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Not-For-Profit Hospitals and Managed Care Organizations: Why the 501(c)(3) Tax-Exempt Status Should Be Revised

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Abstract

Healthcare organizations abuse the 501(c)(3) tax-exempt status—reaping tax benefits but failing to give back to their local communities in return. Congress created the 501(c)(3) tax-exempt status to benefit the poor and impoverished. Yet, not-for-profit hospitals and managed care organizations are neither required to offer services to the poor nor required to offer emergency care services to their local communities. Instead, they charge higher prices in their increasingly concentrated markets. Therefore, consumers subsidize the same not-for-profit healthcare systems that charge them higher prices.

This Article analyzes government-placed incentives under the 501(c)(3) tax-exempt status, demonstrating how not-for-profit hospitals unfairly compete with for-profit hospitals. Studies show that not-for-profit hospitals have larger profit spreads than their for-profit counterparts. This Article will also demonstrate how the government encourages not-for-profit healthcare entities to increase their market power and extract rents from consumers. Today, the out-patient care business model fractionalizes the healthcare industry. Subsequently, not-for-profit healthcare entities can now acquire assets or firms in a piecemeal fashion, resulting in highly concentrated markets.

The third-party payor system and the Affordable Care Act exacerbate the issue, destroying traditional market forces. The third-party payor system creates a disconnect between the true provider and true consumer of healthcare treatment. The Affordable Care Act imposed additional requirements on not-for-profit hospitals—intending to incentivize charitable giving. Instead, the Affordable Care Act's additional requirements incentivize profit-maximizing behavior at the expense of charitable giving. Because the healthcare industry suffers from a misalignment of pecuniary incentives and public health needs, creating clout on who the actual winners and losers are, the tax-exempt status should be revisited.

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Introduction

This Article is part of a broader movement in literature, questioning corporate "bigness" within our economy.[1] Twenty-first century technology enables companies to grow their operations without suffering diseconomies of scale.[2] As a result, markets are shifting for the sake of efficiency towards oligopolistic and duopolistic market structures.[3] Seventy-five percent of American industries have become more concentrated in recent decades,[4] a degree of consolidated economic power not seen since the Gilded Age.[5] In recent years, scholars began writing about corporate "bigness" and the economic and social ills that stem from it.[6] Some scholars challenge well-settled antitrust law to break up big tech firms such as Facebook, Amazon, Apple, and Google.[7] Other scholars suggest the reinvigoration of community values to restore balance to an imbalanced society.[8] However, these scholars focus only on the for-profit sector—ignoring corporate "bigness" within the not-for-profit sector. Tax-exempt hospitals and managed care

Special thanks to Professor Julia D. Mahoney for her encouragement and helpful comments. Thank you for believing in me.

[1] *See* TIM WU, THE CURSE OF BIGNESS: ANTITRUST IN THE NEW GILDED AGE 14, 20 (2018) (Society is filled with widespread anger at big businesses and their behavior in concentrated markets. Many people fear their influence on politics, news, and private information.).
[2] *Id.* at 69–71.
[3] *Id.* at 114–17 (discussing AT&T's monopoly breakup and its reconsolidation, the oligopolistic airline industry and cable industry, and concentrated pharmaceutical and entertainment ticket industry); *see* Suresh Naidu et al., *Antitrust Remedies for Labor Market Power*, 132 HARV. L. REV. 536, 585 (2018) (discussing the efficiency gains from mergers).
[4] *See* WU, *supra* note 1, at 21, 115 (citing the World Economic Form and a study done by Gustavo Grullon); *see also* RAGHURAM RAJAN, THE THIRD PILLAR: HOW MARKETS AND THE STATE LEAVE THE COMMUNITY BEHIND 201 (2019) (stating that business creation in the United States has fallen since the late 1970s).
[5] WU, *supra* note 1, at 14–16.
[6] *See, e.g.*, WU, *supra* note 1; *see, e.g.*, RAJAN, *supra* note 4; *see, e.g.*, Wright, *infra* note 7; *see, e.g.*, Khan, *infra* note 7; *see also* Daniel Crane, *Antitrust and Wealth Inequality*, 101 CORNELL L. REV. 1171, 1173–75 (2016) (discussing the relationship between wealth inequality and market competition and the role of antitrust law to redistribute wealth).
[7] Joshua D. Wright et al., *Requiem for a Paradox: The Dubious Rise and Inevitable Fall of Hipster Antitrust* 2 (George Mason Law & Econ. Research Paper No. 18-29, 2019) ("The 'Hipster Antitrust' label is a lighthearted way to capture a worldview of antitrust regulation expansive enough to solve societal woes ranging from economic inequality to climate change."); *see, e.g.*, Lina M. Khan, *Amazon's Antitrust Paradox*, 126 YALE L.J. 710, 719, 737 (2017) (arguing that the Chicago's School of Antitrust thought, prioritizing consumer welfare, is wrong and betrays the legislative history of the Sherman Act).
[8] *See* RAJAN, *supra* note 4, at xiii–xviii, 214 (arguing that the economic and political concerns today, including the rise of populist nationalism and radical movements on the left, can be traced to the diminution of community).

organizations are also growing in market concentrations, causing healthcare prices to rise. This Article argues for not-for-profit tax reform, combating the economic and social ills that stem from the not-for-profit corporate form.

The 501(c)(3) tax-exempt status is a special treatment under the Internal Revenue Code afforded to "charitable" organizations; it is not its own corporate form of organization.[9] The Internal Revenue Code defines "charitable" broadly. The definition includes a variety of acceptable purposes, such as the relief of the poor and the advancement of religion, education, or science. The tax-exempt status allows organizations to operate tax-free if they meet the necessary requirements. Applicants seeking this status need not be corporate entities.[10] Not-for-profit corporations and unincorporated organizations such as trusts, foundations, and associations governed by a set of bylaws may apply.[11] After qualifying, "charitable" organizations reap tax exemptions from income, real property, sales, and other specialized taxes—relieving substantial tax burdens.[12]

This Article is the first to map the behavioral incentives of tax-exempt hospitals, post-Affordable Care Act, and explains why their charitable giving has waned over the years.[13] In 2019,

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[9] *See* Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299, 302, 330 (1976); *see generally* Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835 (1980); Henry B. Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 54 (1981).

[10] FRANCES R. HILL & DOUGLAS M. MANCINO, TAXATION OF EXEMPT ORGANIZATIONS ¶ 2.05, 1 (Supp. 2012-2).

[11] *Id.*

[12] JAMES J. FISHMAN ET AL., NONPROFIT ORGANIZATIONS: CASES AND MATERIALS 33 (5th ed. 2015).

[13] *See* Robert C. Clark, *Does the Nonprofit Form Fit the Hospital Industry*, 93 HARV. L. REV. 1416, 1447–87 (1980) (discussing the fundamental problems of not-for-profit hospitals in healthcare and potential solutions); *see also* Douglas M. Mancino, *Income Tax Exemption of the Contemporary Nonprofit Hospital*, 32 ST. LOUIS U. L.J. 1015, 1016–20 (1988); *see also* John D. Colombo & Mark A. Hall, *The Future of Tax-exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1 (1992); *see also* Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is the Tax-Exempt Status still Warranted?*, 26 URB. LAW. 143, 143–45 (1994); *see generally* Mary Crossley, *Health and Taxes: Hospitals, Community Health and the IRS*, 16 YALE J. HEALTH POL'Y L. & ETHICS 51 (2016) (evaluating community health need assessments under the Affordable Care Act); *see generally* Michael W. Jin, *Section 501(r): A Better Charitable Tax Exemption for Nonprofit Hospitals*, 69 TAX LAWYER 749 (2016) (evaluating the effectiveness of the Affordable Care Act's 501(r) requirements); *see generally* 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 (2016) (evaluating the effectiveness of the requirement); *see generally* Shirley S. Pan, *Closing the Gaps and*

the United States Senate Committee on Finance probed tax-exempt hospitals for their charitable giving—sending a letter to the Internal Revenue Service ("IRS") asking why charitable giving has decreased over the years while tax expenditures have risen.[14] Perplexed with the statistic, the Senate Committee on Finance requested a report on tax-exempt hospitals' compliance with the Affordable Care Act's additional requirements for tax-exempt hospitals.[15] This Article demonstrates that not-for-profit hospital's waning charitable giving stems from a more-vexing issue, the IRS's interpretation of "charitable" for 501(c)(3) tax-exempt hospitals and not the enforcement of the Affordable Care Act's additional requirements.

