nonprofit hospitals are formally tax exempt, many do pay some amount of money to their state and local governments through payments in lieu of tax (PILOTs).¹²¹ Usually, PILOTs are voluntary payments made by tax-exempt entities to state and local taxing authorities. Their purpose is to give municipalities some revenue stream for the services they provide to tax-exempt organizations that would otherwise pay significant amounts of tax.¹²²

This is not always a bad thing. Property taxes are hugely important for state and local governments. In 2009, it was estimated that nonprofits as a class were exempted from paying between \$17 and \$32 billion in property taxes across the country.¹²³ Of all of the types of nonprofits, hospitals and health care facilities would owe the largest absolute amount of property taxes absent the exemption.¹²⁴ Because the shortfall can be harmful to communities, in many cases, municipal taxing authorities and tax-exempt organizations can work together to facilitate the payment of PILOTs.¹²⁵ They can be an important source of revenue for governments experiencing financial difficulties or contemplating a significant one-time expenditure that promises great social benefit.¹²⁶ In these cases, PILOTs are not sinister; they are a way to facilitate the flow of resources to higher-valued uses in a way that is more tailored to individual situations than the

¹¹⁸ *Id.*

¹¹⁹ Strom, *supra* note 3; Governor’s S.B. No. 945, Gen. Assemb., Sess. Year 2015 (Conn. 2015); Andy Marso, *Hospitals on Guard After Nonprofit Tax Proposal Surfaces*, KANSAS HEALTH INSTITUTE (Jun. 1, 2015), <http://www.khi.org/news/article/hospitals-on-guard-after-nonprofit-tax-proposal-surfaces> [<http://perma.cc/EW6R-QP32>].

¹²⁰ *AHS Hosp. Corp.*, 28 N.J. Tax at 536.

¹²¹ Daphne A. Kenyon & Adam H. Langley, *Payments in Lieu of Taxes: Balancing Municipal and Nonprofit Interests*, LINCOLN INST. OF LAND POL’Y 4-6 (2010), http://www.lincolninst.edu/sites/default/files/pubfiles/payments-in-lieu-of-taxes-full_0.pdf [<http://perma.cc/BFN3-2JUR>].

¹²² *Id.* at 6.

¹²³ *Id.* at 19.

¹²⁴ *Id.* at 5.

¹²⁵ *Id.* at 6.

¹²⁶ Maria Di Miceli, *Drive Your Own PILOT: Federal and State Constitutional Challenges to the Imposition of Payments in Lieu of Taxes on Tax-Exempt Entities*, 66 TAX LAW 835, 836 (2013).

sweeping exemption rules and can be employed in the short run and on a temporary basis. This can allow nonprofits to bolster the communities that support them and build goodwill in areas where citizens disapprove of their exempt status.¹²⁷

Though PILOTs are technically voluntary, researchers have noted that cash-strapped state governments have used the implicit threat of judicial or legislative action against nonprofit hospitals' vulnerable tax exemptions as leverage to extract higher payments (and have done the same to other nonprofits).¹²⁸ Not all states or localities pressure nonprofits into making PILOTs, but there is evidence that the practice has become more common in recent years, especially since the economic downturn that began in 2007. Since 2000, at least 117 cities and 18 states have utilized some form of PILOTs, most commonly in the Northeast.¹²⁹ In 2010, for example, the government of Baltimore, Maryland agreed to forego a controversial "bed tax" in exchange for an agreement from Johns Hopkins and other hospitals to begin or increase PILOTs.¹³⁰ In 2009, the city of Boston, the largest collector of PILOTs in the United States, proposed reforms to its standing program that would assess PILOTs on all tax-exempt organizations above a certain size, which includes several hospitals.¹³¹ While the plan was partially crafted by and drew support from certain nonprofit institutions, it also has its share of critics who argue that the program is coercive.¹³²

Though it is not a problem everywhere, the proliferation of extractive PILOTs is harmful to the nonprofit hospital sector. When municipalities grant tax exemption, it is not solely humanitarian; it is a tradeoff. The government agrees to set aside its taxing authority on the theory that the organizations given preferential treatment will provide some benefit to the community that outweighs the lost revenue.¹³³ The connection between hospitals and public benefit is clear: hospitals keep people healthy, and a generally healthy society has positive effects for everyone in it. Every dollar extracted from hospitals by municipalities through PILOTs is a dollar diverted away from that mission and towards the general operations of the state or local government. This top-down reallocation of funds may or may not be economically sound, but whether or not that is the case is a determination that should be made by a legislature, not through closed negotiations. When PILOTs are coerced rather than freely given, the municipality functionally imposes tax on otherwise tax-exempt entities without the safeguards of a full legislative process.¹³⁴ These functional taxes are imposed unevenly, creating horizontal equity issues. Coerced PILOTs make it difficult for the targeted hospitals to administer charity care and other socially beneficial services and impose another costly burden on

¹²⁷ Kenyon & Langley, *supra* note 121 at 6.

