

HEALTH POLICY REPORT

Regulatory and Judicial Oversight of Nonprofit Hospitals

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The modern hospital bears little resemblance to its ancestors. The charitable institutions of the 19th century mainly tended, rather than treated, the sick, and they served mostly poor patients, whereas the wealthy received care at home. The transformation of hospitals “from places of dreaded impurity and exiled human wreckage into awesome citadels of science and bureaucratic order”¹ occurred during the 20th century, thanks to scientific advances and the maturation of the medical profession and the health insurance industry.² Hospitals today are big businesses that derive most of their revenues from paying patients and health care insurers.

Yet one vestige of the ancestral institution remains: nearly two thirds of hospitals are private, nonprofit organizations.³ In return for exemptions from federal, state, and local taxes, they agree to organize and operate for charitable purposes — strictures that do not apply to their for-profit competitors. In a highly competitive marketplace in which profit margins are narrow, this commitment has generated intense economic, legal, and moral pressures.

Recent litigation illuminates the identity crisis of nonprofit hospitals. More than 100 lawsuits have been filed accusing them of shirking their charitable commitments by charging uninsured patients high fees and then aggressively pursuing these “debts.” The plaintiffs allege that the hospitals have broken their covenant with the community and morphed into profit-seeking businesses. Similar claims have been made by the Internal Revenue Service (IRS) and state attorneys general.

Broader societal expectations of nonprofit hospitals are also growing. As the dominant institutional player in health care delivery, such hospitals naturally are the focus of attention for solutions to the burgeoning problems of runaway costs, unequal access to care, and suboptimal quality. Regulators seek to steer the “nonprofits”

toward these policy objectives and to press for loyalty to their charitable mission through a welter of federal, state, and municipal regulations. Meanwhile, nonprofit hospitals must contend with commercial pressures, primarily in the form of sharp competition from for-profit entities.

With these tensions assuming increasing prominence in health policy discussions, it is helpful to examine the legal environment in which nonprofit hospitals operate. What we find is a great deal of regulatory ferment, no clear direction, and few signs that oversight will become more coherent in the foreseeable future.

THE ROLE OF THE IRS

SECTION 501(c)(3)

The federal government has long overseen nonprofit organizations, including hospitals, through tax laws defining the requirements for nonprofit status. Section 501(c)(3) of the Internal Revenue Code has formed the cornerstone of this regulation since 1954.⁴ The provision sets forth a series of requirements for nonprofit status. The organization must pass an “organizational test,” which refers to statements of religious, charitable, scientific, or educational purpose in publicly filed articles of incorporation. Next, an “operational test” requires that the organization actually operate in accordance with the specified purposes. Nonprofits may not distribute earnings to private persons in the way that for-profit firms do to stockholders, and they must pay fair market value for goods and services. Finally, the organization must adhere to reasonable public-policy norms and avoid activities such as political lobbying and engagement in political campaigns.⁵

The operational test applies not only to the hospital but also to its key constituents — the medical staff. The IRS regards physicians as private persons who may benefit inappropriately

from hospital operations. The hospital often sees physicians as potential or actual competitors, particularly for ambulatory services; however, hospitals are generally restricted by IRS policies and antikickback and self-referral laws from entering into joint ventures with their physicians.

The sweeping language of the organizational and operational tests does not provide clear guidance to a nonprofit hospital board seeking to navigate a path between meeting charitable objectives and making effective business decisions. Federal policies aimed at enhancing competition in the hospital sector further blur the regulatory signals.⁶ In addition, the board's task is complicated by ambiguity about which, if any, charitable activities produce the requisite social benefit to justify privileged tax treatment.⁷⁻⁹ Indeed, the evidence that nonprofit hospitals return more to the communities in which they operate than do for-profit hospitals is mixed.¹⁰ Increasingly, from the perspective of policymakers, the mere existence of nonprofit status carries no presumption of social benefit.¹¹

INTERPRETING AND ENFORCING SECTION 501(c)(3)

The IRS has issued several statements explaining the requirements of tax-exempt status for hospitals, focusing especially on what charitable care means. In 1956, the agency promulgated the first formal criteria for hospitals, which required that the hospital be “operated to the extent of its financial ability” to render services for those unable to pay.¹² Practical difficulties in applying this standard,¹³ lobbying from the nonprofit hospital sector, and unrealistic hope that the advent of Medicare and Medicaid would reduce the need for charitable care¹⁴ led the IRS to refocus in 1969 on the hospital's capacity to provide a “community benefit.” New standards¹⁵ specified some practices that demonstrate such a benefit — a board of directors drawn from the local community; an emergency room open to all, including indigent patients; the provision of other services without regard to the ability to pay or the source of insurance; and other activities that promoted health, including teaching, research, and community outreach.