This Article demonstrates that the 501(c)(3) tax-exempt status for hospitals is no longer justified and should be revised. Congress intended the tax-exempt status to benefit the poor and impoverished—improving the general welfare of the economy in exchange for tax breaks. Yet, tax-exempt hospitals behave just like their for-profit counterparts, breaking their societal contract with the government.[16] Tax-exempt hospitals do not need to offer services to the poor, nor do they need to offer emergency care facilities to maintain their tax-exempt status.[17] Studies show that not-for-profit hospitals, like for-profit ones, raise their prices in concentrated markets and do not provide more uncompensated care.[18] In addition, further studies show that not-for-profit hospitals

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Loopholes: Analyzing Tax Exemption of Non-Profit Hospitals Joint Ventures After the Affordable Care Act, 39 AM. J.L. & MED. 671 (2013) (discussing the problems with implementing the Affordable Care Act's additional requirements).

[14] *See* Letter from Charles E. Grassley, Chairman, Senate Fin. Comm., to Charles P. Rettig, Comm'r, Internal Revenue Serv. (Feb. 19, 2019) (citing Dan Diamond, *How Hospitals Got Richer Off Obamacare*, POLITICO (July 17, 2017), https://www.politico.com/interactives/2017/obamacare-non-profit-hospital-taxes/ (stating the Affordable Care Act has provided hospitals with 20 million more customers while sometimes neglecting the needy neighborhoods around them)).

[15] *Id.*; *see also* I.R.C. § 501(r) (2012); *see generally* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1322, 124 Stat. 119 (2010).

[16] THOMAS K. HYATT & BRUCE R. HOPKINS, THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS 43–55 (4th ed. 2013).

[17] *See infra* note 44–47 and accompanying text.

[18] Tomas J. Philipson & Richard A. Posner, *Antitrust in the Not-for-Profit Sector*, 52 J.L. & ECON. 1, 1 (2009); *see, e.g.*, Ge Bai & Gerard F. Anderson, *US Hospitals are still Using Chargemaster Markups to Maximize Revenues*, 35 HEALTH AFF. 1658, 1663 (2016) (showing that hospitals mark up the prices for medical consumables 2–28 times greater than the costs to purchase them).

pay their employees, on average, more than for-profit hospitals for comparable work.[19]

First, Part I discusses the concerns among different interest groups and why the tax-exempt status should have stricter requirements or be abolished altogether. Second, Part II discusses not-for-profit hospitals, their ability to obtain the 501(c)(3) tax-exempt status, and the pros and cons of the tax-exempt corporate form. Part II further explains how managed care organizations obtain tax-exempt status under 501(c)(4) and how healthcare has evolved over the past century. Lastly, Part III explains why hospitals switched to the out-patient care model and why the third-party payor system is inefficient. Part III also discusses the competitive advantages of the tax-exempt corporate form and how hospitals interact with managed care organizations.

I. Tax–Exemption Concerns

A. Government's Perspective

Tax-exempt entities have deep-rooted traditions in American societal structure.[20] No precise explanation for this tradition exists. Nevertheless, it is clear that the tax exemption was a product of citizens' collective action to combat problems in society in a nongovernmental form.[21] Courts and congressional committees continue to uphold these long-held tax-exemptions and have even created new types of qualifying organizations under I.R.C. § 501(c). The House Committee on Ways and Means stated the following to accompany the Revenue Act of 1938:

> The exemption from taxation of money or property devoted to charitable and other purposes is based upon the theory that government is compensated for the loss of revenue by its relief from financial burden which would otherwise have to be met by appropriations from public funds, and by the benefits resulting from

[19] *See* KAREN P. SHAHPOORI & JAMES SMITH, U.S. BUREAU LAB. STATS., WAGES IN PROFIT AND NONPROFIT HOSPITALS AND UNIVERSITIES 4 (June 29, 2005), https://www.bls.gov/opub/mlr/cwc/wages-in-profit-and-nonprofit-hospitals-and-universities.pdf; s*ee also* Christian King & Gregory Lewis, *Nonprofit Pay in a Competitive Market: Wage Penalty of Premium?*, 46 NONPROFIT & VOLUNTARY SECTOR Q. 1073, 1073 (2017).

[20] *See* Michael Fricke, *The Case Against Income Tax Exemption for Nonprofits*, 89 ST. JOHN'S L. REV. 1129, 1138–39 (2015) ("[F]rom the very beginning of broad taxation in the United States, charitable organizations have been exempt."); *see also* HYATT & HOPKINS, *supra* note 16, at 9, 10, 11.

[21] HYATT & HOPKINS, *supra* note 16, at 11–12.

> the promotion of the general welfare.[22]

Subsequently, in a 1973 Committee, the then-secretary of the Treasury observed:

> [Tax-exempt] organizations are an important influence for diversity and a bulwark against over-reliance on big-government. The tax privileges extended to these institutions were purged of abuse in 1969 and we believe the existing deductions for charitable gifts and bequest are an appropriate way to encourage those institutions. We believe the public accepts them as fair.[23]

This legislative history suggests the government views tax-exempt entities as the very fabric of American life and is unlikely to consider the total subrogation of tax-exempt entities.[24] The justifications supporting the tax-exempt status for not-for-profit hospitals in the early 1900s are no longer present.[25] In the early twentieth century, the United States' healthcare infrastructure was lacking, and healthcare access was not institutionalized.[26] Today, the infrastructure for healthcare is well developed, and citizens can obtain lifesaving treatment within hours. Because the United States' healthcare infrastructure is so well developed and tax-exempt hospitals are not required to give free treatment, the tax-exempt status for healthcare entities does not confer direct benefits to our society. Instead, it only confers indirect benefits—such as developing new, innovative medical procedures or teaching the next generation of healthcare professionals.[27] Accordingly, the 501(c)(3) tax-exempt status should be partially abrogated within the healthcare industry.

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[22] *Id.* at 11 (quoting H.R. REP. NO. 75-1860, at 19 (1938)).
[23] *Public Hearing on General Tax Reform: Testimony from Administration and Public Witnesses Before the H. Comm. on Ways and Means*, 93rd Cong. 6890 (1973) (statement of George P. Shultz, Secretary, Treasury Department); *see also* Paul R. McDaniel, *Tax Reform and the Revenue Act 1971: Lessions, Lagniappes and Lessons*, 14 B.C. L. REV. 813, 852 (1973).
[24] HYATT & HOPKINS, *supra* note 16, at 11–13.
[25] *Id.* at 43–55.
[26] *See generally* Youssra Marjou & Kevin J. Bozic, *Brief History of Quality of Movement in US Healthcare*, 5 CURRENT REVS. MUSCULOSKELETAL MED. 265, 265–66 (2012).
[27] *See* Annetine C. Gelijns et al., *Capturing the Unexpected Benefits of Medical Research*, 339 NEW ENG. J. MED. 693–94 (1998); *see also* Colleen J. Goode et al., *Nurse Residency Programs: An Essential Requirement for Nursing*, 27 NURSING ECON. 142, 143 (2009) (stating that it takes at least one year for a person to master a job within healthcare); *see, e.g.*, Pamela Lyss-Lerman et al., *What Training is Needed in the Fourth Year of Medical School? Views of Residency Program Directors*, 84 ACAD. MED. 823, 827 (2009) (finding that workplace learning is important and distinct from school learning).

The government's tax expenditures on not-for-profit hospitals outweigh the indirect benefits they generate—thus, the *quid pro quo* is no longer fair. In 2014, 501(c)(3) tax-exempt organizations raised $1.94 trillion in untaxed revenue, equating to 11% of the United States' 2014 Gross Domestic Product, approximately half of which is attributable to hospitals and primary care facilities.[28] Further analysis of the empirical evidence indicates 501(c)(3) organizations' profits, which is defined as revenue minus liabilities, increased from $95.5 billion in 2010 to $148.2 billion in 2014.[29]

Despite growing tax expenditures, innovative medical procedures only increased the United States' life expectancy by one percent from 2006 to 2016, from an average age of 77.8 years to 78.6 years respectively.[30] Further, tax-exempt status is not a necessary requirement to engage in teaching medical professionals—any hospital may engage in teaching the next generations of medical professionals. Therefore, the government is allocating huge tax expenditures on tax-exempt healthcare organizations with little economic or social return.[31] Accordingly, the government should tighten the belt on 501(C)(3) tax-exempt hospitals, ensuring tax-payer money is used to benefit the citizens who pay it.

B. Consumers' Perspective

Consumers subsidize an inefficient third-party payor system and receive higher insurance

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[28] *See SOI Tax Stats – Charities and Other Tax-Exempt Organizations Statistics*, INTERNAL REVENUE SERV., https://www.irs.gov/statistics/soi-tax-stats-charities-and-other- tax-exempt-organizations-statistics (last reviewed Aug. 31, 2020); *see also Gross domestic product (GDP) of the United States from 1990 to 2020*, STATISTICA, https://www.statista.com/statistics/188105/annual-gdp-of-the-united-states-since-1990/ (last visited Apr. 20, 2020); *see also* MOLLY F. SHERLOCK & JANE G. GRAVELLE, CONG. RES. SERV., AN OVERVIEW OF THE NONPROFIT AND CHARITABLE SECTOR 10 (2009) (showing hospitals held 38 percent of the total assets and earned 57 percent of the total revenues in the charitable sector).