¹²⁸ Di Miceli, *supra* note 126 at 842-43.

¹²⁹ *Id.* at 843.

¹³⁰ Peter Sicher, *Hopkins and Other Institutions Pay Baltimore \$20.4 Million to Avoid Tax Increases*, THE JOHNS HOPKINS NEWS-LETTER (Jul. 15, 2010), <http://nlonthedl.wordpress.com/2010/07/15/hopkins-and-other-institutions-pay-baltimore-20-4-million-to-avoid-tax-increases/> [<http://perma.cc/Y66Q-UFS7>].

¹³¹ Kenyon & Langley, *supra* note 121 at 21-24.

¹³² Tim Delaney, *Boston's Coercive PILOTs Experiment Should Crash*, HUFFINGTON POST (Jun. 28, 2011), http://www.huffingtonpost.com/tim-delaney/bostons-coercive-pilots-e_b_854531.html [<http://perma.cc/4AB6-G735>].

¹³³ See Rev. Rul. 65-545, 1969-2 C.B. 117 (federal tax exemption is predicated on hospital's benefit to the community); *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1145-46 (noting that reducing the burden of government is an important function of nonprofit hospitals).

¹³⁴ Di Miceli, *supra* note 126 at 855 (concludes that coerced PILOTs are analogous to unauthorized taxes).

already-struggling institutions.¹³⁵ This blunts the positive effects that tax-exemption promotes in the first place.

B. Incongruity between Tax Exemption Standards and Reality of Hospital Administration

Hospitals are huge, complicated businesses, and addressing the issues they face is made more difficult by the fact that they provide services that are essential. Quality healthcare is important for both the individuals who receive it and all others who benefit from living in a generally healthy place. However, the current system grew out of a world where hospitals were simpler and less integral to our society.

The fundamental problem is that tax exemption is all or nothing; a hospital either keeps exemption or loses it. Losing exemption from state property taxes would be massively costly for any hospital. Modern hospitals necessarily own and occupy a huge amount of property. Provena Covenant Medical Center, the hospital discussed in the Illinois case above, occupied approximately nine acres of land and accrued \$1.1 million in property taxes in 2002 and 2003 alone.¹³⁶ Morristown Medical Center, the hospital discussed in the New Jersey case, occupied more than forty acres and is expected to owe more than \$2.5 million in property taxes each year following the decision against it.¹³⁷ Being forced to bear such a cost with little warning could predictably force a hospital to cancel unprofitable services and become for-profit, or close its doors entirely.

In other words, all-or-nothing exemption is too rigid and heavy-handed a tool; a more nuanced, flexible system is needed. Currently, the status quo awards hospitals with exempt status if they provide a quantum of certain services, but offers no benefits to offset the costs of these services above or below that line. This creates strange incentives for hospitals. They have a reason to engage in the activities necessary to attain exempt status, but only to the degree that is absolutely required; beyond that point, charity care is pure cost. It logically follows that the most successful nonprofit hospitals under this regime will be the ones that provide the bare minimum amount of charity care and other socially beneficial services.

There is some evidence that hospitals are acting on these incentives. Several researchers have found that nonprofit and for-profit hospitals provide similar quality of care and do not differ in terms of the number of poor people, children, and seniors they treat.¹³⁸ Compensation packages for nonprofit executives are set specifically to mirror their for-profit competitors.¹³⁹ Some commentators indicate that nonprofit hospitals contemplate making cuts to obstetrics divisions, a practice area that is notoriously unprofitable, in times of financial strain.¹⁴⁰ If hospitals are viewed and treated like

¹³⁵ *Id.* at 843.

¹³⁶ *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1138, 1140.

¹³⁷ Tim Darragh, *Morristown Hospital Loses Property Tax Court Case; Judge Says Facility Does Not Meet Non-Profit Status*, NJ.COM (Jun. 26, 2015), http://www.nj.com/morris/index.ssf/2015/06/morristown_medical_center_loses_tax_case_raising_f.html [<http://perma.cc/P3S3-R8EM>].

¹³⁸ *E.g.*, Colombo, *supra* note 12 at 45-50 (reviewing studies finding little to no difference between nonprofit and for-profit hospitals in terms of quality of care and volume of charity care).

¹³⁹ Rachel Landen, *Another Year of Pay Hikes for Non-Profit Hospital CEOs*, MODERN HEALTHCARE (Aug. 9, 2014), <http://www.modernhealthcare.com/article/20140809/MAGAZINE/308099987> [<http://perma.cc/9FVE-24Z2>].