The IRS soon confronted questions, many of them from the hospitals themselves, about the appropriateness of the requirement of an emergency department, particularly as it applied to specialty hospitals.¹³ In 1983, the IRS issued a

revenue ruling — an official interpretation of how the tax law applies to a specific situation — clarifying that specialty hospitals generally do not need to operate emergency departments and that other hospitals may be excused from this requirement if a state planning agency has deemed such services unnecessary.¹⁶ The ruling created flexibility for some hospitals seeking to obtain or maintain tax-exempt status, although the presence of an emergency department still carries weight in determinations of the tax-exempt status of general hospitals.¹⁷

These IRS rulings form the main guideposts in federal nonprofit hospital law. Unfortunately, their lack of specificity and their origin in a dramatically different health care environment have made the precise contours of what is permissible behavior today quite uncertain. Joint ventures between nonprofit hospitals and for-profit entities are a particularly gray area.¹⁸

Historically, regulatory problems also extended to the enforcement tools available. The IRS was limited to two options: it could permit the conduct under scrutiny or revoke the hospital's tax-exempt status. The severity of the latter option has tended to discourage its use. This problem of enforcement was ameliorated in 1996 by the creation of “intermediate sanctions,”¹⁹ which allow the IRS to impose financial penalties on influential insiders, such as board members and managers, who frustrate the charitable purpose by reaping impermissible private gains or “excess benefits” from the organization. To the best of our knowledge, intermediate sanctions have been applied only once in health care.²⁰ Nonetheless, they represent a much more readily deployable enforcement mechanism than outright revocation.

A BLUNT REGULATORY TOOL

Alternative enforcement mechanisms help, but the IRS still struggles with many questions arising from the increasingly elaborate and innovative arrangements that nonprofit health care systems devise. Consider the 1998 ruling²¹ pertaining to a Maryland-based company referred to in the ruling as OMEGA. The company operated several nonprofit subsidiaries, including a hospital, a rehabilitation facility, a medical research institute, fundraising entities, and several long-term care facilities, all of which cared for patients with neurologic disease and brain injury. The company proposed to convert the hospital and nursing

homes into for-profit organizations and to maintain the holding company and research institute as nonprofits. Surprisingly, the IRS ruled that the reorganization would not imperil the tax-exempt status of either OMEGA or its remaining nonprofit affiliates.

By contrast, St. David's Health Care System, a nonprofit based in Texas, formed a joint venture with Healthcare Corporation of America (HCA), a for-profit hospital chain, in which the two organizations were to pool all their hospital assets in the Austin area.²² The partners agreed that the new hospital conglomerate, including the HCA's hospitals, would honor the community-benefit standard. Furthermore, the agreement included an escape clause giving St. David's a unilateral right to terminate the partnership and liquidate its holdings at any time if it determined that the arrangement had begun to jeopardize or compromise the health care system's charitable duties. After reviewing the joint venture, the IRS revoked St. David's tax-exempt status.²³ The Fifth Circuit Court of Appeals backed the position of the IRS, questioning both the charitable purposes of the partnership and the protection provided by the escape clause.²² (However, on remand to a lower court for a decision on the facts, a federal jury found that the escape clause did vest sufficient power in St. David's to ensure the furtherance of charitable purposes.²⁴)

Squaring the outcomes in the St. David's and OMEGA cases is not easy. Although legal experts may point to subtle distinctions, the broad reality is that the IRS must make fine determinations using a blunt tool — the text of section 501(c)(3) and the modest set of regulations and rulings that apply in the context of hospitals. The confused, sometimes paralyzing nature of federal tax policy and enforcement during the past decade has emboldened state policymakers, who also play a role in the regulation of nonprofit hospitals.