[29] *See* INTERNAL REV. SERVS., *supra* note 28.

[30] Rabah Kamal, *How does U.S. life expectancy compare to other countries?*, PETERSON-KFF (Dec. 23, 2019), https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/#item-start; *see also* ELIZABETH ARIAS & JIQUAN XU, NAT'L VITAL STAT. REP., UNITED STATES LIFE TABLES, 2017, at 10 (2019).

[31] *See generally* U.S. DEP'T TREASURY, TAX EXPENDITURES 2018, at 14 (2016) (showing that the exclusion of employer contributions for medical insurance is the largest tax expenditure at $235.8 billion, twice as large as the second-largest tax expenditure at $112.7 billion).

premiums in return. The healthcare insurance market lacks competition.[32] Consumers take whatever insurance they can get their hands on.[33] Employees demand employer-sponsored insurance programs because of their inherent tax benefits—making employer-sponsored insurance programs an essential commodity for employers to maintain skilled workforces.[34] Employers, as an agent of their employees, can negotiate healthcare insurance contracts and reallocate funds from their employees' wages to purchase them.[35] These comprehensive plans typically provide the most coverage and result in employee over insurance.[36] By accommodating their employees' demand for employer-sponsored health insurance and incorporating their employees' wages into the plan's purchase price, employers buy plans with the most coverage and force employees to take indirect pay-cuts and overconsume healthcare coverage.

Consumers could be contributing to the increasing cost of healthcare insurance, consuming as much healthcare as possible.[37] But this issue could be avoided altogether by getting rid of the third-party payor system. If consumers were required to pay for extra procedures out of pocket, instead of through a third-party intermediary, they would internalize the "true cost" of their consumption. When consumers internalize the "true cost" of their healthcare services, they will only consume procedures that truly matter to them. Because healthcare insurers act as intermediaries between healthcare consumers and healthcare providers, contracting with employers or consumers directly

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[32] *See* Thomas Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217, 236 (2009) ("[B]asic necessities for effective shopping are missing: prices for health services are not readily available, or knowable, ex ante. Likewise, those left to buy health insurance in the individual market have encountered significant problems in comparing offerings and understanding risks associated with co-payment obligations and limitations on coverage.").
[33] *Id.*
[34] *See* Michael Doonan & Gabrielle Katz, *Choice in the American Healthcare System: Changing Dynamics under the Affordable Care Act*, 63 CURRENT SOC. MONOGRAPH 746, 750 (2015); Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 37, 38 (2006).
[35] Havighurst & Richman, *supra* note 34.
[36] *Id.*
[37] *See* Katherine Baicker & Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, 25 J. ECON. PERSP. 47, 52–53 (2011); *see also* Ching-To Albert Ma & Michael H. Riordan, *Health Insurance, Moral Hazard, and Managed Care*, 82 J. ECON. & MGMT. STRATEGY 81, 102 (2004).

on the front-end—for insurance coverage—and healthcare providers on the back-end—for treatment—consumers cannot internalize the "true cost" of their healthcare services.[38]

Consumers of healthcare only observe changes in co-payments and not the "true cost" of their healthcare services.[39] Healthcare insurers know their customers have co-payment price expectations. Therefore, healthcare insurers will extract as much economic surplus as possible from healthcare providers during negotiations, without increasing their customers' co-payments. Even if they change the price of their customers' co-payments, the changes will be insubstantial relative to their prior co-payment. In effect, the degree of economic surplus healthcare insurers and healthcare providers retain after negotiations is a function of their relative market power. The entity with greater relative market power will extract more surplus in the transaction. Because healthcare insurers can negotiate the prices of healthcare services down, increasing their bottom lines, and are not required to pass those gains on to consumers, consumers are unable to capture market surplus within the transaction.

C. Solutions: Moving Forward with the Tax–Exempt Status

The government should revise the requirements for 501(c)(3) tax-exempt hospitals and 501(c)(4) tax-exempt Health Maintenance Organizations (HMOs) in the third-party payor system. Tax-exempt healthcare entities retain too much discretion in their capital allocation, granting them unfair advantages over their for-profit counterparts without proportional societal benefit in return. Two potential solutions to this problem exist, neither of which is mutually exclusive. Either the government tightens the belt on tax-exempt healthcare organizations, or congress reforms the

[38] Havighurst & Richman, *supra* note 34.
[39] *See* Ateev Mehrota et al., *Consumers' and Providers' Responses to Public Cost Reports, and How to Raise the Likelihood of Achieving Desired Results*, 31 HEALTH AFF. 843, 845 (2012); *cf.* Stephen L. Issacs, *Consumers' Information Needs: Results of a National Survey*, 15 HEALTH AFF. 31, 31 (1996); *cf.* E.B. Keeler et al., *Deductibles and the Demand for Medical Services: Theory of a Consumer Facing a Variable Price Schedule under Uncertainty*, 45 ECONOMETRICA 641, 641, 654 (1977).

third-party payor system to a more efficient model.

First, the government should make it harder for hospitals and HMOs to qualify as "charitable" and maintain a tax-exempt status because they behave just like for-profit entities and do not necessarily confer "charitable" benefits to their local communities.[40] Even though tax-exempt hospitals engage in medical research, teaching, or technological innovation,[41] the amount of untaxed revenue the government forgoes is greater than the indirect benefits tax-exempt hospitals generate for society. As a result, tax-exempt hospitals should be prohibited from owning for-profit subsidiaries and should be required to dedicate a portion of their revenue back to their local communities. Along the same lines, hospitals that only specialize in certain types of medical procedures should not be considered "charitable" organizations under the 501(c)(3) tax-exempt status.

Second, the third-party payor system should be reformed to make healthcare markets driven by price competition instead of non-price, competitive factors.[42] Price is the very essence of competition, and without it, markets cannot function. Consumers should internalize the price of the healthcare treatment and the healthcare insurance they receive, which in turn, would reduce overconsumption and increase consumer surplus. Alternatively, the government could reform the third-party payor system to a single-payer system where the government insures all of its citizens. Under a single-payer system, the government would reap huge savings on administrative costs by

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[40] *See* Lisa K. Helvin, *Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 452–57 (2008) (stating that Texas was the first state to pass legislation requiring hospitals to allocate a specific percentage of revenues for charity care and community benefit and that a few other states followed suit); *see generally* Cory Capps et al., *Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?*, [page cited] (Nat'l Bureau of Econ. Research, Working Paper No. 23131, 2017).

[41] *See* Gelijns et al., supra note 27; *see also* Goode et al., *supra* note 27 (finding that it takes at least one year for a person to master a job within healthcare because the healthcare culture emphasizes specialization, technology, and perfectionist standards); *see, e.g.*, Lyss-Lerman et al., *supra* note 27 (finding that workplace learning is important and distinct from school learning).

[42] United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 244 (1940) (defining price competition as the main economic driver in a free market).

eliminating third parties. The government could then reallocate administrative cost savings towards specific public health concerns, such as child obesity.

The first solution is the least contentious of proposed solutions and would be well received by both adherents of redistribution of wealth and free market principles. Adherents of wealth redistribution principles would want to tighten the belt on tax-exempt organizations to ensure tax-exempt subsidies are indeed aiding local communities via charitable giving. On the other hand, adherents of free market principles would view the tax-exempt subsidies as unfair, reducing competition among healthcare entities and raising prices for consumers. The difference in opinion would only pose issues if the tax exemption were abolished altogether. If it were, adherents of wealth redistribution principles would want the new stream of income reallocated to government programs that aid the poor and impoverished. Conversely, adherents of free market principles would likely want the new stream of income appropriated to the government itself, reducing budget deficits or paying down outstanding government debt.

Healthcare reform is the most challenging solution to reconcile. Each philosophical group would get entrenched in their diametrically opposed positions. Adherents of wealth redistribution principles would rally behind a single-payer system, similar to ones adopted in Europe. However, adherents of free market principles would dig their heels in, detesting "big government" subsidizing healthcare for hundreds of millions of Americans. In addition, they would also propose the repeal of government programs such as Medicare, Medicaid, and the Affordable Care Act. This fundamental disparity in opinion is why the United States uses a mixed system, combining a single-payer system with a third-party payor system. Due to this reality, perhaps we should work to revitalize community values, reconciling divergent political factions. Only through unity can we

effectuate change.[43] If the revitalization of community values is the answer, then a tax-exempt distribution requirement may be the key to unified healthcare reform.