¹⁴⁰ Commins, *supra* note 82.

businesses, these moves make sense. A hospital cannot consistently operate at a loss. This position does not conflict with the view that hospitals should create social benefits. If they cannot make ends meet, they cannot care for anyone, and it is good for people across the country to have easy access to medical services.¹⁴¹ Therefore, a tax system that subsidizes hospitals in a way that acknowledges that they are run primarily as businesses that produce strong, positive externalities is warranted.

IV. A UNIFIED REGIME OF HOSPITAL PROPERTY TAXATION

A. Why Subsidize Hospitals at All?

Many economists believe that the free market is the most effective way to provide goods and services to society.¹⁴² If the free market produces the most efficient outcome, taxes that distort behavior produce inefficiency. Based on these assumptions, there is a surface-level appeal to the idea that hospitals should simply not be eligible for tax-exemption. A significant amount of evidence suggests that tax-exempt nonprofit hospitals and for-profit hospitals provide comparable levels of charity care and deliver similar quality of care.¹⁴³ Administrators at nonprofit hospitals often receive high compensation and benefits.¹⁴⁴ Exemption from property taxes costs many state and local governments a huge amount of revenue that could go to other important programs.¹⁴⁵ Given that nonprofit hospitals run essentially like businesses and compete with financially-viable, for-profit companies, it makes some sense to simply eliminate property tax exemption for hospitals and allow the free market to run its course.

However, these facts over-simplify reality. Many economists acknowledge that markets do not produce efficient outcomes in instances where supply and demand for some product do not converge at a socially optimal point.¹⁴⁶ These market failures can occur for a variety of reasons. One commonly-acknowledged source of market failure is the presence of significant externalities. Externalities exist when a person's actions cause some harm or benefit, but that person cannot feasibly be paid to perform or abstain from those actions by the affected party.¹⁴⁷ There is strong evidence that healthcare has positive externalities. That is, when a person is made healthy, society as a whole benefits, not just the healthy person and her doctor.¹⁴⁸ Therefore, subsidizing health in general is warranted. But health is a multifaceted concept, and there is reason to believe

¹⁴¹ See John D. Colombo, *The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L. Q. 343 (2004) (arguing that expanding access to care for previously-underserved populations should be the main criteria for determining tax-exempt status).

¹⁴² See, e.g., MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* (U. of Chi. Press, 40th Anniv. Ed. 2002).

¹⁴³ E.g., Colombo, *supra* note 12 at 45-50.

¹⁴⁴ Landen, *supra* note 139.

¹⁴⁵ Kenyon & Langley, *supra* note 121 at 19.

¹⁴⁶ *Tax Court Rules Against Hospital in Morristown Property Tax Case*, CENTER FOR NON-PROFITS (Oct. 17, 2016), http://www.njnonprofits.org/PropertyTax_MorristownMedical.html [<http://perma.cc/AET7-HC29>].

¹⁴⁷ *Id.* (“Externalities are probably the argument for government intervention that economists most respect.”).

¹⁴⁸ DAVID E. BLOOM, ET AL., *The Effect of Health on Economic Growth: Theory and Evidence* (Nat'l Bureau of Econ. Research, Working Paper No. 8587, 2001), <http://www.nber.org/papers/w8587> [<http://perma.cc/9ZTM-PBGP>] [hereinafter BLOOM, ET AL., *Effect of Health on Economic Growth*].

that nonprofit hospitals currently contribute to it in ways that for-profit hospitals do not, and that incentive structures could be created to help them do so even more effectively.

Nonprofit hospitals do not provide more charity care or deliver better service than their for-profit counterparts, but research shows that nonprofit hospitals do provide important but unprofitable services at far higher rates than for-profits.¹⁴⁹ In other words, nonprofit hospitals are not the sole providers of health care to all people, but they are the only viable option for certain people to receive certain services.¹⁵⁰ For businesses in a free market, access is not always a virtue. If a car company manufactures a bad car, they can drop it from their line; society at large will not suffer. On the other hand, if a hospital eliminates its obstetrics and psychological health divisions because they are unprofitable, pregnant women and the mentally ill will be in serious trouble. Those people, their families, and the people that they interact with will suffer. By providing services that would be difficult to justify for a purely profit-oriented business, nonprofit hospitals create a social value that is difficult to quantify in terms of dollars and cents, but is nonetheless essential.¹⁵¹

The tax system should not ignore this reality; it should embrace it. The current all-or-nothing community benefit model does not accomplish this goal very well. A new system should push hospitals to provide the services that people need without wasting dollars subsidizing those for which there is a competitive market. Hospitals are complex; a nuanced and flexible solution is needed.

B. State Property Tax Exemptions are the Best Choice for Initial Reform

The general critique that antiquated, all-or-nothing tax exemption rules are not flexible enough to adequately create pro-social incentives for complex, modern hospitals can be leveled equally against state-level property tax exemptions and the federal-level exemption in I.R.C. § 501. However, it makes sense to begin reform at the state level.