STATE REGULATORY INITIATIVES

STATUTES, COURTS, AND ATTORNEYS GENERAL

Most states regulate nonprofit organizations through statutes that resemble section 501(c)(3). A number of states have adopted the Revised Model Nonprofit Corporation Act of 1987, a comprehensive set of statutes governing the establishment and operation of nonprofit entities.²⁵ State courts adjudicate disputes between local

and state tax authorities and charities, including hospitals. With the deepening of academic concern regarding the extent to which nonprofit hospitals return social benefits commensurate with their preferential tax treatment,^{26,27} state courts have shown increasing interest in scrutinizing such hospitals' operations, especially the provision of charitable care. The results of the scrutiny are mixed, compounding the uncertainty arising from the federal tax rulings.

In one case, for example, the Utah County tax board declined to exempt a nonprofit hospital from property taxes, ruling that the hospital had failed to deliver sufficient amounts of charitable care.²⁸ The Utah Supreme Court upheld the board's decision. Ruling on a similar case²⁹ several years later, the Vermont Supreme Court ignored the Utah court's analysis and reached an opposite conclusion. It rejected arguments by the city of Burlington that a local hospital had operated contrary to its charitable responsibilities under state law by remunerating executives inappropriately and providing too little free care. Although these two decisions come from different jurisdictions, they illustrate the difficulty of discerning any pattern in the way state courts have viewed questions about nonprofit hospitals' compliance with their charitable purposes. Some of the haphazardness can be traced to genuine state-to-state differences in the applicable laws, but much of it reflects variation in fundamental judicial expectations about how nonprofit hospitals should behave.

State attorneys general have also jumped into the fray, using tactics that range from exhortation to litigation. Their involvement appears to have been spurred by several developments: the spectacular collapse of the Allegheny Health, Education, and Research Foundation in 1998,³⁰ which became the nation's largest failure by a nonprofit; the explosion in the 1990s of "conversions" (transfers of nonprofit assets to for-profit entities that generate substantial capital and raise questions about insider gains and lost community benefits)³¹⁻³⁴; and governance failures in the corporate world more broadly, which have led to demands for improved oversight.³⁵

Attorneys general and other state agencies have sought to use their authority to bring nonprofit organizations under close supervision. These interventions appear to have been fueled by a perception that the boards of nonprofit orga-

nizations can be lax and insufficiently committed to furthering public-policy goals. However, the involvement of attorneys general varies considerably from state to state, ranging from very active (in New York and Minnesota) to moderately active (in California and Massachusetts) to minimal (in many states in the South and the non-coastal West).

CORPORATE AND TRUST LAW

The two main legal bases for state intervention are corporate law and trust law. Corporate fiduciary standards, which have been widely integrated into state nonprofit statutes, demand loyalty (directors must put the corporation's interests before their own) and reasonable care (to the standard of an ordinarily prudent person). The "business judgment" rule creates a legal presumption that directors have complied with the duty of care in making their decision, unless the plaintiff can show that their actions constitute more than ordinary negligence, which is difficult to do. In general, the application of a corporate legal framework tends to give board members of nonprofit organizations substantial latitude in decision making.

Trust law, an alternative legal framework, focuses on protection of the organization's assets, rather than directly on the actions of its trustees. State attorneys general have the authority to enforce charitable trusts through the courts as representatives of the beneficiaries, and some have been able to use this approach to achieve more stringent enforcement than corporate law permits.¹⁰ The central assertion in such interventions is that a charity is not being operated in a manner consistent with its original mission.³⁶

More than 30 years ago, an influential federal court decision³⁷ held that the trend was to apply corporate, rather than trust, principles to directors of nonprofit organizations, reasoning that their duties were virtually indistinguishable from those of their corporate cousins. However, commentators have argued that the ability to ensure accountability to the charitable mission suffers when oversight emulates conventional corporate governance.³⁸ Because nonprofits lack the guiding economic discipline introduced by shareholders and capital markets, corporate-law principles may bestow too much discretion on nonprofit boards.

