

**Are They Holding Up Their End of the Bargain? Non-Profit Health Systems and
Their Deal with the Government**

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*Are They Holding Up Their End of the Bargain? Non-Profit Health Systems
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Non-profit hospitals have a long-standing deal with both federal and state governments. These hospitals are provided significant tax-exemptions and deductions in exchange for the provision of care for the indigent within their community. But not all hospitals receive this exemption; each hospital has to file for the special status with the Internal Revenue Service.

The Internal Revenue Service uses the Community Benefit Standard, enacted in 1969, to determine whether a hospital meets the necessary requirements for exemption. The Community Benefit Standard has several factors that are to be met in order to receive exemption, but not all factors are necessary. Some of these exemptions include; whether a board of trustees controls the hospital, whether the hospital operates an active and accessible emergency room regardless of individual's ability to pay (Folkerts, 2009). But since there is no requirement that all factors be met in order to receive a 501 (c) (3) status, there is a lack of consensus as to what qualifies as "community benefit." This lack of definition and cohesiveness has allowed non-profit hospitals to interpret the standard as they see fit and adjust as they desire (Owens, 2005).

The federal government, through the Senate Finance Committee, did an extensive evaluation of the non-profit health systems sector and noted many problems with charity and compensation but have yet to make any changes to legislation (Folkerts, 2009). Several state governments have also begun deep investigations into non-profit hospitals within their communities and some have revoked the tax-exempt status from hospitals.

In an effort to further explore non-profit hospitals, the Internal Revenue Service did a drastic overhaul of the Form 990, which is an informational return required for non-profits. Unfortunately, this form is not specific enough in quantitative standards and redundant to multiple federal statutes already in place.

There seem to be three obvious options for non-profit hospitals; either to further define community benefit to allow for comparison amongst hospitals, to revert back to the Charity Standard which was enacted from 1956 to 1969, or to eliminate tax-exemptions for non-profit hospitals. Realistically, defining community benefit is most likely due to the fact that many hospitals would go out of business if required to pay all of the taxes they have been exempt from, which would further decrease access to medical care in less affluent communities.

There are currently an estimated 49.1 million Americans who are uninsured and another large segment of the population who are underinsured; which is defined as individuals who have some form of health insurance coverage but when they enter into the healthcare system they are risking significant expenses that will not be covered by their insurance plans (Crossley, 2007; Principe, Adams, Maynard & Becker, 2012). Due to these far-reaching numbers it has become crucial to the United States Federal Government and the citizens of our country to properly understand the healthcare system and the spectrum of available care. As of January 2012, there are 2,904 non-profit, non-government hospitals in the United States, which accounts for 50.47 percent of registered hospitals, and as the baby boomer generation requires more healthcare and new epidemics continue to emerge it is necessary to understand the way in which they function (American Hospital Association, 2012; Schirra, 2011).

Non-profit health organizations function very differently from their 501 (c) (3) counterparts who survive mostly through individual donations with minor fee-for-service aspects, such as admission fees. Hospitals are simply too expensive to build and operate for this structure which had led to a nearly exclusive fee-for-service structure and other models to bring in the necessary funds (Schirra, 2011). In an effort to have sufficient funds to provide access to healthcare, non-profit health organizations have made a long standing deal with both the federal and state governments that they will be provided with significant tax deductions and exemptions in exchange for free or reduced healthcare to the indigent population in their community. The government found it beneficial to support private health systems because it reduced the burden of providing access to such care from the government (Schirra, 2011). The arrangement has an extensive history

beginning with the Tariff Act of 1894 which, “exempted the following organizations from tax: corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes” (Alam, 2010). During these times hospitals were typically run by religious orders and were used almost solely by the poor due to the fact that the wealthy could afford medical care in their homes and were taken care of by relatives. Since 1894, there have been various changes made to the criterion to qualify as a non-profit entity but the essential mission has remained the same and since evolved into the now well-known 501(c) (3) organizations.