The first reason is practicality. The proposed reforms will likely be costly in the short term for hospitals that need to learn and conform to the new rules and for governments that need to create an administrative apparatus capable of executing the program. The relative size of these costs will likely vary from state to state. On the other side of the coin, the benefits of a more nuanced system of tax subsidy for hospitals may be larger in certain states than others. Those with the most to gain can bear the costs of necessary trial and error and, if ultimately successful, can serve as a model that helps subsequent adopters avoid pitfalls. In other words, early-adopter states that fall on the favorable end of the cost-benefit spectrum can help lower economic barriers and uncertainty for those that come later.

Second, reforms at the state level will allow for greater variation. Different states face wildly divergent health policy challenges. It is possible that certain services should generate tax credits in sparsely populated, primarily rural states in the Great Plains because they are universally costly to provide or difficult to access through other means and that the same services can support a legitimately competitive, net-profitable market and should not generate tax credits in more affluent, more densely-populated New England. If states can make these determinations for themselves, they can create a

¹⁴⁹ Horwitz, *supra* note 83, at 1364-76.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*, see also Colombo, *supra* note 142 (emphasizing the importance of nonprofits expanding access to underserved populations, particularly in the healthcare field).

system that more effectively controls administrative costs. By contrast, attempting to start with a blank slate at the federal level could devolve quickly into a nightmare of costly administrative backlog.

In short, it makes sense to begin hospital tax exemption reform at the state level, where experimentation is possible, before attempting to tackle the federal system.

C. Replace All-or-Nothing Exemption with a More Flexible System

To begin to fix the inadequacies of the current landscape of property tax exemptions for hospitals, states must acknowledge that, at their core, modern hospitals are money-driven enterprises. Rather than fight or deny this reality, states should strive to craft rules that use this business-oriented mindset to encourage hospitals to operate in a way that is maximally beneficial for society.

To begin, states should repeal the current all-or-nothing property tax exemptions available to hospitals and replace them with a series of tax credits. Hospitals should be granted credits against their property tax burden equal to the cost of certain services. Additionally, the services that are eligible to generate credits should be regularly re-assessed. This system is similar to the one proposed at the federal level by Professor Nina J. Crimm, but distinct in several important ways.¹⁵² To the extent that the two proposals overlap, there are strong reasons to revisit and revise her ideas at the state level because of the recent political push towards reform and certain provisions of the ACA that will support such a complex system. The system of credits should be generally available to all hospitals except those that would continue to qualify for tax exemption even after the repeal of general exemption, like many municipal, religious, and university hospitals.¹⁵³

These reforms would create better incentives for hospitals by providing subsidies for services with substantial public benefit that would not otherwise be offered and removing subsidies from activities that can be profitable and thus will be provided through a free market. They will also reduce uncertainty and allow hospital administrators to more effectively plan their operations.

1. *Identifying Services that Generate Credits*

One fundamental problem with the all-or-nothing exemption standards currently in force in every state is that they lack the nuance required to create socially optimal incentives for the sophisticated institutions that hospitals have become. Indeed, hospitals are given a reason to perform certain activities, like provide emergency room services and charity care, but only to a degree necessary to obtain exemption. And when other activities are important for the promotion of health but unprofitable and excluded from

¹⁵² Crimm, *supra* note 12 at 101-10. Crimm proposes replacing federal tax exemption for hospitals with deductions or credits that offset the costs of activities deemed to be charitable by a series of regional expert panels and scaled according to broad federal guidelines. While similar to the proposal in this Note, Crimm envisions a system in which a web of federal guidelines creates a general framework for tax exemption within which regional panels have a great deal of discretion. This proposal, by contrast, advocates more bright-line rules and grants more responsibility and discretion to the healthcare providers themselves.

¹⁵³ It is not a foregone conclusion that all such hospitals will retain their exemptions if the rules that currently grant property tax exemptions to hospitals are removed, but it is likely that at least some will, and a system of credits should not extend to hospitals that do retain full exemption.

the schedule of services that can contribute to tax-exempt status, hospitals gain no financial advantage by expanding access or quality of care for their patients.

To realign these incentives, hospitals should be granted credits on a hospital-by-hospital basis for performing activities that meet a few general criteria of public benefit. The activities should be 1) needed by the community, 2) unprofitable for any hospital in the region, and 3) unavailable through other means. These criteria ensure that credits are only awarded for services that are medically important and cannot be provided through a competitive market.

In transitioning to a credit system, states do not necessarily need to abandon all gateway requirements for hospitals to gain tax-exempt status. They could preserve the mandatory nature of certain services by treating them as preconditions for the receipt of tax credits. These elements would need to be concrete and essential for a charitable hospital. For example, states could require all hospitals that want to claim these tax credits to be licensed in the state or to participate in the Medicare and Medicaid programs. While precondition status will give hospitals a very strong incentive to perform a particular function, the drawback is that every item treated as such would complicate hospital administration and would create the risk that some hospitals will be cut off from all of the benefits and positive incentives that would come with access to the credits. Therefore, while states may decide to require some preconditions, it is not clear that any are essential.¹⁵⁴ In addition, states can adopt a softer approach than pure preconditions. For example, a state could allow hospitals that do not accept Medicare and Medicaid patients to receive credits for charity care, but calculate them based on a lower percentage of net costs than the credits extended to hospitals that do participate in those programs.

