Health Should Be a Recognized Human Right in the US: How the Health Care System is Failing Under Federal Tax Policies

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I. INTRODUCTION

Access to affordable, quality health care should be a widely recognized, basic human right. The United States has a moral and legal obligation to provide protection and ensure such access, but is failing from a human rights perspective due to its insistence on using failing tax policies to address changes. International treaties such as the International Convention on the Elimination of All Forms of Racial Discrimination, enumerates rights for citizens to public health, medical care, social security and social services to be accessed without discrimination, and provides that the government has a responsibility to effectively promote equitable access to health care.[1] How those obligations are interpreted and implemented vary from country to country, including in the U.S., where access to health care is not fully considered a basic human right.

Access to health care is important because being healthy is a prerequisite for realizing the political rights enshrined in the United States' founding documents. Not having access to affordable quality health care also stymies a person's ability to pursue other enjoyments. For example, a working parent's child contracts a disease that requires ongoing medical attention and care. The family has access to medical insurance, but their insurance does not cover all the required treatments. The bills begin to pile up, and the parent cannot meet his/her/they financial responsibilities. The hospital providing care for their child ultimately sues the parent to collect these bills and is awarded the full judgment. Payments are ordered at $35.00 weekly, the standard nominal payment order in Connecticut's Small Claims court.[2]

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[1] G.A. Res. 2106 (XX), at 195 (Dec. 21, 1965) (where the specific right to "public health" is enumerated under Article 5(e)(iv) of the declaration).

[2] CONN. GEN. STAT. § 52-356d(c) (2003) (quoting in part "The amount which shall constitute an order of nominal payments shall be set by the judges of the Superior Court.") (Based on my professional

However, post judgment interest capped at five percent for all hospital debts renders it unlikely that the parents will ever get out from beneath this judgment.[3] That judgment negatively impacts the parent's credit report, and could threaten wages or bank accounts through garnishments. Negative reporting on a credit report then affects a person's ability to buy a home, get an affordable car loan, and can even disrupt the ability to gain various types of employment.

The U.S. government has primarily provided access to health care, in hopes to improve health levels of its citizens, through its use of tax policies. These policies are failing primarily because the laws do not enshrine access to health care as a basic human right, unlike antidiscrimination laws. This paper argues that the continued reliance on tax policies to effectuate health improvements is inadequate by itself, and has resulted in U.S. hospitals being more concerned about their bottom line than the health of their communities. If legislators persist in measuring success in health care primarily from a tax policy perspective, and thus in terms of financial efficiency, we will continue to have the same issues with gaining access to affordable, quality health care. Accessing the shortcomings of achieving a standard of health care as a basic human right requires evaluating the historical evolution of U.S. tax policies, their motivation, the country's founding documents and various international agreements. A human rights perspective is the best method of analysis for the purpose of measuring success in health care versus a tax regulation perspective. The United States continues to be home to people lacking access to affordable, quality health care. Without it, our country cannot begin fulfilling an essential prerequisite for the achievement of the rights promised to its citizens.

Throughout history, the U.S. government has addressed health care issues through federal tax statutes and regulations, yet the government has fallen short of ensuring health care as a basic human right. Analysis will illustrate how, historically, some federal policies have focused on promoting health care access through tax exemptions in addition to funding facility construction. Analysis will include examining efforts made by the government through its use of tax regulations to offer limited government health plans to populations deemed most at risk. These same historical federal regulations have encouraged the commercialization of nonprofit hospital behavior; to the point that it makes little financial sense to continue making tax-exemptions a legislative focus. Current federal policies under

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experience working for the Connecticut Judicial Branch, $35.00 weekly has been the set nominal weekly payment fee amount.)

[3] CONN. GEN. STAT. § 37-3a(b) (2018) (quoting in part "[i]n the case of a debt arising out of services provided at a hospital, prejudgment and post judgment interest shall be no more than five per cent per year…").

the Affordable Care Act, which, broadly speaking, promotes both access to health care and provides accountability measures for hospitals by tracking health outcomes. Neither stop the encouragement of commercialized behavior. This type of behavior is counteractive to a goal of achieving health care as a human right.

II. ACCESS TO AFFORDABLE QUALITY HEALTH CARE AS A HUMAN RIGHT

Understanding how well the U.S. meets its obligation to provide access to health care as a basic human right is difficult because conceptualizing the right to health is intricate and multi-dimensional. The lack of a single, universal standard of health for all nations does not allow for easy comparison between countries in this context. The complexity in interpreting health care as a basic human right and lack of a universal standard emphasizes the importance of analysis because: "[w]ithout good health, people may have great difficulty advocating for and benefiting from their human rights. Without adequate human rights protections, harmful conditions and practices that undermine health may persist."[4] In other words, not having access to affordable quality health care means a population will have enhanced difficulties in advocating for their other rights. In other words, managing your disease provides less time you can devote advocating for your rights. Thus, health and human rights are inextricably linked to one another.[5] The "[I]ntersection of human rights and health goes beyond the right to health and implicates a number of other rights (life, liberty, judicial redress, privacy, education, etc.) that have an impact on the ability of a person to achieve good health."[6] Human rights offer a level of minimum entitlement, which people can expect.[7] Some rights are founded in morality and some are founded in legal enactment. They can also be inalienable, absolute and/or universal depending on the context.[8]

The U.S. has shown its commitment to health care through the signing and ratifying of treaties. Protecting a minimum level health care right has been recognized by the U.S. at various levels both domestically and

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[4] Lance Gable, *The Proliferation of Human Rights in Global Health Governance*, 35 J.L. MED. & ETHICS 534, 535 (2007).

[5] *Id.* (citing the works of Jonathan Mann and Larry Gostin).

[6] *Id.*4

[7] *Id.*

[8] Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151, 1154 (2007) (arguing that a legal right to health be first recognized through the federal courts to overcome Congress' inability to act; reviewing South African and Canadian experiences to support that argument, in efforts to achieve effective citizenship and equality of opportunity).

internationally. For example, in 1946 the World Health Organization (WHO) Preamble to the Constitution developed the concept of the right to health: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[9] The Constitution of the WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[10]

Understanding of legal obligations includes the internationally recognized Universal Declaration of Human Rights (UDHR). The UDHR is not a treaty. It does not create legal obligations directly; it is an expression of the fundamental values which are shared by members of the international community. As such, it has influenced the development of international human rights law to the point where it could be argued as binding as a part of customary international law. The 1948 UDHR, passed by the General Assembly of the U.N., mentioned health as part of the right to an adequate standard of living in Article 25.[11] It recognizes the importance of human rights: "*Whereas* recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world…"[12] The UDHR then charges all people and organs of society to "strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance…"[13] In addition, the UDHR outlines human rights in articles addressing specific rights; one unambiguously being health care.[14]

The U.S. has signed or ratified international treaties in a further expression of recognizing its legal obligations. For example, The U.S. has signed and ratified the International Covenant for Civil and Political Rights (ICCPR) and the Convention on the Elimination All Forms of Racial Discrimination, thus becoming legally obligated to these treaties as it would for any domestic law, subject to reservations[15].

The U.S. signed, but has not ratified, the International Covenant for Economic, Social and Cultural Rights (ICESR).[16] The ICESR, adopted by

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[9] *Constitution of the World Health Organization*, 36 AM. J. PUB. HEALTH 1315 (1946).

[10] *Id*.

[11] G.A. Res. 217A (III), Universal Declaration of Human Rights at 52 (Dec. 10, 1948).

[12] *Id*. at 1.

[13] *Id.* at 3.

[14] *Id.* at 52.

[15] G.A. Res. 2200A (XXI) (Mar. 23, 1976); G.A. Res. 2106 (XX) (Dec. 21 1965).

[16] Amanda Littell, *Can A Constitutional Right to Health Guarantee Universal Health Care Coverage or Improved Health Outcomes?: A Survey of Selected States*, 35 CONN. L. REV. 289, 313

the U.N. General Assembly in 1966, is a major U.N. covenant that recognizes health as a human right.[17] According to Article 12 of the ICESR, the right to health includes "the enjoyment of the highest attainable standard of physical and mental health."[18] Article 12 requires that all states recognize that as a right.[19] The U.N. Economic, Social and Cultural Rights Committee has published Comment 14 to ICESR, which outlines the content of the internationally recognized right to health and mandates that it should be implemented and enforced.[20] General Comment 14 provides for three levels of human rights obligations: to respect, protect, and fulfill.[21] The duty to respect requires state parties to refrain from interfering directly or indirectly with the enjoyment of the right to health.[22] The requirement to protect entails countries to take measures that prevent third parties from interfering with the guarantees of Article 12.[23] The responsibility to fulfill requires states to adopt appropriate measures toward the full realization of the right to health.[24] General Comment 14 addresses implementing policies towards the goal of full realization.[25]

The U.S., while having not ratified the ICESR, does draw parallels in its tax regulations from what is found in General Comment 14, Article 53. The comment claims a duty by countries "to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health."[26] When a country is implementing these steps, adopting "a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy" is paramount.[27] Moreover, the national health strategy ought to

(2002) (concluding that "a constitutional right to health does not guarantee universal public coverage or improved health outcomes for a population. A right to health is not necessarily an individual right or a social right, but may be a combination of individual and social rights, and thus, does not fit neatly into the traditional rights dichotomy.").

[17] G.A. Res. 2200A (XXI), International Covenant on Economic, Social and Cultural Rights, at 4 (Dec. 16, 1966).

[18] *Id.*

[19] *Id.*

[20] Comm. on Econ., Soc. & Cultural Rights, Gen. Comment 14, *The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

[21] *Id.* ¶ 33.

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.* ¶ 53.

[27] *Id.*

"identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources."[28] Parallels in U.S. tax regulations to General Comment 14 are reflected in passage of the Patient Protection and Affordable Care Act (ACA), and illustrates the U.S.' movement towards full realization of health as a right.[29]

Another example of the U.S. recognizing its obligations to protect the right to health through international treaties is its signing, but not ratifying, the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), where one of the recognized human rights was a right to health.[30] Demonstrating the founding principles of human rights in U.S. history was the U.S. report submitted to the ICESCR's Committee on the Elimination of Racial Discrimination.[31] In the report, the U.S. outlines its recognition of commitment to human rights while drawing direct references to its founding principles.[32] "Our nation's Founders, who enshrined in our Constitution their ambition 'to form a more perfect Union,' bequeathed to us not a static condition, but a perpetual aspiration and mission."[33] Connecting the commitment to human rights within its founding principles, the U.S. further illustrated its international commitment to the furtherance of human rights.