Unlike certain charitable organizations, such as churches, not all hospitals fall under the 501 (c)(3) category and must apply for tax-exempt status with the Internal Revenue Service (IRS) and must continually prove their need for such status through the annual Form 990 (Alam, 2010). Beginning in 1956, the Charity Care Standard was used as the benchmark to receive tax-exempt status. It required the hospital to provide care to those who are not able to pay and reflected the notion that helping the poor was a core value of being a charity. The current standard used to meet the tax-exemption requirements is the Community Benefit Standard which was enacted in 1969 after Medicare and Medicaid were enacted. The formation of government funded health insurance had a significant impact on the tax-exemption standard because it was believed that indigent care would no longer be necessary in the near future since most individuals would be covered either privately or by federal government programs. Through the enactment of this standard the IRS became more lenient from its previous requirements to no longer necessitate health care be provided for free or at a reduced cost. The IRS also provided factors to determinations of status:

- (1) whether a board of trustees control[s] hospital and, if so whether civic leaders compose the board;
- (2) whether the hospital has an open medical staff and extends privileges to all qualified physicians in the area;
- (3) whether the hospital operates an active and accessible emergency room, regardless of patients' ability to pay;
- (4) whether the hospital provides medical care to all persons able to pay; and
- (5) whether surplus funds, when used, improve the quality of patient care

But, when the IRS issued these aspects it was stated that they were factors of consideration and were not requirements for non-profit status (Folkerts, 2009). Therefore hospitals could be lacking several of these components but still be granted tax exemption.

Unfortunately there is no consensus within the non-profit medical community as to what qualifies as charitable care, especially given the vague nature of the Community Benefit Standard. The lack of agreement of a definition has allowed non-profit hospitals to interpret the standard as they see best fit and to adjust the interpretation as they desire (Owens, 2005). This poses a significant problem for the United States government because they are giving these hospitals significant sums of money each year in the form of tax breaks and deductions with no true way to track the charitable care being offered or how those funds are being spent within the hospital. According to a 1990 study by the Government Accountability Office (GAO), "57 percent of the nonprofit hospitals provided less charitable care than the value of the tax exemption they received" (Folkerts, 2009). Essentially, the GAO report stated that non-profit hospitals are not holding up their end of the deal that was made with the government. The hospitals are receiving exemptions totaling \$12.6 billion in 2002 alone and these funds could have a significant impact on the people who are currently uninsured or underinsured if they were dispersed differently (Alam, 2010; Principe et al., 2010). By receiving a non-profit tax exemption

from both the federal government and the state government, hospitals are exempt from federal income taxes, federal corporate income tax, and exemption from sales taxes, property taxes and employment taxes. They also can receive discount on postal service rates but very important to non-profit hospitals is the ability to receive contributions from private individuals that are tax deductible (Sanders, 1995).

The concerns regarding non-profit hospitals use of the funds received by the federal government was brought to the attention of Senator Charles Grassley, the former Senate Finance Committee Chairman, and after considerable research into the charity, compensation, and community benefit policies he found that non-profits were, “providing less care to the poor than their for-profit counterparts... charging the poor, uninsured patients more for the same service than they charge insured patients”. After such shocking findings, the Finance Committee proposed that non-profit hospitals should have to explicitly define charity care and post the definition throughout their facilities, quantify their charitable care, regularly conduct a needs assessment for the community in which they serve, no longer up-charge uninsured patients, along with a long list of requirements to maintain their non-profit status and continue to receive tax-exemptions (Folkerts, 2009). But these suggestions were made in October 2007 and Senator Grassley has not made any moves to turn these recommendations into legislation. But this was not the first time that concerns have been raised regarding non-profit hospitals provision of charitable care.

After finding data suggesting that uninsured patients are charged, “between two and six times the cost to produce the service. They are then aggressively pursued by debt collection agencies for years” (Kane, n.d.). Over fifty hospitals, in 2004, were sued by

Richard F. Scruggs, a Mississippi lawyer who spear-headed tobacco industry lawsuits, alleging improper charitable care practices. The cases claimed that the hospitals had violated state law and federal law. The federal law that was in question was the Emergency Medical Treatment and Active Labor Act; which forces hospitals to treat patients, in the emergency department, until stable, without regard to their ability to pay. Scruggs also claimed that the hospitals were in breach of contract with the United States government requiring them to provide care in exchange for their tax-exemptions. But the Supreme Court has held up claims that a tax exemption does not equal a contract; which further muddies the responsibilities of non-profit hospitals and the standard in which they are held to (Moskowitz, 2005).