Once hospitals meet the conditions necessary to receive tax credits, the state should determine which services should be eligible to generate credits. States should attempt to designate a wide range of services, like charity care and emergency room services, which generate credits for every hospital by default. They should also attempt to create some metric to pinpoint hospitals and services that should be presumed credit eligible. One way to do this would be to adapt the formula currently used to allocate disproportionate share payments under the Medicare program.¹⁵⁵ These payments award higher reimbursement rates to hospitals that treat a particularly large number of Medicare and Medicaid patients.¹⁵⁶ Hospitals are designated disproportionate share hospitals (DSHs) based on a formula incorporating the total number of inpatient days attributable to Medicare and Medicaid patients relative to the hospital's total pool of patients.¹⁵⁷ Similar criteria could be used to identify specific services at hospitals that should generate credits per se. For example, a service that consistently operates at a loss could be granted per se credit eligibility if a sufficiently high percentage of the patients who utilize it are uninsured or covered by Medicare or Medicaid. Distance-based metrics could also be employed; a state could extend credits to important services offered by

¹⁵⁴ Even without explicit preconditions, functionally, certain choices may make it difficult for hospitals to be eligible for any credits. For example, it would be difficult for a hospital that does not accept Medicare and Medicaid patients to make the case that they meaningfully extend access of necessary services to underserved members of their communities. Still, it may be socially beneficial to extend credits for charity care performed by these hospitals.

¹⁵⁵ 42 C.F.R. § 412.106(b) (2015).

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

hospitals that cannot be obtained from any other healthcare providers within fifty miles. This metric would be similar to the one used to identify sole community hospitals, another special classification that earns higher reimbursement rates under the Medicare program.¹⁵⁸

While different states can and should settle on a wide variety of metrics, the only important criteria is that they be objectively, unequivocally measurable. If a hospital's services meet any of these criteria, they should be deemed to generate credits without the need for any prior administrative approval.¹⁵⁹ Ideally, the majority of hospitals would be able to calculate and claim their own credits directly on their annual returns, giving healthcare providers a greater ability to predict and control their own finances.

While the metrics discussed above should serve as a safe harbor for hospitals seeking to claim credits for specific services, the new law must include a catch-all provision that allows hospitals to receive credits for services that extend needed healthcare access to underserved populations. Individual hospitals should be allowed to petition the state under the catch-all provision and provide evidence showing that other services meet the three criteria that justify the provision of tax credits. To evaluate these petitions, the state should empanel a hospital tax credit evaluation board comprised of specialists in the medical field, hospital administrators, lawyers, and other experts. The board should evaluate the evidence provided by the hospital and either grant or deny credits for those services for a set period of years.

To facilitate the petitioning process for both hospitals and the tax credit evaluation board, states could leverage the new CHNA requirement created through the ACA.¹⁶⁰ Every three years, nonprofit hospitals are required to generate a detailed report on the health needs of the community they serve.¹⁶¹ These reports could serve as the basis for hospitals' petitions. There would be no extra cost in obtaining the necessary data because they would have generated it anyway. The state's board could grant or deny credits for particular services for three year periods, meaning that each hospital will need to make their next petition at the same time that they produce their next CHNA. Such a rule has the added benefit of reinforcing the CHNA requirement by giving hospitals a financial incentive to use thorough, rigorous methodologies and generate a large amount of data about their communities' health.

Critics may point out that tying the CHNA process to tax exemptions will give hospitals an incentive to tweak their findings. However, the potential problems caused by these incentives can be mitigated, if not eliminated. First, the evaluation board should implement ways to check the methodologies employed by hospitals that submit petitions for tax credits. This is why the evaluation board should contain a wide range of experts, including administrators, doctors, and public health specialists. Second, the evaluation board will receive reports from many hospitals, some with overlapping communities. In this way, hospitals can be used to check one another. Currently, the IRS allows hospitals

¹⁵⁸ *Id.* at § 412.106(d)(2)(ii)(B).

¹⁵⁹ This is a significant point of difference between this proposal and the one made by Crimm – under that plan, all services would need to be approved by a regional board before a provider can claim any credits or deductions. Crimm, *supra* note 12 at 106-09.

¹⁶⁰ Patient Protection and Affordable Care Act § 9007, 42 U.S.C. § 18001 (2010); I.R.C. § 501(r)(3) (2015).