The U.S. has also shown its commitment to protect human rights through the passing of legislation that calls for the protection and furtherance of human rights. The 1964 Civil Rights Act is a major example of legislation being passed to protect human rights. Title VI of the 1964 Civil Rights Act, 42 U.S.C. 2000d, and its implementing regulations, which prohibit practices that have the effect of discriminating by state or local governments or private entities receiving federal financial assistance, including schools, *hospitals and health care facilitie*s . . . (emphasis added).[34]

In accordance with the language emphasized in the above quote, Congress ensured hospitals and health care facilities could not legally discriminate. Recent legislation related to discrimination, including discrimination based on race, color, and national origin, or minority groups, are significant to illustrating how the U.S. is making measured increments

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[28] *Id.*

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

[30] G.A. Res. 2200A *supra* note 17.

[31] Rep.'s Submitted by States Parties Under Art. 9 of the Convention, Comm. on the Elimination of Racial Discrimination, CERD/C/USA/7-9 (2013).

[32] *Id*.

[33] *Id.* at 6 (where the U.S. submitted a report on the status of racial discrimination, recognizing its legal obligation to address various areas of racial and ethnic discrimination; including in hospitals).

[34] *Id.* at 8.

towards achieving recognition of health as a human right.[35] The quote above supports the argument that health as a human right is connected to other human rights.[36]

One recently passed piece of tax legislation attempting to meet its obligation to health as a right is the Affordable Care Act (ACA).[37] It has been noted that the U.S. not only extends health insurance to many Americans under the ACA, it further provides additional protections against discrimination. Section 1557 [of the ACA] extends the application of federal civil rights laws to any health program or activity receiving federal financial assistance, any program or activity administered by an executive agency, or any entity established under Title 1 of the ACA.[38]

Under the ACA, nonprofit hospitals have required or are encouraged to behave in a way to better address access to health care for more Americans. The policy fails though to address health care as a human right by increasing the commercialization behavior of nonprofit hospitals. The ACA has also encouraged nonprofit hospitals to integrate their systems, leading to larger mergers that consequently reduce local community inputs in a negative manner from a human rights perspective. Given the role the Internal Revenue Service (IRS) has for regulating the health care sector and influencing its behavior–for example, IRS revenue rulings have shaped hospital behaviors–and that the ACA, as a piece of tax legislation, also is an expression of the U.S.' commitment to health as a human right, reinforces the original premise: calculating tax policies and rules, as related to a right to health, can be only fully accomplished if evaluated from a human rights perspective.

Evaluating tax policies and legislation from a human rights perspective provides the opportunity to determine how effective they are at protecting and ensuring the right to health. To better understand how the U.S. arrived at the current status of a right to health, a historical review of tax legislation is paramount.

When Congress initially provided that hospitals run by charitable religious organizations were exempted from taxable income in the early 20th century, the decision was not motivated by a desire to preserve charitable hospitals as a standalone function. Rather, charitable hospitals served a crucial role in the community, especially for those who would otherwise be financially unable to access this level of specialized health care. Charitable hospitals later become known as nonprofit hospitals. An in-depth historical

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[35] *Id.* at 11.

[36] *Id.* at 8.

[37] Patient Protection and Affordable Care Act of 2010, *supra* note 29.

[38] Rep.'s Submitted by States Parties Under Art. 9 of the Convention, Comm. on the Elimination of Racial Discrimination, *supra* note 31 at 12.

review of the federal policies is provided in the next section. The physical building of hospitals and the administration of hospitals have both been supported by the federal government to increase the infrastructure needed for accessing health care services. Promoting development of the structural framework is important as seen in the following quote:

> Altogether, the structural aspects of human rights can facilitate the recognition of human rights in the context of health; establish the procedural and jurisdictional contours of monitoring, oversight, and enforcement that uphold these rights; and delineate specific mechanisms to support and uphold human rights that affect health.[39]

Analysis of specific legislative efforts by Congress, reviewed later on, supports the notion that infrastructure development was recognized as an important need for health. Since the right to health is a human right, these infrastructure policies are supported from a human rights perspective. Promoting a healthy population motivated Congress when it enacted the legislation exempting taxable income for those qualifying entities and provided financial support to build up the infrastructure.

Over the history of the U.S., the normative behavior of policymakers has developed to increasingly recognize the importance of supporting a right to health beyond infrastructure development. "Human rights norms include the substantive rights set out in international and regional human rights systems and national laws, as well as the interpretive understandings of these rights that subsequently have been developed in multiple fora."[40] Initially, the need to develop an infrastructure for people to gain access to healthcare options was paramount, given the how little was in place at the time. Moving forward, and with additional infrastructure now built, the normative behavior of policymakers shifted to focus on more than buildings. By doing so, "the proliferation of normative interpretations within multiple systems and contexts potentially could have a cumulative and reiterative effect."[41] Health as a human right has not fully developed as the norm in the U.S. at this time, at least not to the extent as it has in other countries. Comparing the U.S. model of health to the systems in other countries is a useful comparison tool. A different perspective is required to fully understand the status of health as a right in the U.S.

Comparison of the U.S. system with other countries illustrates that, while there is not the same level of designating health as a human right, the

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[39] Gable, *supra* note 4, at 535.

[40] *Id.* 4

[41] *Id.*

U.S. does have a national commitment to opening up access to health care. A national commitment to improve access to health care has been a motivating factor for Congress regarding ACA rules that were passed to address accountability. Congress attempted to provide accountability through measures found in the ACA that also provided additional levels of transparency. According to General Comment 14, the national health strategy and plan of action should "be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health."[42] Good governance was also a motivating factor during the congressional hearings that compared nonprofit hospitals with the behavior of for-profit hospitals.

The federal government has an obligation to promote access to affordable quality health care, given health's role in allowing residents to access other rights, and thus is right to focus on health care in furthering its good governance. The concept of health care is considered a social good.[43] The conception of health care as a social good has been based on decades of public policy and philanthropic activity.[44] Evaluating U.S. health care policies from a tax policy perspective falls short, since it treats health care as a private good. Consideration for the concept of health care as a private good when drafting policies and regulations will continue the commercialization development we are experiencing now. Private goods, like cars, are at the mercy market actors' perception in determining which items will generate a net profit. Even nonprofit hospitals are becoming more commercialized and are moving toward treating health care as a private good. Treating health as a private good was not always the norm.

Health care services should not be about generating the best return by ramping up market size through acquisitions and solely focusing on profit-making efficiencies, which is what happens when health is treated as a private good. Focusing on the amount nonprofit hospitals receive in tax-exemptions falls short of a full analysis as well. The focus should, instead, be on the people being impacted. That is what makes analysis from a tax policy perspective or any other focus fall short of the full picture; the people who are impacted by legislations and the resulting behaviors of nonprofit hospitals are at the crux of why a human rights perspective is so important. In the U.S., there is a principled belief that all deserve a right to equality of opportunity.[45] As highlighted previously, the notion of a right to equality of

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[42] Comm. on Econ. Soc. & Cultural Rights, Gen. Comment 14, *supra* note 20, ¶ 55.

[43] David M. Craig, HEALTH CARE AS A SOCIAL GOOD; RELIGIOUS VALUES AND AMERICAN DEMOCRACY 8 (2014).

[44] *Id.* at 117.

[45] Sandhu, *supra* note 8, at 1157.

opportunity can be seen in our founding documents and throughout our history. Over time, the U.S. has sought to achieve this principle. Without access to affordable quality health care though, that cannot be attained. Health is a prerequisite to all other rights. Addressing health as a prerequisite through tax policy is inadequate by itself. A historical review illustrates why this is true.

III. EXEMPTING HOSPITALS FROM TAXES

Congress has passed a number of laws in an attempt to improve access to hospital care, including exempting certain hospitals that meet strict criteria from paying taxes. Early attempts by Congress sought to financially encourage behavior of hospitals so that more people would have access to health care. Hospitals were encouraged to behave a particular way and in exchange were exempted from paying taxes on income. One of the earliest statutory references to a tax-exempt status of charitable organizations came in 1894. The Wilson-Gorman Tariff Act sought to establish a requirement on tax-exempt charitable organizations to operate for charitable purposes.[46] The Revenue Act of 1909 not only mirrored but expanded the language of the 1894 Act to include the phrase: "the idea that tax-exempt charitable organizations should be free of private inurement—in other words, be nonprofit."[47] At the time, there were no large government agencies or anything approaching the complicated framework we have today. Rather, nongovernment organizations, including hospitals, addressed the social and economic issues that otherwise would be unaddressed or under addressed.

A. Development of a Strong Central Government

The U.S. government's original role in society was reduced due in part to some fears of it becoming another monarchy.[48] The origins of the federal government's role were reflected in executive departments at the time: State, Treasury and War. Currently, the number of executive departments has developed into a much farther-reaching, strong central government. Comparatively though, consider Germany's central government development. Social welfare benefits are currently provided through "a complex network of national agencies and a large number of independent regional and local entities-some public, some quasi-public, and many private

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[46] Paul Arnsberger et al., *A History of the Tax-Exempt Sector: An SOI Perspective*, STAT. OF INCOME BULL., 106 (2008), https://www.irs.gov/pub/irs-soi/tehistory.pdf.

[47] *Id.* at 107.

[48] *Id.* at 105

and voluntary" that have a long history.[49] This is unlike in the U.S. where "[a]bsent an established Governmental framework, the early settlers formed charitable and other 'voluntary' associations, such as hospitals, fire departments, and orphanages, to confront a wide variety of issues and ills of the era."[50] Only in 1798 was legislation passed, "An Act for the Relief of Sick and Disabled Seamen", which established a tax of twenty cents per month from a seaman's wages to fund the building of hospitals that would then provide health care for sick and disabled seamen.[51] At the time, the government relied on the voluntary associations though for the masses.

In Germany, public-national agencies date from the nineteenth century but some started earlier, unlike the U.S. who did not develop them until the twentieth century.[52] In fact, the legislation "that established the basis of this system dates from the 1880s and was passed by imperial Germany's parliament, the Reichstag, with the dual purpose of helping German workers meet life's vicissitudes and thereby making them less susceptible to socialism."[53] That legislation has been shown to have laid the foundation from which Germany developed its main principles from, which includes:

> [m]embership in insurance programs is mandated by law; the administration of these programs is delegated to nonstate bodies with representatives of the insured and employers; entitlement to benefits is linked to past contributions rather than need; benefits and contributions are related to earnings; and financing is secured through wage taxes levied on the employer and the employee and, depending on the program, sometimes through additional state financing.[54]

Development in Germany offers a comparison to fully understand the U.S. system of providing health as a human right. The comparison highlights the extensive social policy infrastructure that Germany possessed so early– decades before such a network existed in the U.S. What the U.S. government did have at this time in history was the ability to support organizations, and promote values and principles important to the country. That support was

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[49] LIBR. OF CONG., FED. RSCH SERV., GERMANY: A COUNTRY STUDY 195 (Eric Solsten ed., 3rd ed. 1996).