II. Not-for-Profit Hospitals & The 501(c)(3) Tax-Exempt Status, Managed Care Organizations, and The Government

A. Not-For-Profit Hospitals & The 501(c)(3) Tax Exempt Status

Hospitals can organize their corporate charter as a "charitable" 501(c)(3) tax-exempt organization without changing their substantive operations. The IRS and most state courts do not require 501(c)(3) tax-exempt hospitals to provide free healthcare or services priced below the cost of production to maintain their status.[44] This rule was first promulgated in 1969 when the IRS defined "charitable" for 501(c)(3) hospitals in Rev. Rul. 69-545.[45] Later, in 1983, the IRS amplified their definition of "charitable" for 501(c)(3) tax-exempted hospitals in Rev. Rul. 83-157 ("Second Rev. Ruling"). According to the Second Rev. Ruling, not-for-profit hospitals need not furnish emergency room care where a state health planning agency has determined that the emergency room care would be duplicative of emergency healthcare services available at another medical facility in the community. The Second Rev. Ruling further stated the following:

> [T]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the

[43] *See* RAJAN, *supra* note 4, at 320, 338, 346 (describing how to reinvigorate community values and some common themes that arise in doing so).

[44] Rev. Rul. 69-545, 1969-2 C.B. 117 (stating that tax-exempt hospitals can deny patients who are unwilling to pay unless they are in need of emergency treatment), *amplified by* Rev. Rul. 83-157, 1982-2 C.B. 94; ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 111 (2d ed. 1988) (stating that many states adopted the Model Non-Profit Corporation Act or a variation of it); *see* Simon v. E. Ky. Welfare Rights Org., 425 U.S. 26, 27 (1926) (upholding Rev. Rul. 69-545); *see also* 1 MARILYN PHELAN, NONPROFIT ENTERPRISES: CORPORATIONS, TRUSTS, AND ASSOCIATIONS § 1:11 [confirm source] (Supp. 2009) (a leading treatise summarizing the differences in states' non-profit corporate law); *see also* Hugh K. Webster, *Tax-Exempt Organizations: Organizational Requirements*, 451 T.M. at A-26 (2018).

[45] *See* FISHMAN ET AL., *supra* note 12, at 303 (citing Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL. POL'Y & L. 251 (1991) (stating that Rev. Rul. 69-545 was not based on any thoughtful public policy debate but rather was the result of a successful lobbying effort by nonprofit hospitals, arguing that the arrival of Medicare, Medicaid, and private industry growth would render charitable care useless)).

> community. The class must be sufficiently large, however, so that the community as a whole benefits.[46]

Combining both rulings, the IRS's definition of "charitable" indicates that poverty relief is not a necessary requirement for hospitals to obtain and maintain tax-exempt status.[47] Therefore, not-for-profit hospitals, similar to for-profit hospitals, can still earn profits, charge prices higher than their total production costs, and reinvest those same profits into physical facilities or endowments without helping their local communities.[48]

Even though strict operating requirements reduce the means by which a tax-exempt organization can raise capital, studies indicate that the inherent benefits of the tax-exempt status outweigh the negative aspects of strict operating requirements.[49] Coupling this proposition with empirical evidence that 501(c)(3) organizations are growing in concentration, scale, and profits indicates that the tax-exempt status is being sought out as a better tax structure. Data collected by the IRS and studies conducted by healthcare professionals demonstrate that the 501(c)(3) tax-exempt status is superior. First, the assets of 501(c)(3) organizations almost doubled from 2004–2014, from $2 trillion to $3.7 trillion, even though the number of not-for-profit organizations has been fluctuating sporadically over the years.[50] Second, the margins that 501(c)(3) organizations realize increased year-over-year from 2010–2014, from $95.5 billion to $148.2 billion, a $52.7

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[46] Rev. Rul. 83-157, 1982-2 C.B. 94.
[47] SOUTHWICK, *supra* note 44, at 62, 63.
[48] *Id.*
[49] *See* Bradley Herring et al., *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, 55 J. HEALTH CARE ORG. 1, 1, 9 (2018) ("For policy makers who desire to motivate hospitals to provide adequate community benefits and, in particular charity care to underserved populations, the tax exemption currently appears to be rather a blunt instrument, as many nonprofits benefit greatly from the tax exemption yet provide relatively few community benefits.").
[50] *See Tax Statistics*, INTERNAL REVENUE SERV., https://www.irs.gov/statistics (last visited Oct. 10, 2019) (reviewing the IRS collected data from Form 990 filings to compare not-for-profit organizations' aggregated assets from 2004–2014). Generally, the 501(c)(3) tax-exemption requires organizations to file annual returns on Form 990, disclosing their revenue, expenses, and assets. I.R.C. § 6033 (a)(1) (2012); Hugh K. Webster, *Tax-Exempt Organizations: Reporting, Disclosure and Other Procedural Aspects*, 452-1st T.M. at A-4 (2017) (Because Form 990 increases the transparency of 501(c)(3) organizations, we can use Form 990 filings to analyze not-for-profit hospitals' behavior.).

billion nominal increase in yearly profits or a 57 percent change.[51]

Hospitals receive four primary advantages from the 501(c)(3) tax-exempt status but only one primary disadvantage.[52] First, the organization will gain exemptions from all federal income taxes other than the unrelated trade or business income tax ("UBIT").[53] The UBIT imposes taxes on a tax-exempt organization's regularly conducted trade or businesses "unrelated" to their "charitable" purpose. Despite this tax, the IRS defines "related" activities broadly, giving hospitals ample room to operate tax-free.[54] Second, the organization can gain tax exemptions from various state and local taxes that differ among the states. Third, the organization can receive tax-deductible contributions from donors, subject to certain limitations.[55] Fourth, a for-profit corporation applying for the tax-exempt status can choose to incur windfall gains via retroactive tax benefits, applying the 501(c)(3) tax-exempt status retroactively up to 27 months.[56] The primary disadvantage of the tax-exempt tax status is the prohibition against private inurement.[57] The prohibition of private inurement restricts not-for-profit organizations' ability to raise capital through equity.[58] Therefore, not-for-profit entities can only raise capital by taking out debt, selling goods or services, or

[51] *See Tax Statistics*, INTERNAL REVENUE SERV., https://www.irs.gov/statistics (last visited Oct. 10, 2019) (reviewing the IRS collected data from their Form 990 filings to compare the profits of not-for-profit hospitals since the enactment of the Affordable Care Act in 2010). "Margins" means the spread between the organization's operating cost and their total revenues and is synonymous with "profits."
[52] *See* Webster, *supra* note 44, at A-3–A-4.
[53] I.R.C. § 501(a)–(b) (2012); *see also* I.R.C. § 511(a)(2)(A) (2012) (stating the 501(c)(3) organizations are subject to the UBIT).
[54] Rev. Rul. 69-463, 1969-2 C.B. 131 (holding that leasing hospital space by a hospital to a hospital based medical group is related); Rev. Rul. 69-269, 1969-1 C.B. 160 (holding that hospital parking lots are related activities); Rev. Rul. 69-268, 1969-1 C.B. 160 (holding that hospital cafeterias and coffeeshops were related activities); Hi-Plains Hosp. v. United States, 670 F.2d 528, 535 (5th Cir. 1982) (stating that a hospital's pharmacy sales to nonpatients could be treated as related income, if the sales were infrequent and the hospital was the sole hospital in a small community); *see* SOUTHWICK, *supra* note 44, at 169; *see, e.g.*, United States v. Am. Coll. of Physicians, 106 S. Ct. 1591 (1986) (stating that income received by a medical organization from commercial advertisements in professional journal is taxable unrelated business income).
[55] I.R.C. § 170(c) (2012).
[56] Treas. Reg. § 1.508-1(a)(2)(i) T.D. 9819, 82 Fed. Reg. 29, 730 (June 30, 2017), applicable July 1, 2014 (allowing for 15 months); Treas. Reg. § 301.9100-2 (1997) (allowing for additional automatic 12-month extension); *see* Rev. Proc. 2018-5, I.R.B. 01; *see also* Webster, *supra* note 44, at A- 4.
[57] *See* Webster, *supra* note 44, at A-4.
[58] *Id.*

soliciting tax-deductible contributions.

Hospitals face three main incentives to utilize the corporate form because the law generally treats corporations as separate and distinct from those who created them, own them, or are employed by them.[59] The first reason is limited liability. Under the concept of limited liability, owners of a corporation are not personally liable for the contracts or the torts of the corporation beyond the extent of their investment.[60] The second incentive is continuity of existence.[61] Unlike a partnership, a corporation is unaffected by the death of owners or board members.[62] Lastly, if the corporation is for-profit, it can freely transfer its ownership interest and raise capital through equity with the issuance of stock.[63]

Hospitals can use the not-for-profit corporate form for its inherent tax benefits; however, in doing so, they give up the right to raise capital through equity. Many states do not have laws for not-for-profit corporations, and some adopted the Model Non-profit Corporation Act or a variation of it to govern them.[64] Even though the laws governing not-for-profit corporations vary from state to state, a general rule has emerged. The standard requirement among states is that no part of the income or profit can be distributed for private gain to its members.[65] Therefore, the standard

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[59] Trustees of Dartmouth Coll. v. Woodward, 17 U.S. (4 Wheat) 518, 636 (1819) (opinion of Marshall, C.J.) ("[Corporations are] an artificial being, invisible, intangible, and existing only in contemplation of law. Being the mere creature of the law, it possesses only those properties which the charter confers upon it, either expressly or as incidental to its very existence.").