¹⁶¹ I.R.C. § 501(r)(3)(A)(i) (2015).

with overlapping service areas to conduct joint CHNAs.¹⁶² To prevent collusion and to add an extra incentive for hospitals to collect and report accurate data, joint reports should not be allowed for hospitals seeking state-level tax exemption.

Credits should be extended to different services at different hospitals because hospitals are situated in such complex markets. The purpose of these tax credits is to subsidize needed services that would otherwise be difficult to access for people in the community served by a particular hospital. Which services fit that definition will vary from region to region and institution to institution, and thus so should the credits. For example, obstetrics and psychiatric care are often costly for hospitals.¹⁶³ Expectant mothers may only be able to find essential services at a single facility within convenient driving distance.¹⁶⁴ At these hospitals, it makes sense to subsidize obstetrics. In more affluent urban areas, however, obstetrics can at least break even, and mothers can have a variety of options to choose from when deciding where to receive care.¹⁶⁵ At these hospitals, it does not make sense to subsidize obstetrics. The determinations must also be comparative when communities have access to multiple hospitals. It would be incoherent to subsidize an unprofitable program at one hospital if the same services are available to the community and profitable at a competing institution a few miles away.¹⁶⁶

There are several additional critiques that could be leveled against this plan. Some may argue that running certain hospital tax credit determinations through a board that consists of a relatively small number of appointed individuals may raise concerns of corruption or bias. This can be addressed by insulating the evaluation board from political pressure by making it an independent organization and limiting the term that board members can serve. The composition of the board itself can also be used to mitigate concerns about bias. For example, the inclusion of individuals that have experience working in both rural and urban communities could help to ensure that the board is familiar with and sensitive to the main health issues facing different populations within a state. Finally, board members should be required to disclose any financial conflicts of interest and be excluded from considerations where those conflicts could affect their decision making.

Critics may also contend that transitioning to this plan would be prohibitively costly in the short term. These concerns, too, can be somewhat alleviated. Early adopting states will face the highest short-term administrative costs because they will need to build a new system from the ground-up. But the earliest adopters are also likely to be the states with the most to gain from transitioning to a credits-based hospital property tax system. If a state decides to implement reform, it can be assumed that it has

¹⁶² T.D. 9708, 2015-5 I.R.B. 352 (“[T]he final regulations . . . permit collaborating hospital facilities to produce joint CHNA reports”).

¹⁶³ Paul S. Appelbaum, *The ‘Quiet’ Crisis in Mental Health Services*, 22 HEALTH AFFAIRS 110, (2003), <http://content.healthaffairs.org/content/22/5/110.full>; Commins, *supra* note 82.

¹⁶⁴ *Health Disparities in Rural Women*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS: COMMITTEE OPINION NO. 586, (Feb. 2014), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women>.

¹⁶⁵ *Id.*

¹⁶⁶ Though their function should be relatively limited, the boards should have a fairly large degree of discretion over cases that come before them. For example, a hospital should not be denied credits for their obstetrics program if it treats a large number of Medicaid patients even if a competitor operates a profitable obstetrics department with relatively few or no Medicaid patients.

at least considered the relevant costs and benefits and determined that the balance of the two is favorable.

The transition will also be expensive for hospitals. Though a credits-based system could theoretically bring in more money for a hospital than the loss of property tax exemption removes, in the short term, many hospitals will need to figure out how to effectively compile and present evidence to the evaluation board. These up-front costs, coupled with the existing expense of the CHNA process, may be difficult for struggling hospitals to bear. To remove some of this burden, the system could be announced several years before it takes effect. The state could also allow hospitals to make a “practice” round of tax credit petitions. In the first year of implementation, the evaluation board could give all hospitals who submit petitions for specific credits the choice between transitioning immediately to the credits-based system and keeping their existing exemption for a period of three years after seeing the results. This will allow hospitals to go through the petition process, see how their petitions fared, and learn about to prepare more effectively for the next cycle while maintaining their existing exempt status. Ultimately, this should allow hospitals to craft reasonable predictions about what credits will be available to them once the law goes fully into effect and plan their finances accordingly.

On balance, a centralized oversight board that makes determinations about services that do not fit a state’s safe harbor eligibility provisions ensures that the credit system is adequately flexible to create socially beneficial incentives for hospitals.

2. *Measuring Credits*

Identifying which services at which hospitals should be eligible to generate credits creates incentives for hospitals to provide more of the things that benefit their communities the most. However, this first step alone creates a new problem: how are the credits measured? To create an effective incentive for hospitals to create social benefits, the financial subsidy, the credits, must be tethered to the costs of providing the activity to be subsidized, the eligible services. However, if credits are offered based purely on costs with no other controls or oversight, hospitals would have an incentive to inflate the costs of credit-eligible services. Though most hospitals may not waste time and resources to unscrupulously inflate charity care services, they would also have little reason to ensure that those cases were handled efficiently. Though each state must ultimately evaluate for itself which metric is best, any workable system must contain at least some answer to this challenge.