The availability of free or reduced care to the poor used to be a defining characteristic of non-profit hospitals and the Senate Finance Committee was hoping to go back towards the aforementioned ideal when suggesting that policies be out in the open and available in multiple languages. Non-profit hospitals should not be hiding the fact that they provide care to the poor, they should be proud of the good deeds they are performing for the community. Quantifying the amount of charitable care given each year by non-profit hospitals remains the most difficult task. This is due to the fact that hospitals do not function with one national system; they each have their own way of reporting and collecting information. Some hospitals have switched to electronic medical records which make sorting community benefit information much easier. But the qualities of these computer programs vary drastically upon the financial resources available to the non-profit health system. The requirement to complete a needs assessment every three years would not only benefit the IRS for documentation purposes but it would also

benefit the healthcare system by allowing them to identify current problems within the community and be proactive instead of being reactive while remaining relevant within the community and seen as a current, up-to-date resources.

The IRS and the Federal Government have had concerns regarding the legitimacy of the tax-exemptions since 1942 when the Form 990 was created by the Treasury Department. This original document was filed annually for informational purposes and it only required an income statement, a balance sheet, responses to three questions, and signatures by two executives within the organization. The purpose of the Form 990 was to track non-profit organizations and ensure all funds were being spent properly. Since 1942 the form has gone through multiple evolutions and has gone from being two pages long to a frightening eleven pages plus sixteen schedules. The present-day Form 990 has much greater public access and is also focused upon transparency and compliance (Alam, 2010). The transparency of the Form 990 is one of its most beneficial and critical features due to the fact that non-profit organizations are, “dependent on the public’s trust and goodwill to gain the support they need for the work they do (Jeavons, 2010). Although it is essential to receive specific information from non-profit organizations, the form asks many questions that are already covered by other Federal statutes such as The False Claims Act, The Anti-Kickback Statute, The Stark Law, and The Health Insurance Portability and Accountability Act of 1996.

The False Claims Act came about from the desire to prevent fraud against the government. This act is applicable to all organizations that file claims to the Federal Government, Medicare and Medicaid, thus making all non-profit hospitals liable. The False Claims Act claim can be filed by an individual on behalf of the United States, thus

making this act function as increased transparency which is also a goal of Form 990. The consequences of violating this act are significant enough to act as deterrents, large civil fines plus possible exclusion from all Federal programs which would drive the hospital out of business eventually. This act also promotes good governance, which the IRS is very concerned about, since whistle-blowing policies and prevention of these violations must be in place within each non-profit organization to avoid the negative ramifications of being accused of these abuses (Alam, 2010).

The Anti-Kickback Statute prevents physicians and health systems from financially gaining through patient referrals; similarly to the False Claims Act the Anti-Kickback Statute has very severe consequences. This statute also leads into corporate governance because hospitals must structure themselves and put in place checks and balances to ensure that they are in good standing and not violating these statutes. The Stark Law is very similar to the Anti-Kickback Statute in the sense that is in concerned with referrals with a focus on self-referrals and with personal relationships within referrals. This statute differs by highly suggesting hospitals fill out forms disclosing their relationships in order to stay in compliance with the statute. The Health Insurance Portability and Accountability Act of 1996 is enormous but is most well-known for its focus on patient confidentiality and the handling of patient records (Alam, 2010). All of these acts are important to the transparency of non-profit organizations but it is a waste of tax payers' money to ask these questions for these statutes and again for the Form 990. The Form 990 could be better formatted to probe topics that are not covered by other Federal Statutes.

The state of Maryland required similar information as the Form 990 for their non-profit healthcare systems beginning in 2004. The state required hospitals to report information such as, “community health services, health professional education, mission-driven health care services, research, financial contributions, community building activities and charity care. Just within one state there were significant challenges in reporting such statistics. The state of Maryland hoped that by forcing hospitals to look at the raw data, it could be an impetus for change and since there are currently no rewards or penalties it would have to be entirely on the fruition of the hospital itself.