A recent example of the application of trust-law principles to nonprofit hospitals is the case

of Banner Health System. The company, which operated hospitals and nursing homes in a number of Western states, decided to sell 27 of its facilities in seven states and to apply the proceeds of the sale toward expanding operations in the "high-growth markets" of Colorado and Arizona. Anticipating resistance, Banner Health litigated to stop the attorneys general in South Dakota, New Mexico, and North Dakota from blocking transfers of funds out of state. In New Mexico, the case was settled. The North Dakota federal court refused to rule on the matter because the case did not raise issues of federal law. However, the South Dakota Supreme Court ruled against Banner Health, holding that an implied (or "constructive") trust could be imposed to thwart the company's plans.³⁹ The result was that the states successfully used trust doctrine to wring concessions from the charity.

Regardless of the regulatory approach used, *Banner* and other cases⁴⁰⁻⁴² illustrate an emerging theme in state regulation of nonprofit hospitals. State officials will not necessarily defer to nonprofit hospital boards or even give them the benefit of the doubt as the boards chart the future business directions of their organizations. Rather, appealing to the welfare implications of these decisions for the surrounding communities, state officials are using trust-law and corporate-law arguments to interpose their view of what constitutes inappropriate or appropriate action in light of an organization's charitable purpose. Similar moves have been made to exert control over the behavior of nonprofit health insurance plans.^{43,44}

CLASS-ACTION LITIGATION

In the late 1960s, the "war on poverty" spilled over into the hospital arena. Social activists launched a class-action lawsuit on behalf of persons who had been turned away from tax-exempt hospitals because of their inability to pay for care.⁴⁵ The plaintiffs' ultimate target was the community-benefit standard, which the plaintiffs saw as an unacceptable dilution of the obligations imposed on nonprofit hospitals. The litigation went all the way to the U.S. Supreme Court,⁴⁶ which ruled in *Eastern Kentucky Welfare Rights Organization v. Simon* that the plaintiffs lacked standing to sue privately to enforce the Internal Revenue Code.

After the defeat in *Simon*, this type of consumer activism went into hibernation. It has been reawakened during the past few years by a combination of two forces. The first of these forces is the emergence of techniques of mass tort litigation. The mass tort, or class-action, litigation strategy rests on several procedural devices that permit the consolidation of large numbers of claims alleging similar injuries and raising common questions of law and fact. By rolling dozens to thousands of plaintiffs' damages into a single award, class-action lawsuits make it cost-effective to bring claims that would otherwise be too small to interest plaintiff's attorneys.

The second force is a strong push during the past two decades toward the unionization of hospital workers, perhaps most prominently the push by the Service Employees International Union (SEIU).⁴⁷ Hospital unions are becoming politically astute and aggressive.⁴⁸ Their leaders and members may gain an advantage from characterizing the management of large nonprofit hospitals as profit-oriented. Generating publicity about a hospital's alleged failure to care adequately for the uninsured or, worse, its aggressive pursuit of payment from the poor can strengthen the union's hand in workplace negotiations.^{49,50}

Building on the momentum of these forces, plaintiff's attorneys have launched scores of lawsuits against nonprofit hospitals. They allege that the hospitals have shirked their community responsibilities, particularly in failing to provide free care to poor and uninsured patients. In 2003, two lawsuits (with roots in the SEIU), one in Illinois and the other in Connecticut, field-tested the strategy.⁴⁷ Soon afterward, Richard Scruggs, a prominent Mississippi lawyer and a veteran of successful class-action litigation against the tobacco and asbestos industries, filed "at least 49 federal class action lawsuits charging approximately 370 nonprofit hospitals in 25 states with mistreating uninsured patients by, among other things, failing to provide adequate charity care."⁴⁷

The New York case of *Kolari v. New York–Presbyterian Hospital* illustrates the way much of the litigation has unfolded.⁵¹ The four named plaintiffs were treated at New York–Presbyterian Hospital/Weill Cornell Medical Center. Although all of them were uninsured, they were billed higher fees than were insured patients, subjected to aggressive debt-collection efforts, and in the case of Kolari himself, denied some follow-up services.

The affected class consisted of employed poor persons and certain immigrants who did not qualify for Medicaid or for the hospital's charitable care program yet could not afford the charges. The suit was based on several legal theories, the most prominent of which held that section 501(c)(3) created a contract between the government and the defendants in which the plaintiffs were intended to be third-party beneficiaries.