States could peg the value of the credits to the net cost of providing the eligible services and pair such a system with provisions that require sound practices on the part of hospitals. Hospitals could be required to maintain an ombudsman program to evaluate procedures of credit-eligible services and ensure that they comport with industry standards. The state could also empower an administrative agency to conduct periodic, random audits of hospitals’ credit-eligible activities. The enacting legislation could also subject hospitals to criminal fraud charges for inflating costs or deviating from standard industry practice when handling a credit-eligible patient.

This approach has both pros and cons. One advantage is that it closely correlates the tax credits offered to hospitals with the activities that the state wishes to promote. It also gives state legislatures the power, which could be passed on to the evaluation board, to specifically tailor the credits in a way that creates good incentives and controls costs.

If they worry about excessive costs, states could provide credits at lower rates for services that are nearly profitable and higher rates for care that goes completely unreimbursed. Finally, the state could adjust the multiplier to offer larger or smaller credits as a percentage of the cost of providing the service in question based on how effectively the service relieves a burden that would otherwise be borne by the government. Alleviating government obligations is a critical function of nonprofit organizations, is currently used to determine eligibility for property tax-exemptions in several states, and was discussed in regards to hospitals in the *Provena* case.¹⁶⁷

The main drawback of using actual net costs to measure the value of the credits is that directly policing the practices of doctors and other practitioners will be difficult and expensive. If the punitive measures meant to control cost and quality are too stringent, professionals will have a reason to avoid socially beneficial work, at least in difficult cases. An oversight program must necessarily be enforced, so litigation and its attendant costs will be unavoidable in at least some instances. Finally, no matter the effort, ensuring best practices in the face of a financial incentive for inefficiency will be impossible, and some hospitals will simply get away with inflating the cost of some services and be rewarded with higher tax credits.

Alternatively, states could allocate credits with a fixed service-by-service estimate of costs rather than actual costs. Periodically, the same board responsible for determining whether non-codified services are credit-eligible for each hospital could come together with accounting professionals to create average reimbursement tables for different types of services.

The primary advantage of a proxy measure is that it would create an incentive for hospitals to keep their costs low; a hospital that performs a certain service at a cost point below the fixed level of the credit will be able to pocket the difference. In this way, the credits would become a vehicle to subsidize both scarce, socially beneficial services and innovation in providing them efficiently. Additionally, this system would be more administratively convenient than one that values credits based on the true cost of individual services performed. When filing a return, hospitals would only need to list the type and quantity of credit-eligible care they provided. A measurement system based on actual costs, by contrast, would require hospitals to include a far more in-depth accounting of their operations. A fixed credit system would therefore reduce costs for both the hospitals and state governments. To avoid insufficient credits in extraordinarily expensive cases, the state could also allow hospitals to appeal for a positive adjustment to their credit amount if they can show that a particular case was atypically costly. This would at least mitigate the incentive that hospitals would have to avoid complex credit-eligible patients.

Opposite its advantages, a system of allocating tax credits to hospitals using fixed service-by-service cost estimates has distinct drawbacks. First, while fixed credit amounts would give hospitals an incentive to provide credit-eligible services more efficiently, it would also give them an incentive to keep costs low by sacrificing quality of care. For example, if a new surgical technique in a credit-eligible practice proves both more effective and more costly than the old standard, hospitals may push against its adoption, thereby stifling, rather than promoting, innovation. While this tendency will always be bounded by industry standards and outcomes, it may decrease marginal quality of care in credit-eligible services. Second, developing the credit tables would be costly.

¹⁶⁷ *Provena Covenant Medical Center v. Dept. of Revenue*, 925 N.E.2d 1131, 1145-46.

These expenses could be defrayed somewhat by spacing out the periodic recalculations of the tables, but larger gaps will also increase the risk that technological or other changes will render them inaccurate for a significant period of time. Finally, using a fixed proxy for generating credits will create some discrepancy between the amount of the credit gained by the hospital and the actual cost of treating each patient or providing each service. Absent careful safeguards, this could create opportunities for abuse if hospitals are able to blur the lines between services that can produce different fixed credit amounts.

3. *Other Considerations*

In evaluating this proposal, it is important to consider some final pros and cons from the perspective of both hospitals and states. On balance, this system is intended to provide the most aid to the hospitals with the greatest financial difficulties that provide essential services to otherwise underserved populations. If its state crafts a fair system of refundable credits, it is likely that a hospital that provides a large amount of charity and greatly improves its community's ability to access necessary care will benefit financially from these reforms relative to even full tax exemption. However, inequities may arise between hospitals in states where there is a high degree of variation in property values, like New York and California. A hospital situated in the heart of Manhattan would likely be liable for astronomically high property taxes relative to one in a far-flung suburb of Buffalo.¹⁶⁸ The same problem may arise if the system of credits does not account for variations in property tax rates between localities.