One of the many problems was properly defining charitable care and whether or not to include bad debt. Bad debt is when at the time of service the hospital believes the patient is going to pay the bill but when attempts are made to collect the bill it becomes apparent the patient is unable to do so and the bill is waived (Bradford & Schlesinger, 2009). This varies from the charitable care scenario when the patient and their family apply for free services before the physicians and the hospital render them. Bad debt is often left out of the definition of charitable care due to the fact that the patient may not necessarily be needy but merely negligent or the hospital may have ineffective structure of collecting debts. Certain hospitals also report Medicare shortfalls under charitable care, Medicare shortfalls occur when reimbursement received are below costs. There is debate as to whether this should be included as charitable care because the reimbursement may have been insufficient due to improper coding by the hospital itself (Bazzoli, Clement & Hsieh, 2010). This presents a challenge in comparing charitable care of hospitals since some report as charity and others report as uncompensated care. The hospitals also struggled in their ability to capture all of the necessary information and

interpreting and sorting information correctly with some hospitals using electronic medical records and others not. Some hospitals also use the term uncompensated care in place of charitable care, when in fact uncompensated care is actually charitable care plus bad debt (Darr, 2004). This form of uncompensated care is detrimental to the health system because significant amount of resources are spent in attempting to collect the debt, instead of using proper measures at the beginning of the interaction to determine the ability to pay (Hammer, 2006). Many non-profit hospitals only define charitable care for patients who are one hundred percent above the federal poverty level or below, but this does not take into account the cost of living in each hospital's specific community. Once this information is taken into account plus the number of individuals within the household it is not difficult to calculate what percentage of costs the patient will be likely to pay. This change in structure will save the billing department hundreds of hours attempting to reach patients. It will also aide in rehabilitating non-profit hospitals reputations which have been damaged in light of recent accusations regarding excessive and aggressive measures being taken to be compensated for care by individuals who clearly could not afford their bills (Hammer, 2006).

Unfortunately there has become a visible inconsistency between rhetoric and values, what is said and what is done throughout the non-profit hospital sector (Jeavons, 2010). In recent years, non-profit hospitals and their for-profit counterparts have begun to resemble each other in numerous ways. Regrettably one of these resemblances is in the amount of charitable care they are giving to their community. In a study by the Congressional Budget Office (CBO) it was found that, "nonprofit hospitals still provide only a mean of 4.7% uncompensated care as a share of total hospital operating expenses

and for-profits have a mean of 4.2% uncompensated care” (Folkerts, 2009). Yet one significant difference between non-profit and for-profit hospitals is their service and patient mix. For-profit hospitals are likely to specialize in the services that provide the organization with the most profit such as cardiac and orthopedic care, whereas non-profit hospitals have to balance profit making services which allow them to operate with community needed services, especially in regards to psychiatric care which does not steadily reimburse from Medicare, Medicaid or private insurance. It is assumed that general hospitals provide the same services regardless of ownership; for-profit hospitals just have the advantage to only admit desirable patients that have the ability to pay while non-profit hospitals are expected to accept all patients that come through the door regardless of insurance status or ability to pay. For-profit hospitals also have the benefit of being able to hand select their charitable care cases, focusing on cases that will get them significant public exposure, whereas non-profit hospitals have to focus on the cases in front of them and cannot be as selective due to their overwhelming amount of applications (Horwitz, 2005).

While the public still has the notion of the standard of care being the Charity Care Standard of the 1960’s and not the mild and lenient Community Benefit Standard. It seems as though the non-profit healthcare system has experienced mission creep, which is defined as, “the condition in which a nonprofit loses track of its purpose and spends too much energy following the resources market, slowly and modestly shifting to accommodate resource opportunities at the expense of attention to mission” (Brown, 2010). Mission statements should be the focal point for non-profit hospitals, as this statement is one of the cornerstones of the organization and should function as the

guiding light in all activities within the hospital (Bolon, 2005). All employees of a non-profit hospital should understand the mission and make all decisions from the basis of fulfilling the mission of the organization. If members of the organization are unclear of the mission then they are unlikely to act with its best interest at heart. Mission statements are defined as, “a written, formal document that attempts to capture an organization’s unique and enduring purpose and practices,” which leads one to understand the significance of mission creep (Bolon, 2005). This statement is supposed to be what defines an organization and separates it from all other organizations in the community. But in a study done by Douglas Bolon it became apparent that mission statements between non-profit and for-profit hospitals were incredibly similar. They discussed the same topics, cost, access and quality, and these topics were discussed with minimal amount of attention and detail and with little differentiation between identified members to serve (Bolon, 2005). Given the scrutiny non-profit hospitals are under regarding their tax-exemptions and whether or not they are deserved, it is critical for non-profit health organizations to focus on their missions and explicitly state their desire to provide care to the community and the main concept be providing charitable care. Any person looking into services at a non-profit hospital should be able to clearly identify their charitable interests, not only their desire to provide, “quality healthcare.”