[60] *See* MODEL BUS. CORPS. ACT ANNOTATED § 6.22(b) (AM. BAR ASS'N 2016) (Unless otherwise provided in the articles of incorporation, a shareholder of a corporation is not personally liable for the acts or debts of the corporation, except that he may become personally liable by reason of his own acts or conduct.); FRANK H. EASTERBROOK & DANIEL R. FISCHEL, THE ECONOMIC STRUCTURE OF CORPORATE LAW 40 (1991) (stating that limited liability is *the* distinguishing feature of corporate law, shareholders are not liable for the debts of the corporation); *see, e.g.*, Sea-Land Servs., Inc. v. Pepper Source, 993 F.2d 1309, 1311 (1993) (upholding limited liability as a general default rule as long as corporate formalities are respected and the corporation is not acting as the shareholder's alter ego).

[61] MODEL BUS. CORPS. ACT ANNOTATED § 2.02 cmt. (3)(c) (4th ed. 2008).

[62] *See* SOUTHWICK, *supra* note 44, at 107.

[63] *Id.* at 108.

[64] *Id.* at 111; *see* MODEL BUS. CORP. ACT ANNOTATED, at xix (AM. BAR ASS'N 2013) ("Twenty-four states have adopted all or substantially all of the model act as their general corporation statute, and seven other jurisdictions have statutes based on the 1969 version of the Act."); *see, e.g.*, Nonprofit Corporation Act, MICH. COMP. LAWS §§ 450.2101–450.3099 (1986).

[65] SOUTHWICK, *supra* note 44.

requirement prohibits not-for-profit corporations from raising funds through the issuance of stock.

Despite not-for-profit corporations' inability to raise funds through equity, they can raise capital in three other ways. First, they can charge customers prices for their goods or services.[66] Second, they can raise capital through charitable donations. Potential donors face incentives to donate to not-for-profit organizations because they can receive tax deductions for their donations to a certain extent.[67] Thirdly, they can take out loans to fund their operations.[68] Because not-for-profit corporations retain viable methods for raising capital, they can still compete against for-profit corporations that raise capital through equity.

Not-for-profit hospitals can operate for-profit subsidiaries, separating for-profit business activities from their parent company to ensure that their tax exemption is safe. The extent to which a 501(c)(3) tax-exempt organization can engage in for-profit activities without threatening its tax-exempt status is vague. The IRS has no clear rule. The IRS determines whether a tax-exempt entity engages in too much for-profit activity on an unpredictable case-by-case basis.[69] Thus, not-for-profit entities engage in high-stakes gambling, with their tax-exempt status on the line, when they engage in for-profit activities.[70] Because not-for-profit entities can separate their not-for-profit activities from their for-profit activities through subsidiaries and could lose their tax-exempt status for comingling for-profit and not-for-profit activities, for-profit hospitals face incentives to convert to the tax-exempt corporate form. In effect, for-hospitals could separate their for-profit operations

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[66] Christopher Cheney, *Differences Between NFPs And For-Profits Are Marginal*, HEALTH LEADERS (Mar. 14, 2016), http://www.healthleadersmedia.com/finance/differences-between-nfps-and-profits-are-marginal# (The line between for-profit and not-for-profit hospitals has blurred. Both share the same mission of delivering high-quality care, and both must make sustainable bottom lines in order to achieve their mission.).

[67] *See* INTERNAL REVENUE SERV., CHARITABLE CONTRIBUTIONS FOR USE IN PREPARING 2017 RETURNS 2, 13 (Mar. 12, 2018), https://www.irs.gov/pub/irs-prior/p526--2017.pdf (indicating that the Internal Revenue Code has limitations, known as phaseouts, on the amount a person or corporation can claim as charitable donations).

[68] *See* Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. REG. 139, 160–61 (2007) (A not-for-profit organization can secure its debt against any assets that they own, which can range from real property in the form of real estate to personal property in the form of stocks or bonds.).

[69] Peter Molk, *Reforming Nonprofit Exemption Requirements*, 17 FORDHAM J. CORP. & FIN. L. 475, 478 (2012).

[70] *Id.*

into subsidiary organizations—reaping tax breaks without changing their operations in substantial ways.

Not-for-profit hospitals can also obtain tax-exempt statuses for their subsidiaries if their subsidiaries are an "integral part" of the parent company. The Integral Part Doctrine uses a two-prong approach to determine whether a subsidiary may qualify for tax-exempt status under 501(c)(3).[71] First, the subsidiary may not carry on a trade or business unrelated to tax-exempt activities if the parent carried it on. Second, the subsidiary's relationship to its parent may not enhance its own exempt character to the point that the subsidiary would be entitled to its own 501(c)(3) tax-exempt status when adding the business provided by the parent to the contributions made by the subsidiary itself.

Converting a for-profit hospital to a not-for-profit hospital is quite simple. Generally, a for-profit institution must file a Form 1023 to apply for the 501(c)(3) tax-exempt status, which requires an $850 fee—further reduced for organizations with low expected revenues.[72] Before filing, Form 1023 requires a for-profit entity to do four things: (1) preselect its board of directors; (2) prepare a conflict of interest policy; (3) prepare articles of incorporation; and (4) prepare the bylaws it wishes to implement.[73] For-profit entities can repurpose their board of directors and conflict of interest policies for the new, tax-exempt organization. Similarly, its articles of incorporation and bylaws would only need minor alterations to further a "charitable" purpose listed in 501(c)(3). Because a for-profit hospital can repurpose their board members, corporate policies, and corporate governance documents and do not need to change their day-to-day operations, for-profit hospitals

[71] Treas. Reg. § 1.502-1(b)(1)-(2) (1980); Geisinger Health Plan v. Comm'r, 30 F.3d 494, 500 (3d Cir. 1994) (applying the integral part doctrine to an HMO subsidiary owned by a larger, not-for-profit health system); *see, e.g.*, Squire v. Students Book Corp., 191 F.2d 1018, 1020 (9th Cir. 1951) (holding that a for-profit restaurant and bookstore that used college space, served faculty and students, and devoted its earning to educational purposes were integral parts of a not-for-profit college).

[72] *See* INTERNAL REVENUE SERV., APPLICATION FOR RECOGNITION OF EXEMPTION UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE (2017), https://www.irs.gov/pub/irs-pdf/f1023.pdf.; Webster, *supra* note 50, at A-3–A-4.

[73] *See* INTERNAL REVENUE SERV., *supra* note 72.

face little barriers to entry when converting to a not-for-profit entity.

In practice, a for-profit hospital seeking tax-exempt status would have to rid itself of its shareholders to reincorporate. A for-profit hospital could use a leveraged buyout—using its high-value assets as collateral to obtain loans—to repurchase its stock at a reasonable premium above fair market value.[74] In addition, entities reorganizing as a 501(c)(3) tax-exempt corporation must pass an organizational test and an operational test to qualify and maintain their status.[75] The organizational test relates to the organization's purpose as described by the organizational charter, whereas the operational test relates to the actual activities conducted by the organization.[76]For-profit hospitals convert to not-for-profit status to build trust with the local community and manage public relations.[77] On the other hand, not-for-profit hospitals convert to for-profit corporations because of financial concerns and board perceptions on mission achievement.[78] Although the line between organizational statuses seems fluid, hospitals converting from a not-for-profit hospital to a for-profit hospital face more barriers. An organization seeking this conversion typically needs permission

[74] *See, e.g.*, Smith v. Van Gorkom, 488 A.2d 858, 858–97 (Del. 1985), *overruled by* Gantler v. Stephens, 965 A.2d 695 (Del. 2009) (imposing fiduciary duties upon board members to have their corporate shares valued by a third-party before purchasing them in a leveraged buyout.).

[75] Treas. Reg. § 1.501(c)(3)-1(a)(1) (1980) (stating that organizations that fail either test will not be considered exempt from taxation as a public charity).

[76] Treas. Reg. § 1.501(c)(3)-1(b)(1)(iv) (1980); Colorado State Chiropractic Soc'y v. Comm'r, 93 T.C. 487, 493 (1989) (holding that an organization's primary purpose could be determined from a review of its bylaws as well as its articles of incorporation); *see also* Webster, *supra* note 50, at A-10.

[77] *See* Kamal R. Desai et al., *Hospital Conversions from For-Profit to Nonprofit Status: The Other Side of the Story*, 55 MED. CARE RES. & REV. 298, 309–13 (1998) (finding a lack of controversy surrounding for-profit conversions: policy makers and community leaders presumably welcome for-profit conversions because they believe that nonprofit ownership will lead to greater benefits in the community. However, there is no empirical evidence suggesting that for-profit conversions actually result in more uncompensated care to the communities and that the "net payoff" of conversions are still uncertain.).