This problem is another reason that reform should begin at the state level, where it would be far easier for the states that face particular challenges to craft unique solutions than it would be on a much larger scale. For example, states could at least mitigate these disparities by pairing a system of credits with a provision that values hospitals for tax credits based on their use of the land that they occupy rather than fair market value. Similar statutes are already employed by various states to subsidize agricultural land.¹⁶⁹ The drawback to such a solution is administrative costs; alternative valuations will ultimately require more bureaucratic intervention in a system that, even at its most streamlined, will necessarily be highly complex.¹⁷⁰

While these measures may be required to administer the system of tax credits more fairly in certain situations, the purpose of the proposal would be defeated, especially from the perspective of the state, if the rules were too hospital friendly. These rules are meant to subsidize the most socially beneficial behaviors of hospitals and to cease subsidies to activities that are essentially competitive. In other words, if the system is working correctly, many hospitals that currently enjoy total exemption from state property taxes will either need to greatly alter their activities to generate more tax credits

¹⁶⁸ See Andrew Haughwout, et al., *The Price of Land in the New York Metropolitan Area*, 14 FED. RES. BANK OF N.Y. 3, 1 (2008), http://www.newyorkfed.org/medialibrary/media/research/current_issues/ci14-3.pdf [<http://perma.cc/NU7G-YQ2M>] (describes sale of unimproved land in Manhattan in 2000 for over \$2,300 per square foot); Bellevue, NYC HEALTH & HOSPITALS, <http://www.nychealthandhospitals.org/bellevue/html/about/history.shtml> [<http://perma.cc/7GFC-AGAR>] (Bellevue hospital in Manhattan occupies a campus of approximately 1.7 million square feet).

¹⁶⁹ See, e.g., Kan. Stat. Ann. § 79-1476 (West 2016); Fla. Stat. Ann. § 193.461(6)(a) (West 2016); Utah Code Ann. § 59-2-503 (West 1953).

¹⁷⁰ Crimm, *supra* note 12 at 110 (acknowledging that the proposed tax credit system is “complex, and likely to pose numerous administrative challenges”).

or begin paying at least some property taxes. While the devil is in the details, many states will probably create systems that are expected to increase net tax revenues, particularly from urban areas where they currently forego the greatest amount of property taxes to exempt hospitals and where municipalities are already most likely to employ PILOTs to temper the effects of all-or-nothing exemption.¹⁷¹ When reforms are administered well, therefore, states and their citizens can expect a shift in hospital behavior towards more socially beneficial practices and an increase in general tax revenue that can fund other important programs.

V. CONCLUSION

Hospitals have been exempt from tax in the United States for more than a century. However, they have evolved from typical charities to complex businesses and the tax law has not kept pace. For-profit hospitals that do not differ from their nonprofit counterparts in a variety of meaningful ways have proliferated,¹⁷² but the positive externalities of widespread, easy access to quality healthcare continue to justify subsidy.¹⁷³ The system must be reformed to acknowledge this reality. New rules must continue to subsidize essential, socially beneficial hospital functions and avoid interfering in competitive markets by subsidizing activities performed by certain hospitals and failing to do so for essentially identical functions of other institutions. All-or-nothing exemptions cannot accomplish these goals because they are not equipped to differentiate between a hospital's many functions.

The reforms proposed in this Note attempt to accomplish these twin aims by replacing current state-level property tax exemptions with a series of tax credits. First, states should identify objective safe harbors that hospitals can use to claim credits for services that are charitable or increase access to care. Second, states should establish a catch-all rule that allows an evaluation board comprised of experts to evaluate hospital functions that do not fall into any of the safe harbors, but should be eligible to receive credits. Specific hospital programs should be deemed eligible if they 1) are essential medical services, 2) are not provided for a profit by any hospital easily accessible to the community, and 3) are not accessible through any other means. Finally, the credits must be valued according to a hospital's net cost of providing the eligible services. This can be accomplished either by measuring actual costs or through the periodic establishment of a schedule of fixed credit amounts for specific services.

If implemented, these reforms would allow nonprofit and for-profit hospitals to compete fairly in markets for services that are readily available and maintain subsidies for activities that extend unprofitable, socially beneficial services to those for whom access would otherwise be difficult. Especially in light of the recent expansion of the low-reimbursement Medicaid program, this new system will help hospitals provide services that are not strictly charitable but are nonetheless important without jeopardizing their financial position. Finally, reform will allow states and localities to generate needed revenue in areas with robust, competitive health services markets.

¹⁷¹ Kenyon & Langley, *supra* note 122 at 6, 19.

¹⁷² *E.g.*, Colombo, *supra* note 12 at 45-50.

¹⁷³ BLOOM, ET AL., *Effect of Health on Economic Growth*.