[50] Arnsberger et. al., *supra* note 38, at 105.

[51] An Act for the Relief of Sick and Disabled Seamen, ch. 77, § 1, 1789 Stat. 605 (1798).

[52] Steven A. Ramirez, *The Law and Macroeconomics of the New Deal*, 62 MD. L. REV. 515, 517 (2003).

[53] LIBR. OF CONG., FED. RSCH SERV., *supra* note 40, at 195.

[54] *Id.*

made directly through enacting legislation related to taxes, such as exempting certain organizations from paying taxes.

B. The Historical Shift from Patients as Direct Consumers to Third-Party Payers

Passage of legislation related to taxable income was influenced by the societal needs at the moment. For instance, the need in the 19th century was for hospitals to be built for people to access health care services. Consider the comparison to Germany who at a similar time, was more advanced in their infrastructure. By providing exemption to taxable income, Congress was providing incentive to build up health care infrastructure in the U.S. Given health insurance had not been widely needed and the costs of procedures were mostly paid out-of-pocket, emphasis on building the infrastructure was logical. "Prior to the turn of the 20th century, workers relied primarily on their own, their families', or the communities' resources in the event of a health or economic emergency."[55] This meant cost was controlled at the consumer level, since consumers were responsible for their own payments. That changed in the mid-20th century.

Noticeably in the U.S., beginning after World War II, employment-based health insurance started gaining momentum because employers could not give raises to their workers. "In 1948, less than half of Americans owned medical coverage."[56] With a tight labor market, employers looked for other options that would be attractive to people, but did not increase wages. At the same time, court decisions and federal legislation assisted in making worker benefits a genuine part of collective bargaining, which also helped accelerate the offering of employer-sponsored benefits.[57] Health insurance was one of the benefits employers used to attract workers. It was also a benefit to employees since it did not count in the calculation of the taxable benefits, as wages do.[58] In fact, these tax preferences provided significant subsidies for

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[55] U.S. GOV'T ACCOUNTABILITY OFF., GAO-06-285, EMPLOYEE COMPENSATION: EMPLOYER SPENDING ON BENEFITS HAS GROWN FASTER THAN WAGES, DUE LARGELY TO RISING COSTS FOR HEALTH INSURANCE AND RETIREMENT BENEFITS 5 (2006).

[56] Christy Ford Chapin, *Ensuring America's Health: Publicly Constructing the Private Health Insurance Industry, 1945–1970*, 13 ENTER. & SOC'Y 729, 734 (2012).

[57] U.S. GOV'T ACCOUNTABILITY OFF., GAO-06-285, EMPLOYEE COMPENSATION: EMPLOYER SPENDING ON BENEFITS HAS GROWN FASTER THAN WAGES, DUE LARGELY TO RISING COSTS FOR HEALTH INSURANCE AND RETIREMENT BENEFITS 5 (2006).

[58] Jacqueline Wallen & Sherman R. Williams, *Employer-Based Health Insurance*, 7 J. OF HEALTH, POL., POL'Y & THE L. 366 (1982) (whose authors state that "Employer-based health insurance (insurance that is purchased by employers for their employees and financed through employer or joint employer-employee contributions) is currently subsidized in part by the federal government through tax exclusions for employer contributions to employee health insurance plans. This subsidization costs the federal government close to 10 billion dollars a year in lost revenues." in their abstract).

health insurance companies then, as today.[59] As employment-based health insurance began to proliferate–by 1982, over 80 percent of workers were eligible for health insurance at their jobs[60]–the need for coverage grew, as did medical costs.

Growing medical care costs meant a developing need for health insurance. Higher medical costs meant the traditional form of paying out of pocket for health care services was moving further out of reach for people and medical insurance assisted with bringing those higher-cost procedures into reach. Health insurance plans were primarily an employer-based benefit. The growing demand for an ability to pay for health care though meant there was a need for health insurance beyond it being a benefit to employment. In reaction to this, the federal government began putting into place the infrastructure that would directly assist people, rather than relying on charitable hospitals, with their health care needs. In fact, by the mid-1960s, the emphasis was directly on government intervention to provide health services for citizens in need:

> Once the Medicare and Medicaid programs were added in 1965 to the existing system of employment-based health insurance and provided coverage to the elderly, disabled, and many of the poor, more than 85 percent of Americans had an arrangement whereby someone else paid for some or all of their medical services.[61]

That meant eighty-five percent of Americans had a third-party paying for their medical costs, whether it was an employer-based insurer or a government-backed program. The federal government was no longer solely reliant on charitable nongovernmental organizations to provide medical services to people who otherwise could not afford them. The demand for developing a hospital infrastructure where people could access charitable care was being replaced with a need to develop health insurance infrastructures.

Health care providers began to change with the shift in who was making the payments. The majority of individual patients no longer needed to negotiate pricing with their doctors, as payments were increasingly made by

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[59] U.S. GOV'T ACCOUNTABILITY OFF., GAO-06-285, EMPLOYEE COMPENSATION: EMPLOYER SPENDING ON BENEFITS HAS GROWN FASTER THAN WAGES, DUE LARGELY TO RISING COSTS FOR HEALTH INSURANCE AND RETIREMENT BENEFITS 2 (2006).

[60] Wallen & Williams, *supra* note 49, at 366.

[61] BRADFORD H. GRAY & MARK SCHLESINGER, THE STATE OF NONPROFIT AMERICA 73 (Lester M. Salamon ed., 3d ed. 2002).

a third-party entity. With the removal of the consumers from the pricing model, came a large rise in medical costs; increasing the need for more comprehensive health insurance. "This system of third-party payment facilitated the rapid growth in health care expenditures that brought U.S. health care costs from 5 percent of gross national product (GNP) in 1960 to 14 percent by the mid-1990s."[62] Thus, while the privileged tax-exempt status continued to be offered to nonprofit hospitals, their treatment of patients, how treatment was offered, and the type of care offered, was changing all around, and that change was based upon who was making the payments. Tax-exemptions continued unchanged for nonprofit hospitals even though the shift from patients primarily being responsible for payment went to a third-party payer.

While tax policies remained unchanged for nonprofit hospitals through the shift from patient to third-party payers, the underlying need to assist people who could not pay out-of-pocket expenses was changing. When Congress passed legislation creating tax exemptions, it was the best tool the federal government had to further health care initiatives and influence behaviors. People were paying for their health care themselves and third-party payers were not as prevalent. Additionally, the health care system and overall governmental framework in the U.S. had not developed to the level we understand today. The motivations for tax-exemptions–to support and influence nonprofit hospital behavior by encouraging their work of providing health care to those who otherwise would lack services–no longer existed. Examination of the historical motivations for these tax policies provides a clearer understanding.

C. Historical Motivations for Nonprofit Status Have Changed Even Though Tax Policies Still Seek the Same Results

The historical motivation for nonprofit hospitals to be tax exempt no longer exists in the same manner; people typically no longer pay for health care out-of-pocket and thus are less reliant on the charitable works of nonprofit hospitals. A nonprofit organization is an entity that cannot distribute its net earnings, if there are any, to individuals who exercise control over it.[63] Earning a profit is permitted as a nonprofit entity. However, there are some restraints on how net earnings can be distributed. Any net earnings must be reserved to finance further production of the services it was created to provide.[64] In the case of a tax-exempt nonprofit hospital, this

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[62] *Id.*

[63] Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 838 (1980).

[64] *Id.*

would likely be met by providing charity care to its patients and meeting the "community benefit" requirement.[65] The IRS has the authority to interpret congressional intent as it relates to whether a nonprofit hospital is meeting the legal requirement of "community benefit". Interpretation has developed over time, beginning with requiring nonprofit hospitals to be organized and operated for primarily charitable, scientific or educational purposes.

In 1954, the Internal Revenue Code (IRC) codified into law the tax-exemption status of nonprofit hospitals.[66] As discussed above, the law originally required nonprofit hospitals be organized and operate for primarily charitable, scientific or educational purposes, as codified in the IRC under Section 501(c)(3).[67] To qualify, a hospital had to show that it was, in fact, organized as a nonprofit charitable organization, with a mission of providing for the care of the sick. To do so, the hospital had to meet certain qualifications, such as the hospital operating in a way while still offering services for people who were not able to pay.[68] That meant the hospital could not operate exclusively for people with the ability to pay. Furthermore, its net earnings could not be paid to controlling members, but rather the net earnings had to be used to further the scope of why the organization was created–caring for people who could not pay for their medical care, themselves.[69] That changed fifteen years later.

In 1969, with Internal Revenue Ruling (IRC) 69-545, the IRS modified its stance on nonprofit hospitals, and changed the requirement of caring for patients at reduced rates or without charge.[70] With the new regulations, hospitals were free to accept all patients and still remain in compliance of the tax-exemption requirements. The IRS ruled a "nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose."[71] Thus, the promotion of health was similar to the relief of poverty, advancement of education, and religion in that it was recognized as the purpose of the general law of charity. The IRS' ruling came from the government's perceived benefit of offering health services to the whole

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[65] Christine L. Noller, *Community Benefit, Accountable Care Organizations and Population Health: Tax Implications for ACOs and Nonprofit Hospital Participants*, 30 HEALTH L. 16, 21 (2017) (stating "IRS regulations acknowledge that health needs identified in a CHNA may include ensuring adequate nutrition or addressing social, behavioral and environmental factors that influence health in the community.").

[66] Rev. Rul. 56-185, 1956-1 C.B. 202 at *1.

[67] *Id.*

[68] *Id.*

[69] *Id.*

[70] Rev. Rul. 69-545, 1969-2 C.B. 117 at *4.

[71] *Id.* at *2.

community.[72] In doing so, the IRS pivoted from the traditional notion that nonprofit hospitals were being granted these tax benefits to assist indigent members of the community, and instead focused on the whole community. No longer was there a restriction against exclusively serving those who are able and expected to pay; rather a hospital applying profits to expand and upgrade facilities and equipment, and to improving patient care, medical training, education and research would meet the requirements for nonprofit status.[73] The readjustment of interpreting Section 501(c)(3) in IRR 69-545 promoted a "community benefit" standard.