[78] *See* David M. Cutler & Jill R. Horwitz, *Converting Hospitals from Not-For-Profit to For-Profit Status: Why and What Effects?* 12–13 (Nat'l Bureau of Econ. Research, Working Paper No. 6672, 1998); *see also* SARA R. COLLINS ET AL., THE FOR-PROFIT CONVERSION OF NONPROFIT HOSPITALS IN THE U.S. HEALTH CARE SYSTEM: EIGHT CASE STUDIES 1, 1–3 (2001) (finding that not-for-profit hospitals' financial distresses were caused by a variety of factors, including inability to adapt to prospective reimbursement changes in the Medicare Program and technological advancement in patient care. However, the study could not determine the exact reasons why the hospitals were sold to for-profit organizations.).

from their state attorney general, typically an elected official who wants to win public support.[79] Current studies suggest that the public, on the whole, has preconceived beliefs about "not-for-profit" entities—believing they do good things for society and should be trusted, even when, in fact, they do little good.[80] Because state attorneys general want to win public support, and the public has preconceived notions that not-for-profits are good for society and should be trusted, state attorneys general will probably deny any conversion requests to maintain public support.

Empirical evidence indicates not-for-profit hospitals only provide marginally more uncompensated care than for-profit hospitals despite little difference in their economic behavior.[81] This study used eleven years of detailed data on hospital competition and several measures of charity care. Specifically, it found no differences in the propensities of for-profit and not-for-profit hospitals to provide more charity care as their market power and margins increased. Since tax-exempt hospitals are not required to give free care under the IRS's interpretation of "charitable,"

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[79] FISHMAN ET AL., *supra* note 12, at 169–77 (citing *e.g.*, Vacco v. Diamandopoulos, 715 N.Y.S.2d 269, 270–71 (1988) (The New York Attorney General has the responsibility to oversee not-for-profit entities with his *parens patriae* authority.)); *see also* MARION R. FREMONT-SMITH, GOVERNING NONPROFIT ORGANIZATIONS 152, 319 (2004) (stating that most states have non-distribution constraints on liquid or nonliquid assets to individuals which could in itself prevent the conversion of a not-for-profit entity).

[80] *See* Jennifer Aaker et al., *Nonprofits are Seen as Warm and For-Profits as Competent: Firm Stereotypes Matter*, 37 J. CONSUMER RES. 224, 237 (2010) (concluding that people judge companies along similar dimensions as they do other people, and that nonprofits are generally considered to be high in "warmth"); *see cf.* Nick Lin-Hi et al., *Does CSR Matter for Nonprofit Organizations? Testing the Link Between CSR Performance and Trustworthiness in the Nonprofit Versus For-Profit Domain* 26 INT'L J. VOLUNTARY & NONPROFIT ORGS. 1944, 1949, 1962 (2014) (concluding that higher level of perceived trustworthiness can lead to a competitive advantage over for-profit firms).

[81] Cory Capps et al., *Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?* 3 (Nat'l Bureau of Econ. Res., Working Paper No. 23131, 2017) (finding similar levels of uncompensated care among for-profit and not-for-profit hospitals and questioning whether tax exemptions for not-for-profit hospitals are an efficient method for funding care for the poor); *cf.* Gloria J. Bazzoli et al., *Community Benefit Activities of Private, Nonprofit Hospitals*, 35 J. HEALTH POL. POL'Y & L. 1000, 1022 (2010) (finding that nonreligious, not-for-profit hospitals in California and Florida gave around the same amount of uncompensated care, including Medicaid spending, as for-profit hospitals); *cf.* Paul Gertler, *Does it Matter who your Buyer is? The Role of Nonprofit Mission in the Market for Corporate Control of Hospitals*, 53 J.L. & ECON. 295, 305 (2009) (finding that not-for-profit hospitals behave like for-profits when dealing with for-profits in a market for corporate control). *But see* William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 439, 453 (1995) (citing Thomas J. Hoerger, *"Profit" Variability in For-Profit and Not-for-Profit Hospitals*, 10 J. HEALTH & ECON. 259, 273 (1991) for the proposition that not-for-profit hospitals react in different ways); Clark, *supra* note 13, at 1417, 1455 (citing studies that conclude for-profits have lower costs than nonprofits); *see generally* Amanda J. Vaughn, *The Use of the Nonprofit "Defense" under Section 7 of the Clayton Act*, 52 VAND. L. REV. 557, 562–67 (1999) (summarizing literature testing the differences between for-profit and not-for-profit hospitals).

are growing in size and scale,[82] and have the same propensities as for-profit hospitals to give free care or not when their profit margins increase, the current 501(c)(3) tax-exempt status departs from its original purpose to benefit the poor and impoverished.

B. Managed Care Organizations & The Government

Managed care organizations are the primary healthcare delivery and financing mechanism in the United States.[83] The two most prevalent types of managed care organizations are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). HMOs are organizations that both underwrite insurance risk and arrange the provision of healthcare services through a specified delivery system.[84] PPOs are comprised of physicians and hospitals that contract with employers and third-party payors to provide comprehensive healthcare services to subscribers on a fee-for-service basis.[85] Even though HMOs do not promote a sufficiently large class of the community to be "charitable" under 501(c)(3), HMOs can still obtain tax-exempt status as a social welfare organization under I.R.C. § 501(c)(4).[86] Because HMOs can still obtain tax-exempt status, consumers are subsidizing both the insurers and the healthcare providers within the third-party payor healthcare model.

Federal legislators changed healthcare over the years, attempting to meet the healthcare needs of their people while curbing the rising cost. Healthcare legislation can be grouped into three eras:

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[82] *See* KAUFMANHALL, 2017 IN REVIEW: THE YEAR M&A SHOOK THE HEALTHCARE LANDSCAPE 1, 8 (2018), https://www.kaufmanhall.com/sites/default/files/legacy_files/kh_report-ma-year-in-review_d4-rebrand.pdf (indicating that the number of mergers of hospitals and healthcare systems have increased steadily from 50 to 115 a year respectively from 2009–2017, and that not-for-profit systems were 75% of the transactions, acquiring not- for-profit and for-profit entities in 2017); *see also* KAUFMANHALL, 2018 M&A IN REVIEW: A NEW HEALTHCARE LANDSCAPE TAKES SHAPE 1, 2 (2019), https://www.kaufmanhall.com/sites/default/files/documents/2019-01/2018-merger-acquisition-year-in-review_kaufman-hall.pdf (indicating that the size of the transacting parties have been growing at a compounded annual growth rate of 13.8 percent since 2008); *see generally* Greaney, *supra* note 32, at 217, 231 ("Hundreds of hospital mergers occurred in the 1990s, and by 2003 ninety-three percent of the nation's population lived in concentrated hospital markets.").

[83] THOMAS K. HYATT & BRUCE R. HOPKINS, THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS 243 (4th ed. 2013).

[84] *Id.* at 243.

[85] *Id.* at 244.

[86] *See id.*

(1) Progressive Health Insurance Era; (2) Expansionary Health Insurance Era; and (3) Containment Health Insurance Era.[87] During the Progressive Health Insurance Era, from the 1890s–1920s, insurance was most concerned with the negative features of capitalism and high-density overcrowded cities, focusing primarily on employment and its side effects.[88] The Expansionary Health Insurance Era, from the 1930s–1960s, was driven by the need to improve healthcare services. As medicine developed tools to treat illnesses and hospitals became the central means to deliver healthcare services, healthcare costs began to increase.[89] Thirdly, The Containment Insurance Era began in the 1970s in response to rapid increases in healthcare spending driven by recently enacted Medicare and Medicaid programs.[90] As a result of healthcare cost and spending increases, several pieces of *ex post* legislation were enacted, such as The Economic Stabilization Act of 1970,[91] The Health Maintenance Organization Act of 1973,[92] and The Health Planning and Resource Development Act and its Certificate of Need requirements in 1974.[93]

According to scholars,[94] five main factors contribute to rising healthcare costs: (1) technology as a cost-driver;[95] (2) a fragmented, uncoordinated system of insurers and healthcare providers;[96]