From all the research accumulated it appears as though non-profit hospitals have lost sight of their original mission to care for the indigent and they have seemingly forgotten their portion of the deal with the United States Government. According to several studies, this divergence from the mission has been occurring for several decades in the non-profit hospital sector. Beginning in the late 1990’s there was a shift of hospital

boards of directors from being exclusively community based to mixed with medical staff and senior management of the hospital. The notion behind this shift was rooted in functioning more like a traditional corporation and to maintain a competitive edge. There are pro's and con's to the mix on the board of directors of a non-profit hospital; the benefit being increased access to clinical information and the belief that participation on the board will make physicians more loyal to the hospital in which they practice. But, members of the board who are employed by the hospital have different interests than members of the community. There can also be difficulties when the board is comprised of community leaders, they often have different interests that can conflict and the hospital will try and pacify all members therefore diluting their mission and having disjointed charitable care (Owens, 2005). Physicians and senior management have financial interests at heart for the non-profit hospital as it will benefit them in various ways; whether it is new technology throughout the hospital or pay raises. Community members have all members of the public at heart and have charitable care as their focus because there is no financial gain for them (Young, 1996). This new representation on the governing board of a non-profit hospital must be carefully examined in an effort to remain mission centric and focused upon charitable care. There was a long-standing history between community leaders and non-profit hospitals since they were originally rooted in donations and aid in formation of hospitals. This relationship grew into representation from as many different sectors of the community as possible, who did not have a financial interest in the hospital but only in the well-being of the community and its members receiving proper care. The shift in board composition has created segregation between the community and the hospital and the hospital risks losing touch

with the needs and desires of the individuals in which they serve (Young, 1996). There is also a statistically proven positive correlation between community board members and the amount of uncompensated care provided to the community, indicating that community board members are more charitably focused than their medical staff and executive counterparts (Alexander et al., 2008). Non-profit hospitals have also struggled in compensation for their executives. Currently, they are competing with for-profit hospitals for executives, which have a much larger capital base and extensive incentives for their employees. As well, executives of non-profit hospitals should have an entirely different focus than their for-profit counterparts. Non-profit executives should be rewarded for their provision of charitable care, not by their ability to increase the bottom line. This is another example of how the mission statement of non-profit hospitals is not being lived by all of its employees (Owens, 2005).

It has been suggested that non-profit health organizations be held to the Sarbanes-Oxley Act, which was passed in 2002. This piece of legislation held for-profit organizations to specific standards regarding their governance and internal structure regarding decision making (Alexander et al., 2008). Several initiatives have been passed by states to accomplish three things:

“Enhance the independence of governing boards from senior management, increase board accountability to communities and other key stakeholders, and reduce conflicts of financial interest between board members and the organizations they govern.”

Despite the interest from both state and federal governments, there is little evidence connecting these ideals to the success and effectiveness of hospital boards (Alexander et

al., 2008). Part of the complexity of governing boards is the multiple relationships concurrently having expectations; the board must act on behalf of the community but the board must also act in the best interest of senior management. Unfortunately the goals and needs of these two relationships do not always align (Alexander et al., 2008). But, accountability has been statistically proven to be positively correlated with community engagement. The evaluation of community health measures and the evaluation of leadership benefitted the amount of charitable care received and meeting the community's needs. Whereas when the board assumes the majority of decision making capabilities, there is a negative association to community engagement. This is critical for non-profit hospitals to take into consideration, allowing the board of directors to make all decisions is not in the best interest of the organization. There needs to be a distribution of power and the ability to bring in necessary experts. This study has shown that the indicators used by the Sarbanes-Oxley Act of 2002 do not provide the same results in the non-profit hospital arena. These attributes were thought to increase board independence and the community needs being heard throughout the governance of the organization, but they have weak associations with benefits to the community such as charitable care and community engagement (Alexander et al., 2008).