Granting tax-exemptions is a useful tool to encourage behaviors in nonprofit hospitals. Tax policies governing nonprofit hospitals seek to encourage access to health care services were necessary when enacted, since there was not a sufficient governmental framework to provide access to health services directly. Shaping the behavior of hospitals was accomplished by encouraging care for uninsured or underinsured patients who have limited means–or no means–to pay for their medical needs. "Early hospitals or 'alms houses' were supported solely by donations and staffed by volunteers–there was no expectation of payment from patients."[74] Tax policies have intentionally shaped nonprofit hospital behavior by impacting the way they treat patients, including who their patients are. Early on, Congress had enacted tax-exemptions to encourage nonprofit behavior in a way that avoided the need for the government to spend money on similar direct services in hopes that doing so will offset any revenue losses from exempt taxable income.[75] Encouraging nonprofit entities this way, at least in the case of hospitals, helps lift the financial burden of covering health care services.

Exempting otherwise taxable income for hospitals is not the only method Congress uses to encourage behavior in hospitals. Nonprofit hospitals also have access to tax-exempt bond financing and tax-deductible charitable donations (for the donor).[76] Over the years, these tax policies have greatly influenced nonprofit hospitals' behaviors.

D. A Brief Historical Review of Medicare and Medicaid

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[72] *Id.*

[73] *Id.* at *3.

[74] George A. Nation III., *Non-profit Charitable Tax-Exempt Hospital–Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care to All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 155 (2010).

[75] U.S. GOV'T ACCOUNTABILITY OFFICE.GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 1 (2008).

[76] *Id.*

In addition to tax exemptions and attractive (and inexpensive) financing, the federal government sought to further influence nonprofit hospitals' behavior with other tools. For example, leading up to the 1980s, there were perceived and likely actual deficiencies in the method used by Medicaid and Medicare for calculating payments. Evidence of deficiencies is apparent when reviewing the lack of control either had over controlling what was paid for their policy individuals: "Prior to the 1980s, Medicare, Medicaid, and the health insurance industry had very inadequate means of controlling what they paid for, how much they paid for it, or both."[77] Medicaid and Medicare were created to provide coverage to people whom the government felt needed the most assistance in meeting their own health care needs. At the time, the initial focus was not on the rising medical care costs. Focusing on coverage and not accounting for potential future rising costs created an incentive to generate more costs by offering more services.

Medicare and Medicaid reimbursed hospitals for the services provided, but found the government could not control what would be now considered unnecessary care or an allowable cost.[78] The situation for private health insurance companies was not that much different. "Payments to institutions from insurance companies were based on the institutions' *bills*, so there was no constraint on costs there."[79] Without proper controls or accountability measures, prices increased.

At the beginning of the 1990s, several institutional changes occurred as a response to increased costs. These changes included adjusting payment methods, and creating new oversight and accountability mechanisms.[80] There is power in numbers, and so to gain those numbers, health insurance companies consolidated to have more leverage in negotiating terms with hospitals. The move to consolidate took two major forms. "First was the enrollment of insured populations into health plans that both provided managed care functions and negotiated terms with providers. Second was the consolidation among insurers and managed care organizations themselves."[81] Even as these changes occurred, the interpretation of satisfying the nonprofit requirement as a hospital did not.

The health care industry was the target of a perfect storm of affects, leading to increased pricing, given the IRR 69-545 standard of a "community benefit" and the increased reliance on third-party payers, such as Medicare and Medicaid. People used to pay for services directly. Supporting nonprofit hospitals was logical since they were serving

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[77] GRAY & SCHLESINGER, *supra* note 52.

[78] *Id.* at 73–74.

[79] *Id.* at 74.

[80] *Id.*

[81] *Id.*

underprivileged populations and the government lacked a comprehensive infrastructure in which to offer assistance. As the government has developed a larger set of tools to address societal concerns, including offering its own form of health insurance coverage with Medicare and Medicaid and granting income exceptions for employer provided health insurance to employees, the need for financially supporting nonprofit hospitals has decreased. That perfect storm came to the public's forefront as more people became overwhelmed financially due to medical bills; enough to spur congressional action.

E. Congressional Hearings

The IRS revenue rulings regarding Section 501(c)(3) for nonprofit hospitals did not fully address the concerns of Congress, spurring them to hold hearings. Specifically, Congress was concerned with the state of health care, the financial burdens on Americans and the lack of transparency of pricing. In June 2004, the U.S. Representative Committee on Ways and Means Subcommittee on Oversight issued an announcement regarding tax exemptions and pricing practices of hospitals.[82] The committee highlighted that "there are more than 300,000 reporting tax-exempt 501(c)(3) entities. Hospitals represented a small proportion (1.9 percent) of total reporting charitable 501(c)(3)s but, in 2001, constituted 41 percent ($337 billion) of total expenditures."[83] The announcement by the subcommittee was to review hospital pricing systems while focusing on the lack of transparency of those systems. The subcommittee expressed concern that a lack of transparency was creating barriers through which consumers could not make informed decisions. The subcommittee also reviewed where consumers get care and what options for increasing information about hospital pricing were available.[84]

Public awareness was raised when the *New York Times* published a story about lawsuits "contending that the hospitals violated their obligation as charities by overcharging people without insurance and then hounding them for the money."[85] Those lawsuits were eventually dismissed before trial. However, the lawsuits did serve as a starting point for the conversation for what Americans imagine as the benefit they were receiving for providing

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[82] *Pricing Practices of Hospitals: Hearing Before the Subcomm. on Oversight of the H. Comm. on Ways & Means,* 108th Cong. 2 (2005).

[83] *Id.*

[84] *Id.*at 2–3.

[85] Reed Abelson & Jonathan D. Glater, *Suits Challenge Hospital Bills of Uninsured*, N.Y. TIMES (June 17, 2004), http://www.nytimes.com/2004/06/17/business/suits-challenge-hospital-bills-of-uninsured.html.

nonprofit hospitals tax-exempt status. The impressions did not line up with the reporting in these articles. For instance, the impression Chairman Bill Thomas of California held in regard to nonprofit hospitals compared with for-profits was: "If I blindfolded you, took you into a hospital, took the blindfold off you and led you around to look at the hospital, you would be hard pressed to determine whether it's a 501(c) not-for-profit or a for-profit."[86] Comparing nonprofit and for-profit hospitals, these are two entities that are recognized under the tax code very differently, even though they carry out identical duties and purposes.

The 2004 subcommittee hearing examined the current hospital pricing systems and focused on the lack of transparency in hospital charges. The hearing focused on the intended outcome versus the actual outcome of the Internal Revenue Code Section 501(c).[87] Taxable income is designated exempt from governmental collection in hopes of achieving an intended outcome. Based on the testimony, it can be expected that nonprofit hospitals would behave differently than for-profit hospitals. Chairman Thomas further illustrates this point when discussing the desire to differentiate between nonprofit versus for-profit hospitals: "[Y]ou would at some time and under some circumstances [want to differentiate], the not-for-profit aspect would display a different behavioral profile than the for-profits, and that is basically what we are going to try to do."[88] Lawmakers wanted to determine the current status of hospital behavior and invited a select group of experts to provide testimony on the subject of tax exemptions and pricing practices of hospitals.

Hospital pricing methods lack transparency to a point that even the hospital's own staff may have no idea what a procedure costs, both for nonprofit and for-profit hospitals. Testimony provided by Dr. Nancy Kane, professor of Harvard School of Public Health, pointed out that hospital pricing models are "based on market-based negotiations, and the self-pay are not in a very good bargaining position when they arrive at the hospital door, or when they try to seek information on the Web..."[89] Ultimately, you have the scenario of groups of individuals being represented by their health insurance groups and you have people without representation as uninsured individual negotiators. The large insurance companies are able to negotiate discounts based on the perceived group's health that they represent. "So, the self-pay and only a few indemnity carriers are left paying on the basis of hospital charges, the charges are set indeed to cover the negotiated discounts

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[86] *Pricing Practices of Hospitals*, *supra* note 72, at 7.

[87] *Id.* at 2–3.

[88] *Id.*at 8.

[89] *Id. at* 14.

of everyone else."[90] Large insurance companies use their market size to negotiate prices in favor of their members and that is a win for those members. However, such negotiations leave people who do not have a large insurance company negotiating on their behalf to cover the discounts awarded to those who do. Historically, this problem was not considered a culprit for pushing up costs for people without coverage, because not all insurance companies were aggressive in their negotiations. "[B]ack when the discounts were around 16 percent, back in 1982, and many more payers were indeed paying on the basis of charges . . . ." then it was not as a glaring issue.[91] However, this has been replaced by the process of negotiating pricing, which has "brought those discounts up to 46 percent (median) in 2002 . . .therefore, the markup of charges over hospital costs has grown from about 120 percent of cost to 180 percent, and again, that is the median."[92] Having discounts rise from around 16 percent in 1982 to 46 percent median in 2002 alone would be cause for concern. Good health insurance coverage becomes vital in order to receive savings on medical procedures. People without adequate health insurance are left to cover everyone else's discounts. People without health insurance at the time were often jobless because most Americans receive health coverage through their employer. Or the people were possibly working a number of part-time jobs, none of which offered health insurance. People in these scenarios are most at risk financially. The way the system functions, they are also most impacted by the prices since they are covering the discounts. If at-risk people do not pay, the hospitals sue them and often request post-judgment interest.[93]

In this analysis, the actual price hospitals charge to their patients is unrelated to the actual cost of the services the hospitals provide. How well any hospital does at negotiating prices with the health insurance companies influences the pricing to at-risk people, regardless if the hospitals are nonprofit. Negotiation of pricing benefits people with health insurance at the expense to those without; and, typically, those without are under employed. If the intended outcome of providing nonprofit hospitals tax exemptions is to benefit the community, unequal treatment of patients financially works against the intended outcome.

Another expert invited to provide testimony at the 2004 congressional subcommittee hearing was Dr. Karen Davis, president of the Commonwealth Fund, a healthcare research foundation. In her executive summary to the subcommittee, Dr. Davis testified that hospital costs were

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[90] *Id.*

[91] *Id.*

[92] *Id. at 14.*

[93] Abelson & Glater, *supra* note 75.

accelerating and at "the same time 71 million Americans [were] experiencing problems paying medical bills or [were] paying off accrued medical debt."[94] She also testified that financially vulnerable people were at risk because of the direct pricing policies of select hospitals.[95] In the historical analysis of how America got to where it was when she testified, Dr. Davis said that when the federal government was a leader in the healthcare sector, hospital costs grew at a slower rate. Dr. Davis testified:

> Given the resurgence in health care costs, the increasing numbers of uninsured, abundant evidence that the quality of care is not what we would have and have a right to expect, and the fact that administrative costs are now the fastest rising component of health care expenditures, it is time to consider a leadership role for the federal government in promoting efficiency and quality in the health care system.[96]

Congress and the American people had continued to believe that nonprofit hospitals, given their historical traditions with charitable care, would carry this leadership role as an agent for the federal government. Nonprofit hospitals were thought to be a solution for rising health costs and the increasing number of uninsured Americans; even though the legal standard for nonprofit status had become independent of assisting financially troubled individuals with IRR 69-545. Dr. Davis testified in favor of not only preserving a nonprofit hospital and health care sector, but also strengthening it. Dr. Davis felt that nonprofit hospitals were a "major source of uncompensated care and community benefit" that could be requested to "not…charge uninsured patients more, to work out feasible payment plans, and not to employ unreasonable collection tactics."[97] On average, research supports her conclusions.