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[87] Barry R. Furrow, *Cost and Control and the Affordable Care Act: CRAMPing our Health Care Appetite*, 13 NEV. L.J. 822, 827 (2013); *see also* Paul Starr, *Transformation in Defeat: The Changing Objective of National Health Insurance, 1915-1980*, 72 AM. J. PUB. HEALTH 78, 78 (1982).
[88] *See* Furrow, *supra* note 87, at 827.
[89] *Id.*; *see also* Barry R. Furrow, *Health Reform and Ted Kennedy: The Art of Politics…and Persistence*, 14 N.Y.U. J. LEGIS. & PUB. POL'Y 445, 449 (2011).
[90] *See* Furrow, *supra* note 87, at 828 (stating that federal health expenditures jumped from $42 billion in 1965 to $420 billion in 1985, a ten-fold increase, due to Medicare and Medicaid).
[91] The Economic Stabilization Act of 1970, Pub. L. No. 91-379, §§ 101–206, 84 Stat. 799 (1970).
[92] Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, §§ 1301–15, 87 Stat. 914 (1973).
[93] National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 6–8, 88 Stat. 2225 (1974); *see also* David S. Salkever & Thomas W. Bice, *The Impact of Certificate of Need Controls on Hospital Investment*, 54 HEALTH & SOC'Y 185, 185–86 (1976) (studying the efficacy of certificate of need programs).
[94] *See* SOUTHWICK, *supra* note 44, at 223 (citing Eli Ginzberg, *The Monetarization of Medical Care*, 310 NEW ENG. J. MED. 1162, 1162 (1984) for its definition of "Monetarization," meaning the money economy has penetrated all facets of the healthcare system.); *see also* Furrow, note 87; *see also* Maureen J. Bluff & Timothy D. Terrell, *The Role of Third-Party Payers in Medical Cost Increases*, 19 J. AM. PHYSICIANS & SURGEONS 75, 75 (2014).
[95] Furrow, *supra* note 87, at 833, 836 ("Technology puts the policymaker between Scylla and Charybdis: it offers providers and patients tools for improved treatment and simultaneously allows them to charge more. Patients do not fret about the cost of new technology if they have good insurance, and too many providers want them even if it lacks evidence of efficacy.").
[96] *Id.* at 830 ("A progressive fragmentation of care has occurred as the result of the multiplicity of reimbursement

(3) the aging population;[97] (4) unnecessary healthcare screenings;[98] and (5) additional regulation from the Affordable Care Act.[99] Because the factors contributing to rising healthcare costs are so numerous, federal legislators struggle to keep healthcare prices down through healthcare reform.

III. Interactions in a Third-Party Payor System: Hospitals and Managed Care Organizations

A. Healthcare Post Affordable Care Act & The Third-Party Payor System

Today, after the passage of the Affordable Care Act, hospitals face increasing pressures to transform themselves into long-term care facilities.[100] Not-for-profit hospitals utilize budget cuts and mergers to achieve long-term success. Budget cuts require not-for-profit hospitals to sustain operations with less capital. Mergers increase a not-for-profit hospitals' economies of scale—reducing their cost of production and increasing their bargaining power in their employment, supply, and insurance contractual negotiations.

Hospitals use the out-patient care service model to cut the costs of patient care and increase the quantity of healthcare services they provide. In the out-patient care service model, patients are first diagnosed by a primary care physician and then referred to a specialist for treatment. From an economic point of view, out-patient care is a successful form of cost reduction because it incentivizes specialization among different healthcare practice groups. Instead of having a few

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sources for healthcare: Medicare is for the elderly; private employment-based insurance is available to working adults; Medicaid is for the poor; hospital emergency facilities give care to undocumented immigrants . . . and the Veteran's Administration treats the large population of veterans in need of treatment.").

[97] *See The Nation's Older Population is Still Growing, Census Bureau Reports*, U.S. CENSUS BUREAU (June 22, 2017), https://www.census.gov/newsroom/press-releases/2017/cb17-100.html ("The nation's median age rose from 35.3 years in 2000 to 37.9 years on July 2016. . . .'Baby Boomers began turning 65 in 2011 and will continue to do so for many years to come.'").

[98] *See* SHANNON BROWNLEE, OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER 5 (2007) (arguing that one-third of the money spent on healthcare is spent on care that does nothing to improve our health).

[99] *See* Irwin M. Stelzer, *Antitrust Enforcement and the Hospitals*, 47 NAT'L AFF. 36, 39 (2015) (stating that compliance with the Affordable Care Act requires considerable investment and has incentivized hospital mergers); *see* Lawrence E. Singer, *Considering the ACA's Impact on Hospital and Physician Consolidation*, 46 J.L. MED. & ETHICS 913, 914–15 (2018) (stating that hospitals have pressures to consolidate under the Affordable Care Act to reduce compliance costs).

[100] Furrow, *supra* note 87, at 830.

general care facilities, our healthcare industry has small, specialized out-patient facilities. Although this fractionalization reduces the cost of care, it increases the administrative cost of patients. Patients no longer enjoy the "one-stop-shop," and must go through different entities and administrations to receive healthcare. Even though the out-patient business model lowers consumer convenience satisfaction and increases administrative expenses, hospitals still choose the out-patient business model for its profits—sometimes exceeding twenty-five percent of the hospital's income.[101]

Out-patient procedures have their advantages, reducing patient recovery time and the costs of performance. However, they create fundamental problems. The out-patient fee-for-service reimbursement model leaves patients subject to high, unregulated prices. Under the fee-for-service arrangement, healthcare services are unbundled and paid for separately. This fractionalization of service incentivizes physicians to provide more healthcare services because payment is dependent on the quantity of care, rather than the quality of care. Thus, one problem that federal legislators face is whether they should counteract the negative effects of the fee-for-service reimbursement payment model with pay-for-performance financial programs.[102]

The third-party payor system eliminates price competition among providers.[103] Healthcare providers must contract with healthcare insurers to increase their customer base, while healthcare insurers contract with employers or consumers to increase their insurance pools. Healthcare insurers act as self-interested intermediaries between the true provider and the true consumer of healthcare services—destroying traditional supply and demand market forces in a healthcare

[101] *Id.*; *see also* STEVE JACOB, HEALTH CARE IN 2020: WHERE UNCERTAIN REFORM, BAD HABITS, TOO FEW DOCTORS AND SKYROCKETING COSTS ARE TAKING US 204 (2012); *see generally* Frank A. Sloan, *Commercialism in Nonprofit Hospitals*, 17 J. POL'Y ANALYSIS & MGMT. 234, 235–56 (1998).
[102] *See* Andrew M. Ryan & Rachel M. Werner, *Doubts About Pay-for-Performance in Health Care*, HARV. BUS. REV. (Oct. 9, 2013), https://hbr.org/2013/10/doubts-about-pay-for-performance-in-health-care.
[103] ROBERT J. ENDERS ET AL., MANAGED CARE AND ANTITRUST: THE PPO EXPERIENCE 5 (1990).

transaction. Therefore, the healthcare industry does not respond to traditional supply and demand market forces.[104] Even though the United States has a single-payer system for those over the age of 65 and those below the poverty line, this paper only analyzes the third-party payor system, which covered 67.5 percent of the United States' population in 2016.[105]

B. Not-for-Profit Hospitals and their Competitive Edge Over For-Profit Hospitals

Not-for-profit corporations and for-profit corporations face the same incentives.[106] Any corporation must cover its cost in the long run in order to operate.[107] A corporation may sustain losses in the short term; however, it is unfeasible to incur losses in the long term. The charitable purposes of not-for-profit corporations and the mission statements of for-profit corporations are functionally the same. Both types of corporations offer goods or services in order to promote their charitable purpose or mission statement.[108] Because both types of corporations want to promote their charitable purposes or their mission statements, they both face incentives to maximize profits.

Not-for-profit hospitals would rather reap tax-exempt subsidies than possess the right to raise funds via equity.[109] Not-for-profit hospitals retain direct subsidies from the federal government via their tax-exempt status and could further qualify for state subsidies. These tax benefits are

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[104] *Id.* (citing J. CHRISTIANSON, CURRENT STRATEGIES FOR CONTAINING HEALTH CARE EXPENDITURES: A SUMMARY OF THEIR POTENTIAL, PERFORMANCE, AND PREVAL (1985)); *see also* Charles D. Weller, *Free Choice as a Restraint of Trade in American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1352–53 (1984).

[105] *See* JESSICA C. BARNETT & EDWARD R. BERCHICK, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016, at 1 (Sept. 12, 2017), https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf.

[106] *See generally* Philipson & Posner, *supra* note 18; *see also* Sloan, *supra* note 101, at 234 ("The hospital industry is undergoing massive change . . . partly because of changes in payment practices, demand for hospital inpatient care is shrinking. This has led to hospitals closures and mergers, and some conversions . . . Hospitals are not only integrating horizontally, but vertically."); *see also* Mark J. Cowan, *Nonprofit and the Sales and Use Tax*, 9 FLA. TAX REV. 1077, 1080 (2010) ("Indeed, the line between nonprofit organizations and for-profit commercial enterprises has become blurred. Therefore, the revenue and policy issues at stake are perhaps more important than they were when the exemptions were enacted.").

[107] *See* Cheney, *supra* note 66.