Many non-profit organizations were concerned about protecting their assets and their livelihood during the recession, especially for healthcare in light of accountable care organizations, which lead to an influx of multi-sector relationships similar Millennium Park in Chicago, Illinois and the Indiana University Health System throughout the state of Indiana. These relationships can facilitate many benefits for all three sectors, non-profit, for-profit and government, but they must be treated very delicately. Hospitals may

benefit from a merger due to reduced competition, higher utilization rates, and decreased administration costs; even though it has been proven that over time these benefits do not lead to increased efficiency (Ferrier & Valdmanis, 2004). Accountable Care Organizations were formed with the belief that healthcare providers could work together with an individual patient across multiple offices and locations. The federal government has incentivized healthcare providers, through Medicare reimbursement rates, to partake in these organizations by rewarding them for meeting certain interfacing and quality standards along with reduced healthcare costs. Accountable Care Organizations must meet certain criteria in patient care as well as structure of the organization such as, having shared governance amongst all participants' appropriate power in the decision-making process (Garner, 2011). As beneficial as Accountable Care Organizations may be for the patient, having an interactive continuum of care, they have proved to be difficult for non-profit hospitals that have now built a partnership or joint venture with for-profit physician groups or clinical services. The benefit for the insured patient may be noteworthy, there is research indicating that such large healthcare systems are detrimental to indigent populations. As the systems grow, the responsiveness and connectedness to the community weakens and therefore less charitable care is provided and less community benefit is delivered by system hospitals versus independent hospitals (Alexander et al., 2009). A subtle balance must be found between the superior care for the insured patient and the availability of care for the uninsured patient.

The multi-sector relationships proved to be very tricky for St. David's Healthcare System when they lost their tax exemption in light of a partnership with a for-profit healthcare company (St. David's Healthcare System, Inc. v. United States of America,

2003). St. David's believed that the partnership allowed the organization to further its mission and charitable functions, but they had to prove that they were not also promoting non-charitable interests and intense scrutiny of the organizational structure of the partnership ensued. After the district court in Texas ruled in favor of St. David's Healthcare System, on appeal the win was vacated and remanded for trial.

There seem to be three logical options to fix the problem that has been plaguing our healthcare system for decades. The IRS could revert back to the Charity Care Standard for tax-exemption; this would essentially tighten up the purse strings. By changing the standard hospitals would be forced to give free or reduced cost medical care to the poor and would not consider health promotion or bad debts as charitable care. The reversal of the Community Benefit Standard would mean many hospitals would lose their exemption, in an effort to prevent hospitals from closing there could be a five year adjustment period to allow hospitals and health systems to catch up with legislation. After the five-year adjustment period is when exemption status would be revoked and taxation would begin.

Another option would be to further define charitable care within the Community Benefit Standard and set quantifiable standards to be met annually. Similarly with reverting to the Charity Care Standard there would be a significant time lag in allowing hospitals to catch up since they have been functioning this way for fifty years. By setting definitive standards and criterion, over a period of time, it will become much easier to compare hospitals and notice which ones are not providing enough charitable care. There are definite downfalls to this option though; it has been proven by the state of Maryland that it is not easy to set parameters within one state, not fifty. Hospitals would have to be

on more of an even playing field in terms of available information and accessible software to properly format and codify the information for there to be accurate and fair comparison between them.

The third option, the most dramatic, would be to eliminate tax exemptions. While this is a drastic option, given that the Federal government gives non-profit hospitals upwards of 12.6 billion dollars annually. Since this is such a significant sum of money and the government is already functioning with such a high level of debt it may benefit the nation significantly. For-profit hospitals get minor exemptions for their charitable care and if they evened the playing field financially there may be more drive and competition to provide charitable care. The 12.6 billion dollars not being spent in exemptions could still go to the healthcare system by funding for Medicare, Medicaid, or the new individual mandate will drastically change the health insurance front as well. But there could also be disastrous consequences to removing such a large proportion of hospital capital. If hospitals do not receive their 501 (c) (3) status then they will no longer receive tax-exemptions but they will also no longer be able to deduct contributions made by individuals and those charitable people would most likely take their funds elsewhere. Therefore if hospitals lost their non-profit status they would immediately be losing two of their largest forms of capital (Schirra, 2011). This type of action would be unfortunate for those non-profit hospitals that have remained mission-centric and are providing an adequate amount of community benefit; they would be unfairly punished by the actions of others (Kane, n.d.). Multiple studies have shown that for-profit, or investor owned hospitals, provide roughly the same amount of charitable care as their non-profit counterparts plus they benefit their community by paying taxes. It is also important to

take into account that non-profit hospitals are typically located in less affluent areas than their for-profit counterparts, which leads researchers to believe that they have a higher demand for charity care. Due to their location, by removing their tax-exemptions could possibly hurt the uninsured individuals of the community more than the executives of the hospital (Schneider, 2007). The individual mandate is actually expected to benefit non-profit hospitals greatly because the population they are expected to serve for free or at reduced cost will be decreasing rapidly, but it will not solve all of the problems. What has been made clear from the research and studies is that the non-profit healthcare system is not functioning properly and needs to be addressed. Senator Grassley began the fight towards stricter standards but unfortunately has chosen not to proceed with new legislation. It has also come to the forefront that the IRS and Congress are unclear as to what standards non-profit hospitals should be held to, which has allowed them to run rampant for years. Overhauls need to occur on both sides of the fence, the changes cannot only come from the government or only from the non-profit sector. The changes must occur as a partnership working together to better the care being given to patients regardless of their ability to pay.