Dr. Davis's testimony compared pricing behaviors of nonprofit hospitals and for-profit hospitals. Her research had shown "nonprofits are more willing to provide care that is marginally profitable or loses money in order to advance a broader mission of excellence in patient care, medical education and cutting-edge research" compared to for-profit hospitals that,

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[94] *Hospital Pricing Behavior and Patient Financial Risk: Hearing on 'Pricing Practices of Hospitals' Before the Sub. Comm. On Oversight of the H. Comm. on Ways and Means*, 108th Cong. 2 (2004) (submitted testimony of Karen Davis, President, The Commonwealth Fund).

[95] *Id.*

[96] *Id.* at 4.

[97] *Id.*

in her opinion, were more focused on the bottom line as it related to profits.[98] Despite citing several newspaper reports that nonprofit hospitals were overcharging uninsured patients, Dr. Davis testified that nonprofit hospitals are the better model of delivering health care since their mission is focused on future health benefits.[99]

What Dr. Davis' testimony failed to address, however, was how similar these two entities are in their behavior. Similar behavior is not a concern if you do not consider the intended outcome of exempting nonprofit hospitals from taxes. While nonprofit hospitals may provide some services at, or below, net profit returns, both types of hospitals charge uninsured patients higher rates for services compared to insured patients charges and also pursue debt collection, including post-judgment interest. This is a concern if the intended outcome is to increase health. Charging more for services and assessing post-judgment interest to people already struggling to pay bills is counterproductive to the intended outcome of providing nonprofit hospitals benefits related to their income generation.

Lacking access to pricing information as a consumer has also contributed to artificially-inflating heath care costs. Unlike other areas affected by consumer behavior, hospital care is different in that the consumers do not have the pricing information available to make informed choices. The actual pricing varies from hospital to hospital, and depends on how well the health insurance companies have negotiated their discounts.[100] Peter Lee's, President and CEO of the Pacific Business Group on Health in San Francisco, California, testimony at the congressional hearing in 2004 highlights how the lack of information to consumers, coupled with varying pricing negotiations for services by insurance companies both create a challenge for market correction. He provided testimony on three issues relating to Chairman Thomas' blindfolded example of not knowing if a hospital was nonprofit versus a for profit. "[F]irst, staggering cost increases, second, huge variations in cost and quality of hospital care, and, third, the failure of the market to address these issues effectively."[101] Mr. Lee also testified that a lack of transparency hindering a patient's ability to compare hospitals' quality and efficiency, as well as hospital consolidation, which can stifle competition, have contributed to why pricing has risen to the levels

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[98] *Id.* at 6.

[99] *Id.* at 21.

[100] Leah Snyder Batchis, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care?: Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMPLE L. REV. 493, 501 (2005) (which stated "Private insurance and managed care companies negotiate discounts ranging from fifteen to fifty percent, often in return for including the hospital in their service network.").

[101] *Pricing Practices of Hospitals, supra* note 72, at 22.

being reported.[102] He does not differentiate between the nonprofit hospital behavior model versus the for-profit hospital behavior model as it relates to rising costs.

Mr. Lee testified about variations in costs at different hospitals both between different communities and within the same communities; variations which did not behave in response to typical market pressures.[103] For instance, "[g]all bladder and heart surgery costs three times as much in Sacramento as it does in San Diego. Cesarean sections cost twice as much in Sacramento as it does in Los Angeles."[104] Not drawing a distinction between nonprofit and for-profit hospital behaviors in this context indicates there is not a significant expectation in difference between the two behaviors.

Mr. Lee further testified there is no correlation between high costs and the quality of care provided. "A patient is about twice as likely to have a wound infected in the bottom 25 percent of hospitals as in the top 25 percent; a similar likelihood for getting pneumonia after surgery."[105] These examples demonstrate the importance of transparency and the need to ensure that tax dollars are effectively being used in the manner intended by Congress. Mr. Lee left the committee with the following; "[C]onsumers need to have the information to make informed treatment choices. They don't. Providers need to be paid differently for better performance. Today, they aren't. Without those two changes, we will never have a working market to reform hospital delivery."[106] The emphasis on consumers having greater access to information and providers being compensated based on quality of care would become components in the ACA. Improvement on these two fronts was believed to be better not only for the patients but also in providing additional accountability in terms of pricing. Through surveys, like those the Center for Studying Health System Changes administer, data collected has indicated employers too are making adjustments to incentivize employees into playing a more active role in their health choices.

Dr. Peter Ginsburg, an economist and president of the Center for Studying Health System Change (HSC), testified on hospital pricing issues. "HSC is an independent, nonpartisan health policy research organization funded principally by The Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research".[107] Through their work, they conduct

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[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.* at 23.
[107] *Id.* at 19

surveys of households and physicians in order to get a national representation. At the time, they also performed visits to monitor any changes in the local health systems of 12 U.S. communities.[108] Through these visits and from the data collected, the organization has found "[e]mployers have been changing their health benefit plans to emphasize patient financial incentives to use less care and to be sensitive to prices."[109] Unfortunately for uninsured patients, Dr. Ginsburg also found that they were charged the highest prices of any patient unless a hospital has a pricing practice of setting the costs of services to a patient's income.[110] Dr. Ginsburg's research also found a correlation between new medical technologies and increased health care costs.[111] Nonprofit hospitals though can satisfy a requirement to remain compliant with their special tax exemption status by purchasing new technology. The newest medical facilities and technologies position nonprofit hospitals to be more competitive in the health care market while also justifying their tax status. When the consumer is incentivized though, through access to more information, better choices on care can be expected, per Regina E. Herzlinger.

Regina E. Herzlinger, the Nancy R. McPherson professor at the Harvard Business School, testified before the committee that consumers should be in charge of their spending.[112] However, consumers require information to effectively do so, much like information needed for good outcomes in the stock exchange. "When President Franklin Delano Roosevelt was elected President there was no transparency in the capital markets. There were no annual reports. There was no information that shareholders had."[113] Once the Securities and Exchange Commission (SEC) was organized, there was much better access to information by consumers that effectively allowed them to make personal choices. SEC regulations require transparency for the buyer's protection and to foster efficiency. Disclosing and disseminating information are keys to achieving this goal.[114] Dr. Herzlinger used the following example: Consider the position of a consumer when that consumer buys a vehicle versus the issues when a consumer purchases health care services. When purchasing a car;

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[108] *Id.*
[109] *Id.* at 18.
[110] *Id.*
[111] *Id.*at 19.
[112] *Id.* at 54.
[113] *Id.*
[114] *Id.*

> 1. *Consumers are the buyers*.
> 2. *Manufacturers can freely vary prices* in response to changes in their production and sales. For example, they currently are slashing the prices of cars with large inventories, such as the Impala.
> 3. *Consumers have access to excellent information on both prices and quality* from private sector organizations, such as *Consumer Reports* and J.D. Power.[115]

These attributes of buying directly, freely adjusting pricing, and the consumer having access to comparable information are all missing in health care. Hospitals typically negotiate and have their services paid by third-party insurers, which remove consumers' market power to influence change. Once pricing has been negotiated, it cannot vary for patients under that plan until the next time the prices are negotiated–again without consumer input. Additionally, these prices vary depending on how well the third-party insurers are able to negotiate. Thus, it is not the cost of the service which drives how much is charged an insured patient, but rather the negotiated, predetermined pricing scheme.

> Further, because many of the third-party insurers demand discounts off list prices, hospitals raise the prices to convince the insurers that they are receiving substantial discounts. For this reason, hospital charges have risen three times faster than their costs from 1995–2002. These list prices are then typically charged to individual uninsured consumers who lack market power.[116]

Comparisons, like Dr. Herzlinger's, wielded influence on how Congress came to view their role in addressing the overarching issues in the health care industry. Specifically, the comparisons illustrate how Congress could use their role as the legislative body of government to shape the behavior of nonprofit hospitals. This testimony also addressed the notion that hospital pricing information is difficult to obtain and when consumers do get information, the quality of that data is not such that it is easy to analyze.[117]

Members of the committee were troubled with the lack of easily understandable data and some of the points made by those testifying. Chairman Thomas said "that it is just as charitable to charge a rich man as

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[115] *Id.*

[116] *Id.* at 55.

[117] *Id.*

a poor man, which may be the theme of why we are looking at pricing under the 501(c) section of the Code."[118] He also questioned Dr. Ginsburg's assertion that medical technology is the driving force behind rising health care costs. As Chairman Thomas highlighted, the way the pricing system is structured and the mechanism in which we pay for services creates the correlation between new medical technologies and rising health care costs.[119] Dr. Ginsburg clarified her original testimony by saying: "I would differentiate between the capitated environment which has the incentives to use only valuable technology, and the fee-for-service environment, which unfortunately is our dominant payment mechanism, which tends to accept almost all technology."[120] The health care system was not making a distinction between valuable technologies versus new technologies when it came to pricing methods.

Congresswoman Nancy Johnson from Connecticut testified that the current payment system rewards technology that is expensive for diagnosis or treatment.[121] That way, the hospital can negotiate higher prices based on the fact the technology is expensive. The current payment system does not reward technologies that would improve care quality, increase efficiencies, and otherwise reduce overhead costs.[122] Thus, you are not financially rewarded for improving the process; you are rewarded for developing the newest, largest most advanced piece of technology. Tax exemption legislation intending to provide access to quality, affordable health care in order to achieve other protected human rights and the pricing methods appear to dilute achievement of the intended outcome.