The court emphatically rejected the claim. Relying on the *Simon* decision from 30 years earlier, it found that the plaintiffs lacked standing to sue in federal court. The judge's opinion advised the plaintiffs to "consult a map or a compass or a Constitution because Plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch."⁵¹ In addition, the court found nothing in the Internal Revenue Code to support this type of claim, dismissed the other federal-law claims, and rejected various state-law claims brought under fraud and charitable-trust doctrines.

Nearly all federal and state courts that have ruled on class-action lawsuits against nonprofit hospitals to date have reached the same decision as the *Kolari* court.⁵² Although the prospects of success in federal court now appear to be very slim, plaintiffs continue to pursue class-action claims in state courts across the country. More than 100 such claims had been filed by the end of 2005, and there are signs that some of these cases may be more successful than their federal counterparts.^{53–55} Most notably, Catholic Healthcare West and Sutter Health, two of the largest nonprofit hospital systems in California, have both settled class-action lawsuits, refunding fees charged to hundreds of thousands of uninsured patients.^{56,57} Arguments that nonprofit hospitals engaged in unfair trade practices appear to be faring better than those alleging breaches of tax and contract law.

Although the number and influence of dismissals easily outweigh those of the plaintiffs' victories at this stage, the situation could change. The history of class-action litigation suggests that even a few early settlements can influence the future course of the litigation.⁵⁸ Indeed, negative publicity or perceived legal risk may be enough to prompt hospitals to change their approach to charitable care. It seems likely that many hospitals today are rethinking their discounting and collection policies.

The litigation has clearly renewed attention to the definition of community benefit and the role of charitable care. The American Hospital Association (AHA) recently promulgated new policies on each, providing what it hopes will be a standard definition of community benefit for reporting to the IRS and suggesting that charitable care involve free care for those whose income is below 100% of the poverty line and graduated discounts for those whose income is between 100% and 200% of the poverty line.⁵⁹ However, the AHA has also sought legislation to protect hospitals that comply with this definition from class-action lawsuits. The proposed definition of community benefit is broader than that sought by other hospital associations, such as the Catholic Health Association of the United States, and does not seem likely to deter the stepped-up IRS oversight of hospitals on which Congress is now insisting.⁶⁰

CONCLUSIONS

The laws that govern the conduct of nonprofit hospitals are complex. Today more than ever, multiple regulators are seeking to enforce standards of charitable purpose, and the rules are constantly evolving. Adding to the complexity is a range of other laws we have not delved into — antitrust, fraud and abuse, and local environmental and land-use regulations.

To some extent, this convoluted evolution is inevitable; it reflects unresolved and contested policy questions that go to the heart of the nonprofit model. How much and what sort of services should the nonprofits deliver to justify their preferential tax treatment? Should they be thrust fully into head-to-head competition with for-profit hospitals or spared that? If the latter, what trade-offs would society confront in the quality, availability, and efficiency of health care services?

However uncertain the regulatory environment may be, it does not appear to be driving away preferences for this ownership model. The future of nonprofit hospitals seems assured, though formidable challenges lie ahead. These hospitals face cost increases that will outpace reimbursement, particularly from public payers. They also face growing competition from medical staffs interested in tapping into profits from procedure-based care that can now be performed in an outpatient setting. The struggle of nonprofit hospitals to maintain unprofitable services that are

needed by the community, such as emergency care, at the same time that more profitable services are lost to their own medical staffs will probably intensify.

These challenges press nonprofit hospitals to develop increasingly aggressive business models. They will seek to avoid bad debt and to attract patients who are well insured. They will also be increasingly interested in joint ventures with medical groups to provide physicians with the profit they might otherwise seek through for-profit ambulatory care and surgical centers. The days when nonprofit hospitals relied on charitable giving and were led by volunteer board members with little understanding of health care markets are gone. Indeed, one might argue that leaders of nonprofit hospitals are failing to act diligently if they do not test the boundaries of legal permissibility by considering every technique that their for-profit competitors use.

As nonprofit hospitals strike out in these directions, federal regulators, state officials, and plaintiffs will police the resultant frictions between the hospitals' business practices and their charitable obligations. A recent investigation by the U.S. Senate⁶¹ and an ongoing IRS audit of hundreds of nonprofit hospitals⁶² provide a taste of things to come. To the hospital board falls the unenviable task of demonstrating and articulating obedience to a charitable purpose in an increasingly harsh commercial environment.

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