The Federal government has not been the only ones taking notice; several state governments have also taken measures to ensure their investments. In 2004, the Department of Revenue for the state of Illinois rescinded Provena Covenant Medical Center's tax-exempt status because the local tax committee determined that Provena was, "transferring profits out of the community to a corporate headquarters" all while suing patients for uncompensated care. The profits being moved by Provena Covenant Medical Center to the large corporate headquarters were then being dispersed to for-profit

divisions of their large health system (Unland, 2004). The removal of their tax-exempt status then made the healthcare system liable for property taxes of roughly one million dollars annually (Darr, 2004). Provena Covenant Medical Center immediately filed an appeal and the circuit court of Sangamon County ruled in favor of the healthcare system for both a charitable and a religious exemption. The Department of Revenue then filed an appeal and the appellate court ruled in favor of the removal of the tax-exempt status and therefore reversed the judgment of the circuit court. Finally, the Supreme Court of Illinois granted certiorari and then affirmed the judgment of the appellate court therefore removing the tax-exempt status of the Provena Covenant Medical Center (Provena Covenant Medical Center v. Department of Revenue, 2010). This decision highlighted the fact the notion that although the Federal government currently uses the Community Benefit Standard, state governments still have the right to make their own determinations (Darr, 2004). The state of Illinois and the Department of Revenue has used the same criteria to deny three hospitals their tax-exemption in 2011 alone (Carlson, 2012). This adds another layer of complexity to the non-profit hospital status within the United States. According to this ruling, it is possible for a hospital to be given a non-profit status and therefore tax-exemption from the Federal government but fail to meet the necessary standards of the state that the hospital resides.

The Supreme Court of Illinois has held in Provena Covenant Medical Center v. Department of Revenue (2010) that the healthcare system had been too aggressive in their desire to collect outstanding debts. These extreme efforts led to several individuals to file for bankruptcy. Another rising issue is the problem of uninsured individuals paying higher rates for services than their insured counterparts. This occurs within hospitals

because they make deals with large insurance companies to offer services for a reduced fee in order to be in-network. Thus making the bills of the indigent, who did not file for charitable care, several times higher and therefore more unlikely to pay (Darr, 2004).

The ramifications of non-profit hospitals actions throughout the state of Illinois acted as the impetus for the Tax-Exempt Hospital Responsibility Act to be proposed in January, 2006. This act would be a watchdog for the hospitals earning the privilege to receive such generous deductions, to ensure they are providing, “at least eight percent of total operating costs in care for uninsured or poor patients” (Office of the Illinois Attorney General, 2006). Surprisingly, hospital officials seemed to be very supportive of the new law that will quantify how non-profits qualify for their exemptions. But, the amount of care necessary will also be dependent upon assessed property values, therefore older hospitals in low-income areas will be required to do less charitable care than brand-new hospitals with highly desirable real estate (Carlson, 2012).

At roughly the same time as the Provena Covenant Medical Centers Case, North Attleborough, Massachusetts was going through the same problems half way across the country. The town revoked the tax-exempt status of a physicians’ clinic that was affiliated with a non-profit hospital for their minimal access to care, higher prices for services for uninsured individuals, and the arrangement between the practice and hospital was of grave concern. But the most appalling fact in the case was that the physicians’ clinic had no charity care policy and no walk-in policy or hours for patients without health insurance (Unland, 2004). It became abundantly clear that the problem of charitable care abuse and definition is a nationwide problem, affecting hospitals with varying sizes and specialties. Regardless of the affluence of the community in which the

hospital is located, there is the underlying question of whether or not they are meeting their standard for care and are they going to come under attack as so many hospitals have in recent times.