Dr. Ginsburg agreed with regard to the role new technologies play and pointed out that there is a problem with medical services; ". . .inadvertently overpaying for some services, usually the newer ones where there are still productivity increases and underpaying the others."[123] A lack of transparency in market pricing, according to Dr. Herzlinger, hurts consumers because that means consumers lack information to make them good shoppers, which creates a misallocation of services.[124] A misallocation of resources was an important notion during this hearing that would play a major role in further motivating Congress to act and eventually pass the ACA. While there is not a direct link between the testimonies examined here

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[118] *Id.* at 68.
[119] *Id.* at 70.
[120] *Id.*
[121] *Id.* at 75.
[122] *Id.*
[123] *Id.*
[124] *Id.* at 79.

and the passage of the ACA, there was an overarching move by Congress towards addressing the issues brought to light after the *New York Times* article.[125]

At the time of these hearings, despite all of Congress' actions, the U.S. had not achieved access to affordable quality health care in a manner consistent with what was intended by providing the special tax exemption status to hospitals meeting specific criteria. This lack of achievement motivated the committee's attention to how significant tax breaks are benefitting the American people and the difficulty in being able to even measure that benefit. Chairman Thomas said that "…given the significant tax break that not-for-profits provide, we should see to a certain degree discernible differences among a number of taxes that you would examine the materials."[126] However, throughout the examined testimony, none of the experts were able to provide enough evidence to make that decision in Chairman Thomas' opinion as to a perspective on how nonprofit and for-profit hospitals differ.[127] Further highlighting this, in his visits to communities around the country, Dr. Ginsburg found that both for-profit and nonprofit hospitals had expanded operations into the suburbs.[128] Typically, suburbs have a high percentage of privately-insured patients, which highlights that there are market incentives for both types of hospitals since privately-insured patients' insurance company will typically pay more for the same services as compared to other types of patients.[129]

Some pricing incentives are not evident in the data alone though, with one example coming from Duke Medical Center. Dr. Herzlinger provided the example of Ralph Snyderman, CEO of the Duke Medical Center, who innovated a new treatment for congestive heart failure that reduced the costs by twenty percent in one year.[130] These savings came from making people healthier so that they used hospitals less, and when they did use hospital services, their stays tended to be shorter–and less expensive. Dr. Herzlinger also said:

> In a normal marketplace, this kind of innovation would reap large rewards. Ralph Snyderman lost virtually all the savings because under a large third-party system, which is not agile and not responsive to innovations, he gets paid for

[125] Abelson & Glater, *supra* note 75.

[126] *Id.* at 71.

[127] *Id.*

[128] *Id.* at 74.

[129] *Id.*

[130] *Id.* at 83.

> treating sick people and the healthier they are, the more money he loses. That is the problem with a volume-based model that says, well, the big insurer can get big discounts. Perhaps that is so. The big insurer can also stifle the innovation, which is the heartbeat of the productivity in America.[131]

Volume-based models require more patient visits to be successful, which in this scenario requires more sick people coming into the office. That is a particularly strange goal for the government to work toward. Focusing on commercial outcomes–rewards for more sick people coming in for visits–rather than on the quality of health or access to affordable health care does not ensure or protect individuals' basic right to health. Health is paramount in accessing other human rights and we should not have volume-based modeling when it comes to health.

F. Congressional Studies by the Government Accountability Office

Afterwards, the Government Accountability Office (GAO) launched a comprehensive study at the request of the House of Representatives Subcommittee on Oversight and Reform to determine how the tax-preferred status is achieving its goal.[132] The study was meant to better understand the benefits provided by nonprofit hospitals.[133] It examined whether nonprofit hospitals provided levels of uncompensated care and other community benefits that are different from other hospitals. From that 2005 study, government hospitals mostly dedicated much larger portions of their patient operating expenses to uncompensated care when compared to nonprofit and for-profit hospitals.[134] The study also found that while nonprofit hospitals as a whole were devoting more resources toward uncompensated care when compared to for-profit hospitals, this largely was concentrated within a small number of hospitals.[135] Consequently, uncompensated care costs were not evenly distributed throughout the examined hospital systems.[136] In 2006, the Chairman of the House Committee on Ways and Means requested the Congressional Budget Office (CBO) to examine different measurements in

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[131] *Id.*

[132] U.S. GOV'T ACCOUNTABILITY OFF., GAO-05-743T, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS 1 (2005).

[133] *Id.*

[134] *Id.*

[135] *Id.*

[136] *Id.*

the surrounding communities for the levels of benefits as provided by different hospitals.[137]

The resulting analysis, focusing primarily on the differences in uncompensated care policy, is surprising. The CBO found "[n]onprofit hospitals were more likely than otherwise similar for-profit hospitals to provide certain specialized services but were found to provide care to fewer Medicaid-covered patients as a share of their total patient population."[138] The study sought to determine whether nonprofit hospitals were providing enough of a community benefit to warrant the government's exemption of taxes.[139] Researchers found no consensus among hospitals when determining how and what they measured as a community benefit as relating to Internal Revenue Ruling 69-545's interpretation of the requirements under Internal Revenue Code Section 501(c)(3).[140] To illustrate the lack of consensus researchers highlighted how uncompensated care typically is regarded as a proper measure by the IRS for determining the level of community benefit provided by a nonprofit hospital.

Research showed uncompensated care's limitations as a measuring tool given the term "uncompensated care" does not differentiate between charity care for the indigent, which is more clearly a type of community benefit, and bad debt, which is not necessarily a community benefit.[141] To better illustrate the difficulties of analyzing data on the basis of uncompensated care, consider the following example of bad debt: imagine a nonprofit hospital incurring debt as a result of a high-income individual, who has insurance, but fails to pay the deductible for provided hospital services. By law, that loss is then counted toward the community benefit requirement.[142] It might be argued that "community" includes all people, even those with high-incomes, but congressional intent in providing tax-exemptions to hospitals originally focused its efforts "to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."[143] With IRC Section 501(c)(3)'s requirements developed under IRR 69-545 to include the community as a whole, Congress felt further clarification was warranted.

The need for further clarification led to the GAO's *Nonprofit Hospitals;*

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[137] CONG. BUDGET OFF., NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (2006).

[138] *Id.* at 1.

[139] *Id.*

[140] U.S. GOV'T ACCOUNTABILITY OFF. *supra* note 132

[141] CONG. BUDGET OFF. *supra* note 137 at 9.

[142] *Id.* at 9–10.

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

Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefits study in 2008.[144] The study included a description of intent, and noted that certain activities are performed by nonprofit hospitals to meet the community benefit standard in order to "to benefit the approximately 47 million uninsured individuals in the United States who need financial and other help to obtain medical care."[145] Fully examining the extent of how much a community benefit is and the quality of that benefit is difficult to gauge. While some consensus exists for certain standards and guidance, there is not an overall consensus as to how bad debt should be defined. The unreimbursed cost of Medicare (the difference between a hospital's costs and its payment from Medicare) as community benefit could be included by some hospitals when reporting on how they are meeting their community benefit goals.[146] The various activities defined as community benefits by nonprofit hospitals were found to create significant differences in the amount of community benefits reported. Additional limitations for accountability and comparison, useful for the government when creating public policy, resulted from different types of activities being defined and claimed as community benefits. One example is a hospital reporting their community benefit at the individual level while another hospital reports at the health care system level. Moreover, state data showed "differences in how nonprofit hospitals measure charity care costs and the unreimbursed costs of government health care programs can affect the amount of community benefit they report."[147] Together, these hearings, along with testimonies, and congressional studies, motivated Congress to address what was accurately perceived as a larger health care system concern. Ultimately, the testimonies and studies provided a backdrop for congressional discussions regarding health care reform in the United States and to the passage of the Affordable Care Act.

IV. COMMERCIALIZATION OF HOSPITAL BEHAVIOR

Nonprofit hospitals have historical and legal characteristics that set them apart from for-profit hospitals. This was intentional. "Economic theory suggests that government may want special tax treatment (either a subsidy or lower tax rate) for activities when a competitive market would fail to

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[144] U.S. GOV'T ACCOUNTABILITY OFF., GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFITS (2008).

[145] *Id.*

[146] *Id.* at 24.

[147] *Id.* at 7.

produce an efficient outcome."[148] Health care is different from a consumer good in that a consumer can readily replace something like a watch, but a consumer would find it more difficult to do the same with his or her health.[149] Consider when a patient receives the wrong type of treatment for an ailment; the outcome is far different from when a consumer receives the wrong type of watch. Medical consumers want the right treatment to be available when the consumers need that treatment.

Consider, though, if treatment is only available in the market when it is offered at a cost-efficient level. Potentially, the patient has reduced access to care if the treatment is not available. On the other hand, having too much care available ultimately could reduce profitability of a treatment to a point that the treatment is priced out of the market. There is also the cost of having more treatments available at one facility to consider.

Costs would be high for any institution that attempts to have all treatments available, all the time. Failures in the market can develop when you have private agents responsible for providing a public good or goods that generate positive externalities and are not doing so to the fullest extent possible.[150] For example, consider medical research performed by hospitals. "Hospital activities that may create positive externalities include research and development, community education, medical education (to the degree health care professionals do not capture these benefits through returns to human capital), and disease control."[151] However, for-profit entities generally will not enter a market if they perceive an actual or future financial loss. When hospitals avoid offering certain services in the community it may reduce services since they may under-produce hospital outputs deemed to be unprofitable.[152] Not offering services to the community creates a problem in health care systems, since not every treatment that could benefit the community will be profitable. Encouraging the retention of unprofitable services is one reason the government has sought to keep nonprofit hospitals in the market. By providing hospitals with a large number of financial incentives, the goal is to keep hospitals in markets that would not be

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[148] William M. Gentry & John R. Penrod, *The Tax Benefits of Not-For-Profit Hospitals, in* THE CHANGING HOSPITAL INDUSTRY: COMPARING FOR-PROFIT AND NOT-FOR-PROFIT INSTITUTIONS 285, 289.

[149] U.S. GOV'T ACCOUNTABILITY OFF., GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFITS (2008).

[150] Gentry & Penrod, *supra* note 132.

[151] *Id.*

[152] *Id.*

profitable.[153] The influence of governmental incentives has changed over time, though, given that nonprofit hospitals are no longer primarily financed through donations and block government financing.

Historically, nonprofit hospitals were doing charitable work, and thus there were policy motivations to protect charitable hospitals from tort liability. Currently, nonprofit hospitals rely more heavily on revenues from the sale of services than on donations and block governmental financing. The historical development of tort liability for nonprofit hospitals explains this shift in reliance. Traditionally, nonprofit hospitals once enjoyed immunity from tort liability, unlike their for-profit counterparts. This immunity has slowly eroded, which further illustrates how similar nonprofit and for-profit hospitals have become. "A legal distinction that has now largely disappeared concerns *tort liability*, from which nonprofit hospitals enjoyed immunity as charitable institutions in many states."[154] There are several theories and policy arguments that were used to support tort liability immunity.

One popular theory is that if the nonprofit charitable organization was held liable, their payment would come from a trust fund and that type of payment would be a breach of the legally recognized trust entity.[155] A nonprofit hospital's employee liability factored into this theory as well. Another theory held that charities were not responsible for negligent acts of their employees, understood as *respondent superior*, since the nonprofit derives no profits.[156]

It was believed that anyone accepting charitable services would not then in turn hold the charity entity liable for negligence and use their assets for something other than what those assets were created to do. Pursuing a judgment against a nonprofit would be a violation that the court would not uphold.[157] Finally, there is a benefit to society with nonprofit charitable hospitals having a tort exemption in that it removes a risk, thus encouraging these types of organizations.[158] Not only were nonprofit hospitals free from

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[153] Nation, *supra* note 64, at 177 (providing an example of Ascension, a Roman Catholic affiliated hospital system that focuses on profits in deciding whether to keep hospitals open or close their doors.) ("However Ascension's charity care at two point five percent of its patient revenue for 2008 gave it the highest percentage among the nation's five largest nonprofit hospital systems. Nonetheless, Ascension recently closed an unprofitable hospital in Detroit, a city that had forty-two hospitals in 1960 and now has only four, even though or likely because the number of city residents without health insurance continues to increase.").

[154] BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS 63 (1991).

[155] *Id.*

[156] *Id.*

[157] *Id.* at 63–64.

[158] *Id.* at 64.

paying taxes and getting access to various forms of governmental financing, they were also exempt from tort liabilities. Both of these influences changed, given that most of the financing now comes from sale of services and the exemption from tort liability has evolved to no longer provide the same understanding of "charitable immunity." These factors and others have led to the commercialization of nonprofit hospitals:

> Notwithstanding the basic legal distinctions, nonprofit hospitals have undergone several changes that increase their similarity to investor-owned hospitals . . . (1) the heavy reliance on revenues from the sale of services, (2) hospitals' dependence on economic performance for gaining access to capital, (3) the decline of local control resulting from the rise of multi-institutional systems, and (4) the proliferation of hybrid for-profit-nonprofit organizations.[159]

The less a hospital relies on donations and government block funding, the more the hospital relies on revenues from the sale of services. This is a cause for concern because such reliance could impact decisions about patients' care.

If a nonprofit hospital is concerned about attracting patients and providing a range of services that will encourage patients and physicians to use their hospital versus another facility, then there likely will be, and has been, a move towards factoring market pricing and outcomes into health care treatment decisions. Doing so may leave patients without access to treatments that have been deemed to underperform financially. "These changes have implications for the premise on which accountability in health care has traditionally rested: that health care institutions as nonprofit organizations have been animated primarily by goals of community service, not by economic aims, and that local control provided needed accountability."[160] Economic outcomes shifted to be more and more important over time. There have been other influences impacting the shift towards the commercialization.

Furthering the underlying factors in the shift toward commercialization has been a nonprofit hospital's access to credit-approved loans. Nonprofit hospitals have traditionally relied on large donations and government block funding as a major source of funding, which is further evidenced by the following example: the federal government provided major funding to expand the number of hospital beds. The Hill-Burton program was enacted

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[159] *Id.* at 65.

[160] *Id.*

in 1946 under the Hospital Survey and Construction Act to provide substantial subsidies for construction of nonprofit and public hospitals.[161] It was considered a necessary intervention to expand access to health care for employees working in war production facilities during World War II in addition to addressing a lack of access to health care for individuals in poor, rural areas.[162] At the time, it was believed both these groups did not have sufficient access to health care, and the program remains the largest piece of federal legislation of its type to focus on construction of nonprofit and public hospitals.[163] It became so popular that the federal government amended the original enactment to increase funding. "From July 1947 through June 1971, $28 billion in funds was distributed for the construction and modernization of health care institutions."[164] The legislation was a success from the perspective that it added hospital beds. Under it, the number of nonfederal short-term general hospitals grew from 4,375 hospitals in 1948 to 5,875 in 1975.[165] While this hospital bed expansion program was active, third-party payers were growing as employers began to offer health insurance to lure and retain employees. Third-party payers provided new revenue streams.

With the new funding streams, there was a reduction in revenue risk since the hospital no longer was solely reliant on government funding. By shifting to reliance on third-party payers, and with it the idea of more patients equaling more money, hospitals were provided stability in revenue as compared to government funding, which can be influenced by the political winds, and donations, which can be sporadic. As more patients received coverage under health insurance plans, the financial risk of patients not paying was reduced, and hospitals' revenue streams became more reliable.[166] A reliable, steady revenue stream reduces risk associated with investing which opened hospitals to a source of investment revenue previously unattainable.

Hospital bonds first got a credit rating in 1968, which made investing less risky. The reason for this was simple; independent rating agencies published their assessment of credit worthiness and allowed investors to compare risk in a more consistent manner. In 1968, Standard & Poor's credit

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[161] Andrea Park Chung et al., *Subsidies and Structure: The Lasting Impact of the Hill-Burton Program on the Hospital Industry*, 99 REV. OF ECON. AND STAT. 926, 926–27 (2017).

[162] *Id.* at 926.

[163] *Id.*

[164] *Id.*

[165] *Id.*

[166] Steven Golub, *The Role of Medicare Reimbursement in Contemporary Hospital Finance,* 11 AM. J.L. & MED. 501, 505 (1985).

rating gave its first health care bond.[167] The better your economic score, the lower your borrowing costs. Lower borrowing costs meant hospitals did not have to pay as much if their credit ratings were lower and that also influenced its access to more financing.[168] Any entity searching for funding will be concerned about borrowing costs. When a hospital is concerned about economic scores for tapping into investment pools, even as a nonprofit hospital that may not have a direct board of directors representing shareholders, adjustments are made to keep building new facilities.

Focusing on building new facilities is not the same as focusing on patient care, and a hospital's concern could arguably be the credit rating agencies that publish their credit-worthy assessments. With the expiration of the Hill-Burton program, it would be a financially prudent decision, when finances are a key influence, to factor a hospital's credit rating to reduce borrowing costs for future facility construction. Future facility construction is also important when there is reliance on service-based funding as new facilities create new services to be offered to the community. Offering more services to the community has also been a way nonprofit hospitals satisfy the requirements for that status, while increasing the volume of patients seen and charging for procedures.

Hospitals have not always charged for every procedure, though, and doing so is an example of their commercialization. This developed as a result of the third-party payment entities demanding accountability for what their customers were receiving. When cost-based reimbursement was first introduced by the private Blue Cross Insurance plans and then adapted by Medicare and Medicaid, the reimbursement provided further justification for hospitals to focus on investment financing.[169] That was due to the need for revenue. More revenue meant a hospital could remain competitive as they expanded. This expansion included new facilities and equipment. "More importantly, Medicare and Medicaid incorporated a cost-based reimbursement system for capital costs."[170] Doing so led to an expansion spurred by these cost-based reimbursements and increased hospitals' use of debt financing.[171] Medicare's policy of paying a return on equity capital to those for-profit providers highlights another influencing factor on why nonprofit hospitals would seek out debt financing as well. It encouraged the reduction of equity financing that created a shift to debt financing.[172]

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[167] GRAY, *supra* note 139, at 69.

[168] *Id.* at 70.

[169] Golub, *supra* note 151, 166at 505.

[170] *Id.* at 505–06.

[171] *Id.* at 506.

[172] *Id.*

Access to tax-exempt debt as a common revenue source made it easier for hospitals to shift to that form of debt as a primary source of capital. By the 1980s, a majority of hospital construction was funded by debt.[173] The federal government had ended its national program aimed at building more hospitals. In fact, hospitals that could achieve higher performance and increase their creditworthiness, positioned themselves to participate in mergers.

Mergers are another example of hospitals' attempt to expand their services and increase the number of patients it provided care for. "Through mergers, hospitals might be able to remove ineffective management, promote economies of scale by reducing duplication of fixed assets and services, and allow for the synergistic benefits generally characteristic of mergers in other industries."[174] Concerns about achieving economies of scale, monitoring the credit ratings and the motivation to move into debt financing are all a move away from the original perspective many had regarding nonprofit hospitals and result in further convergence of behavior when compared to for-profit hospitals. Mergers mean there is less control locally–and, in turn, less accountability at the local level.

Accountability can be measured through a hospital's quality. Since nonprofit hospitals historically have not focused on economic outcomes or gains, they should be expected to place a higher emphasis on quality. Higher quality performance has traditionally been associated with a higher expenditure of costs. Thus, if you want to maintain quality performance based on market demands, like for-profit hospitals, then there can be a lower level of quality expected when compared to nonprofit hospitals, since the emphasis is on profits.

However, this was not found in a conducted survey that compared quality performance indicators between nonprofit and for-profit hospitals. Authors of a 1992 study concluded that both nonprofit and for-profit hospitals were able to provide similar overall quality.[175] This is troubling from a policy standpoint because ". . .the social expectation is that even persons who are disadvantaged because of their health, low income, or other factors, such as race or ethnicity, have access to high-quality health care."[176] If hospitals, both nonprofit and for-profit, are primarily concerned with economic outcomes, then patients will suffer. From a human rights perspective, this is important.

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[173] *Id.*

[174] *Id.* at 524.

[175] Frank A. Sloan, *Commercialism in Nonprofit Hospitals*, 17 J. POL'Y ANALYSIS AND MGMT. 234 (1998).

[176] *Id.* at 235.

Important for public policy purposes is the question whether nonprofit hospitals are becoming less committed to such 'noncommercial' activities and when nonprofits convert to for-profits, whether these activities cease almost entirely.[177]

The conversion of nonprofit hospitals to a hybrid system–or an outright conversion to a for-profit system–signals the convergent behavior of these two types of hospitals. Leading up to the early 2000s, many nonprofit hospitals sought permission from public policymakers to convert themselves to for-profit status.[178] These conversions resulted in executive compensation to those skillful enough to perform a successful conversion.

The amount of conversions led to the IRS issuing regulation to control executive compensation. "In 1999 it issued regulations requiring the governing boards of nonprofit service providers, research organizations, and foundations to document how they set executive pay."[179] To comply with this law, hospital boards hired consulting firms to analyze data in the region so that they were in compliance with the regulation. While doing so, these consultants did not factor in the distinction between nonprofit and for-profit entities' compensation levels, but rather used the health sector as a whole entity.[180] Comparisons across the health sector as a whole, in regards to executive compensation, further evidence the convergent behavior between nonprofit hospitals and their for-profit counterparts.

Convergent behavior was likely to happen. Nonprofit hospitals have not been required to act in a charitable manner since IRS Revenue Ruling 69-545, and they were encouraged through other policies to behave in a manner similar to their for-profit counterparts. Nonprofit hospitals behaving similarly to for-profit hospitals have had an impact. Consider characteristics of the health care field: a specialized field, with high expectations, and requires extensive knowledge. The characteristics support the importance of why health is a human right.