In many ways, non-profit health organizations have been able to run free for the past forty-three years, since the Community Benefit Standard was passed. The free reign these organizations have been allowed and the complexity of their organizations has been a significant detriment to their community. Unlike for-profit organizations, non-profit health systems do not answer to shareholders who are performance driven and they are lacking in accountability. For-profit health systems must answer to the Sarbanes-Oxley Act of 2002 and the Securities and Exchange Commission; which require significant amounts of transparency and high standards for governance (Hayden, 2003). Non-profit organizations only have the community to stand before, which does not always have an option in choosing where to receive care given our countries stratification of healthcare. These health organizations have to rely upon their staff and board of directors to be engaged enough within the community to know whether or not programs are successful, since most non-profits provide services that are market failures hence why for-profits have chosen not to provide such services. Due to the type of services being provided, non-profit organizations cannot depend on Adam Smith's invisible hand of competition because these services are not economically or socially desirable. This structure makes non-profit health systems reliant upon their upper-level management and their board of directors to ensure the organization is as transparent and community centric as possible. Non-profit organizations are held responsible by the Internal Revenue Service, through the Form 990 and the Centers for Medicare and Medicaid Services through the Medicare

Cost Report, but neither of these bodies have a clear-cut definition for charity care or properly defined places to report such information in their forms (Kane, n.d.).

There are many options available both to the government and to the non-profit healthcare systems themselves in how to address these concerns but lawmakers must remember that the healthcare market does not function as a typical competitive market, they must act accordingly. It has become apparent that nation-wide standards and quantitative measures must be formed. Until these standards are formed and accounted for there can be no real comparison amongst hospitals. The government will have to intervene to specify the inputs and to dictate the proper way to report such information but the redundancies of the Form 990 are currently benefitting no one and only complicating matters instead of clarifying them. Once hospitals have had the time to adjust to these standards and reporting measures, the government will be able to take all necessary action; the process will be long and arduous so it must start now. But the focus must remain on making these changes to benefit society but to avoid closing hospitals and making access to healthcare even more disparate and difficult. Non-profit executives and senior management should take the opportunity, while still available, to be a part of the discussion and be proactive in identifying their charitable care. The best decisions will be made for the country when the industry and the government are having a conversation about regulations and statutes, not when the government hands them down to the non-profit sector. Non-profit hospitals must become more introspective and more aware of their policies and practices on all levels of their organization as well as more involved with the community surrounding them. Step out of the bubble in which the

hospital functions and ask local health access charities where improvements can be made (Unland, 2004).

The current system has allowed non-profit health systems great freedom in innovation and to be community specific, but it has caused resistance to external accountability that must be addressed if they desire to receive tax-payers money (Kane, n.d.). A delicate balance must be found to have fiscal benefit as well as quality medical care being provided, throughout the entire continuum, for all individuals. It is also imperative to note that all hospitals, including non-profit, must procure enough services to have a profit annually. The difference is how those profits are distributed; non-profit hospitals cannot exclusively provide charitable care. But the amount of care they do provide and whether bad debt and Medicare shortfalls are considered part of the charitable care they provide is up for debate (Bazzoli, Clement & Hsieh, 2010). Also to be noted, the lack of sector wide definitions has provided for studies with similar goals to have widely differing outcomes, until a standard is set it will be impossible to definitively know the implications of the tax-exemptions provided by state and federal governments to non-profit health systems. As the individual mandate for health insurance comes into effect, all non-profit hospitals will have to adjust accordingly and the healthcare system will see dramatic changes throughout all levels of care.

After the abundance of research done into non-profit hospitals and their taxation requirements, further definition of “community benefit” is the most realistic action for both state and the federal government to take. This action will allow changes to incrementally occur, but begin immediately whereas reverting to the Charity Care Standard or eliminating non-profit exemptions entirely would require long-term goals and

risk the decrease of accessible medical care for indigent populations while insured patients will still be able to enjoy access to healthcare.

Transparency is a value for nearly all non-profit organizations, as it should be. But for non-profit health systems education for the public is just as crucial as access to hospital documents. The current healthcare system is so complicated and overwhelming that without proper knowledge of sector norms and services it could be to the detriment of the public. Informational sessions explaining the way health insurance functions within our nation, and how hospitals report certain information will prevent miscommunication and will be a stepping stone to a rehabilitated reputation when the community sees the non-profit health system willing providing financial documents and being forthcoming voluntarily and not only when under the gun.

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