There are policy motivations to encourage behavior that is not market-seeking, founded in the importance of health as a human right. For instance, when a nonprofit hospital seeks to satisfy the community benefit requirement to retain its special legal status, it may consider offering services in the community that are missing. For-profit seeking entities can be expected to focus on maximizing profits. The consolidation of nonprofit hospitals, that are attempting to become more efficient by focusing on

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[177] *Id.*

[178] Daniel M. Fox, *Policy Commercializing Nonprofits in Health: The History of a Paradox From the 19th Century to the ACA*, 93 MILBANK Q. 196 (2015).

[179] *Id.* at 197.

[180] *Id.*

maximizing revenue streams, risks running counter to the intended policy encouragements Congress envisioned. "Hospital consolidation has the effect of dampening competition among providers and insurers and giving particularly large hospital groups bargaining leverage in the reimbursement negotiations."[181] Consolidation reduces local authority and control since the decision-makers are not typically part of the impacted community. Furthermore, consolidation of providers runs counter to what many people feel should be a nonprofit hospital's focus. Specifically, their role historically has been as a safety net for those who otherwise would be without health care.

The ACA expected to impact the consolidation trends, and, ultimately, the commercialization trend. "In addition to significantly expanding the number of insured patients, the ACA will bring new reimbursement models designed to incentivize the provision of more integrated and coordinated care."[182] An easy method of developing integrated and coordinated care is for hospitals to consolidate. Passage of the ACA put pressure on nonprofit hospitals to consolidate, furthering the commercialization of hospitals. Unaffiliated nonprofit hospitals that may be financially distressed do not have access to sharing expertise and efficiencies available to multi-state organizations.[183] In fact, the "ACA is limited in its efforts to contain health care spending, and either does not address certain issues at all or does so insufficiently."[184] For many nonprofit hospitals, merging with another nonprofit hospital or selling to a for-profit hospital is potentially the most viable option financially. It potentially may be the only option to improve their operating margins, ensure continued access to credit and capital, acquire and implement information technology, and otherwise develop necessary efficiencies of scale and coordination–all foreseeably required to meet the new imperatives of the ACA.[185]

Passage of the ACA may have been motivated to increase access to health care coverage. However, it also has had the perhaps unintended effect of encouraging the commercialization of nonprofit hospitals. For example, the ACA made changes to existing law such as the addition of the Community Health Needs Assessment (CHNA) in its efforts to be more accountable. The ACA requires tax-exempt hospitals to create a CHNA

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[181] Susan Adler Channick, *Health Care Cost Containment: No Longer an Option but A Mandate*, 13 NEV. L.J. 792, 810 (2013).

[182] Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 103, 150–51 (2015).

[183] *Id.* at 151.

[184] Channick, *supra* note 165, at 793.

[185] Corbett, *supra* note 167, at 151.

every three years and should be developed alongside community stakeholders.

Other requirements of the ACA include identifying the community the hospital serves, surveying the community to determine health care issues, conducting a quantitative analysis of health care issues, and formulating a three year plan.[186] The result, though, of the CHNA section on hospital accountability from a revenue perspective, is more consolidation of hospitals so that the organizations can meet these requirements. Becoming part of a network that understands the new regulations and the most efficient manner to meet their requirements, like that of the CHNA section, can be appealing to avoid penalties.

Consolidating into a network that already understands and knows the path to satisfying the requirements of the ACA, like that of the CHNA, thus enhances the benefits perceived by hospital administrations to consolidate. "Provider consolidation is likely to get worse as health networks seek to take advantage of the ACA's economic incentives in favor of ACOs. Since the very definition of an ACO is provider integration, there is every reason to predict continued provider consolidation."[187] The government's attempt to encourage nonprofit hospital behavior through economic incentives has actually increased the incentive to integrate systems. A useful method to integrate systems is to buy other companies and consolidate.

Further incentivizing consolidation is the ACA deadline of when Medicaid payments will decrease with the anticipated reduction in payments being made to cover uninsured patients given the anticipated increase in coverage. Nonprofit hospitals that seek to offset those reductions in payment rates are consolidating to gain larger market shares because ". . .those with negotiating leverage with insurers are likely to continue to use their market power to get higher reimbursement rates from the private market in order to offset the losses that are anticipated from a higher percentage of Medicaid reimbursement."[188] Not only does the ACA incentivize consolidation by promoting integrated services, it also does so by reducing Medicaid reimbursements.[189] Without maintaining Medicaid reimbursements at prior levels, nonprofit hospitals have an incentive to consolidate so that they are able to negotiate with health insurers for better contractual rates.

In addition, the ACA encourages consolidations by its penalties for noncompliance. The ACA contains penalties beyond revocation of the non-profit status for noncompliance. Revocation was not widely used prior to the

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[186] Patient Protection and Affordable Care Act, *supra* note 29

[187] Channick, *supra* note 165, at 811.

[188] *Id.*

[189] *Id.* at 801

ACA, and the IRS provided hospitals an opportunity to make corrections that would allow them to move back into compliance. With the passage of the ACA, there are new "…monetary penalties or temporary suspension of tax-exempt status at the facility level" that are not levied for omissions or errors that are corrected quickly and are inadvertent or minor.[190] Additionally, hospitals that are not in compliance with the ACA regulations could be made to temporarily pay income tax as if the entity was not exempt from taxes under § 501(c)(3).[191]

Each development illustrates how commercialized behavior in nonprofit hospitals have developed over the years and further displays how nonprofit hospitals behave similarly to for-profit hospitals. Nonprofit hospitals increasingly are operating in a for-profit fashion; this commercialized behavior has been encouraged in part by federal policies, which include the passage of the ACA and continuing tax-exemption policies. This is important, not just from a tax policy standpoint or on a cost-basis analysis. Rather, the real importance is examination from a human rights welfare perspective; a perspective Congress impliedly had when it began offering entities the multitude of benefits afforded to nonprofits.

V. THE AFFORDABLE CARE ACT AND ITS IMPACT ON HOSPITALS QUALIFYING FOR TAX-EXEMPTION

The Affordable Care Act (ACA) has expanded the requirements of nonprofit hospitals and is attempting to ensure more accountability on the part of nonprofit hospitals. By requiring nonprofit hospitals to do more than simply provide a "community benefit," the ACA has impacted nonprofit hospitals' behavior. However, the ACA has resulted in the acceleration of nonprofit hospitals' commercialization when compared to for-profit hospital behavior.

The ACA's strategy to prioritize preventive services and population health through community health improvement activities gave a new focus to health care services. While its impact on nonprofit hospitals is still being examined, its passage has significantly affected all types of hospitals. Leading to the passage of the ACA, there was congressional scrutiny that resulted in new community benefit requirements that fell in line with the overall strategy of the ACA's priority of preventive care.[192] The new community benefit requirements also were intended to expand

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[190] Erica A. Clausen & Abbey L. Hendricks, *Cultivating the Benefit of § 501(r)(3): § 501(r)(3) Requirements for Nonprofit Hospitals*, 20 LEWIS & CLARK L. REV. 1025, 1038 (2016).

[191] *Id.* at 1039.

[192] Julia James, *Nonprofit Hospitals' Community Benefit Requirements*, HEALTH POL'Y BRIEF, (February 25, 2016), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_153.pdf.

accountability and transparency.[193] This was due in part to congressional scrutiny, which questioned whether nonprofit hospitals were providing sufficient returns to justify their tax-exempt status.[194]

To qualify for tax exemptions, hospitals must continue to operate under the "community benefit" standard, in addition to meeting new requirements such as "the community health needs assessment requirements."[195] The community health needs assessment requires taking into account input from representatives of the community, which can represent broad interests. This includes representatives with special knowledge of or expertise in public health.[196] An organization can meet the requirements provided they have performed a community health needs assessment at certain intervals, while also showing they have adopted an implementation strategy to meet the community health needs identified through such an assessment.[197]

Nonprofit hospitals must also develop financial assistance policies that meet the requirements of charges, and the billing and collection requirement.[198] The financial assistance policy requirements include creating criteria for determining eligibility for financial assistance, and whether such assistance includes free or discounted care.[199] There must also be a written policy that will inform people of the basis for calculating amounts charged to patients, the method for applying for financial assistance, and whether there is a separate collections and billing policy.[200]

The policy must also include a list of actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies. The nonprofit hospital must also have taken the necessary measures to publicize the policy throughout the community that is served by the organization.[201] Additionally, there must be a written policy "requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy . . . ."[202] To meet the obligations required under this section, the policy must restrict charges to no more than

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193 *Id.*

194 *Id.*

195 26 U.S.C. § 501(r)(1)(A) (1909).

196 *See generally* 26 U.S.C. § 501(r)(3) (1909).

197 *Id.*

198 *See generally* 26 U.S.C. § 501(r)(4) (1909).

199 *Id.*

200 *Id.*

201 *Id.*

202 26 U.S.C. § 501(r)(4)(B) (1909).

the amounts generally billed to individuals who have insurance that covers such care. The section also prohibits astronomical charges.[203] An organization will meet the billing and collection requirements:

> . . .only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy . . . .[204]

Determining the reasonableness of a hospital's efforts can be a challenge, given that each hospital may have unique interpretations of this. Requiring some additional measures prior to engaging in extraordinary collections, though, reflects congressional intent to provide people with an opportunity to ask for assistance if they are eligible.

To summarize, operators who wish to maintain their tax exemption status must implement a community health need assessment every three years, and adopt an implementation policy that relies, in some part, on people who can represent the broad interests of the community served. The operator must establish a financial assistance policy and an emergency medical care policy if they offer emergency services, place limits on charges so they are no more than the amounts generally billed to individuals with insurance covering the same care. Finally, these operators must forego extraordinary collection actions against an individual before making reasonable efforts to determine whether the individual is eligible for assistance under the hospital organization's financial assistance policy.

VI. CONCLUSION

In conclusion, access to affordable quality health care is important from a human right perspective. In the U.S., we have struggled for centuries to create a workable health care system. We have some of the best health care available in terms of quality and speed of care. However, it is not equally available and there are those that still do not have access to meaningful, quality health care that is free of financial burden to them. If you are lucky enough to work for an employer with access to good health care insurance, then you are a privileged person. Health care costs continue to rise, bringing more and more care out of the financial reach of people. That is a failure by the government of its implied responsibility owed to people; without health

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[203] *See generally* 26 U.S.C. § 501(r)(4) (1909).

[204] 26 U.S.C. § 501(r)(6) (1909).

people will not be able to exercise their other afforded and constitutionally protected rights.