[108] *Id.*

[109] *See Some nonprofit hospitals are among the most profitable*, CBS NEWS (May 2, 2016), https://www.cbsnews.com/news/some-nonprofit-hospitals-are-among-the-most-profitable/ ("Nonprofits reinvest net income into 'the latest technology, newer equipment, modern facilities, highly trained staff.'"); *cf.* Harris Meyer, *Not-for-profits dominate top-10 list of hospitals with biggest surpluses*, MODERN HEALTHCARE (May 2, 2016), http://www.modernhealthcare.com/article/20160502/NEWS/160509991; *cf.* AM. HOSP. ASS'N, AHA HOSPITAL STATISTICS 1 (2017).

predictable and not subjected to future costs. On the other hand, raising funds via equity requires the corporation to issue stock and pay dividends on future earnings. Because equity has a higher cost of capital, in the long run, not-for-profit hospitals unfairly obtain cheaper sources of funding to grow their operations.

Not-for-profit hospitals, in comparison to their for-profit counterpart, sustain bigger margins to reinvest in themselves.[110] Larger margins equate to more working capital to reinvest into "cutting edge" technology, attracting the most qualified doctors.[111] On that same token, not-for-profit hospitals face incentives to reinvest their larger pools of working capital into the aesthetic looks of their hospitals and patient amenities. In doing so, not-for-profit hospitals can increase consumer satisfaction, which in turn could increase their charitable donations.[112] Because tax-exempt hospitals have larger pools of working capital to reinvest into the most "cutting edge" technology, the aesthetic looks of their hospitals, and patient amenities, they have unfair competitive advantages in the healthcare services they provide. Not only are their doctors more skilled, but their facilities have greater aesthetic appeal and amenities—increasing consumer satisfaction.

Due to larger margins, not-for-profit hospitals pay their employees more than their for-profit counterparts. Two studies compared employee pay between tax-exempt hospitals and for-profit hospitals—finding an odd result. Specifically, the studies concluded that not-for-profit hospitals paid their qualified nurses, on average, more than for-profit hospitals, and as a result, attracted better nurses.[113] These studies support the proposition that not-for-profit hospitals have an unfair

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[110] *See* Niran Al-Agba, *The Fairy Tale of a Non-Profit Hospital*, HEALTH CARE BLOG (Apr. 25, 2017), https://thehealthcareblog.com/blog/2017/04/25/the-fairy-tale-of-a-non-profit-hospital/; *see generally* Donald L. Sharpe, *Unfair Business Competition and the Tax on Income Destined for Charity: Forty-Six Years Later*, 3 FLA. TAX REV. 367(1996).

[111] CBS NEWS, *supra* note 109 ("Nonprofits reinvest net income into 'the latest technology, newer equipment, modern facilities, highly trained staff.'").

[112] Meyer, *supra* note 109 (finding that profits were influenced by retail price markup, prestige, teaching status, a mix of uninsured patients, and not-for-profit status).

[113] *See* Karen P. Shahpoori & James Smith, *Wages in Profit and Nonprofit Hospitals and Universities*, BUREAU LAB. STAT. 4 (June 29, 2005), https://www.bls.gov/opub/mlr/cwc/wages-in-profit-and-nonprofit-hospitals-and-

competitive edge because they are able to allocate more funds to their employees' wages. Because not-for-profit hospitals pay their employees more for comparable work, hospital employees face financial incentives to shift their place of employment from for-profit hospitals to not-for-profit hospitals in the long run.

Unlike for-profit hospitals, religious not-for-profit hospitals can explicitly ask potential employees what their religious affiliations are during the hiring process and can choose to hire or not hire a potential employee on that basis.[114] Armed with this information, religious not-for-profit hospitals can discriminate against skilled employees that do not share the same religious beliefs as the institution. Coupling this unique ability with the proposition that Christian employees, on average, provide better customer service due to their religious beliefs, religious not-for-profit organizations can systematically assemble and maintain better workforces than their for-profit counterparts.

The proposition that Christian employees provide better customer service than non-religious employees with similar skills is reasonable and supported by studies.[115] For example, Catholic social teaching encourages adherents to treat the sick with love, compassion, and respect for human dignity.[116] Because Catholic social teaching promotes healing the sick and studies suggest religious

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universities.pdf (finding that the average hourly rate for all workers in private for-profit hospitals was lower than the average hourly rate for all workers in private not-for-profit hospitals); *see also* King & Lewis, *supra* note 19, at 1073, 1074, 1081, 1087 (finding that the pay is highest in not-for-profit hospitals, partly because they attract better educated and more experienced nurses, but partly because they pay comparable nurses more than for-profit hospitals do).

[114] *See* Bruce N. Bagni, *Discrimination in the Name of the Lord: A Critical Evaluation of Discrimination by Religious Organizations*, 79 COLUM. L. REV. 1514, 1533 (1979) (The 1964 Civil Rights Act outlawed employment discrimination on the basis of religion, however, it made an exception for religious corporations if the employment of an employee with a particular religion is necessary to perform work connected to religious activities.).

[115] Burton A. Weisbrod, *The Future of the Nonprofit Sector: Its Entwining with Private Enterprise and Government*, 16 J. POL'Y ANALYSIS MGMT. 541, 549–50 (1997) (statistical studies indicate satisfaction is highest at church-related not-for-profit facilities and lowest at for-profit facilities (using grounds, rooms and furnishings, staff, social activities, and treatment services as measures)); *see generally* Ellen Idler & Allan Kellehear, *Religion in Public Health-Care Institutions: U.S. and U.K. Perspectives*, 56 J. FOR SCI. STUDY RELIGION 234, 238 (2017) (stating that the religious presence of healthcare organizations can manifest informally through their employee beliefs and not just through explicit organizational action).

[116] Bishops of Maryland, *Care of the Sick and Dying*, CATHOLIC CULTURE (Oct. 14, 1993), https://www.catholicculture.org/culture/library/view.cfm?recnum=5311; *see also* John Molyneux, *It's Time to Take*

leadership teams are better at servicing patients than non-religious teams,[117] religious not-for-profit hospitals likely serve patients with better customer service. If this were true, Catholic not-for-profit hospitals unfairly compete in the marketplace. Patients will respond to the benefits religious not-for-profit hospitals produce and use these facilities more in the long run. In essence, if an average consumer's healthcare coverage allows them to choose between identical services at either a for-profit hospital or a Christian not-for-profit hospital, the average consumer would likely choose the Christian not-for-profit hospital.

Not-for-profit organizations face less regulation than for-profit organizations and thus, retain more discretion in their business endeavors.[118] In response to the Enron and WorldCom scandals, where corrupt executives enticed corporate investment using fraudulent accounting methods, the 2002 Sarbanes-Oxley Act ("Sarbanes-Oxley") compelled for-profit corporations to implement additional accounting requirements—increasing transparency and deterring corruption.[119] Even though debates extending the additional accounting requirements to not-for-profit organizations took place, Sarbanes-Oxley was never extended to regulate them.[120] Thus, not-for-profit entities avoided additional government oversight of Sarbanes-Oxley regulations along with any costs associated with it.

Our Medicine: An Interview with Sister Carol Keehan, D.C., U.S. CATHOLIC, May 2010, at 19, 23 (statement of Sister Carol Keehan, President and CEO of the Catholic Health Association) ("An ideal, Catholic healthcare system would treat everyone with dignity and perpetuating a Catholic healthcare tradition asking the sick 'what they can do for you,' instead of how much are we required to do for you.").

[117] *See* Daniel Burke, *Religious Hospitals Better? Study Says Catholic and Church-Run Hospitals More Efficient, Provide Superior Care*, HUFFINGTON POST (Aug. 17, 2010), https://www.huffingtonpost.com/2010/08/17/study-says-religious-hosp_n_683932.html ("When your mission is rooted in Jesus who healed the sick, only the top quality care will do.") (last updated Dec. 6, 2017).

[118] *See* Paul Rose, *The Corporate Governance Industry*, 32 J. CORP. L. 887, 896, 899 (2007); *see also* Isida Tushe, *The New York Nonprofit Revitalization Act, From the Foundation of The Sarbanes-Oxley Act to Implementation*, 18 INT'L J. NOT-FOR-PROFIT L. 65, 66–69 (2016).

[119] *See cf.* Joseph Mead, *Confidence in the Nonprofit Sector through Sarbanes-Oxley-Style Reforms*, 106 MICH. L. REV. 881, 886–88 (2008); *see generally* Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, § 101, 116 Stat. 745 (2002).

[120] *See* Francie Ostrower, *Nonprofit Governance in the United States: Findings on Performance and Accountability from the First National Representative Study*, 3–4 URB. INST. (2007); *see also* Nick Lin-Hi et al., *supra* note 80.

For-profit boards and executives face more scrutiny in their business decisions than not-for-profit boards and executives. Shareholders hold for-profit boards and executives accountable, whereas non-profit boards and executives are only accountable to themselves.[121] For-profit boards and executives must generate reports for their shareholders on a consistent basis, while not-for-profit boards and executives do not.[122] The frequency of reporting restricts for-profit boards' and executives' choices—in fear of potential shareholder litigation. Because not-for-profit boards and executives face less scrutiny in their business decisions, they have more discretion in how they derive their profit margins.

Due to a lack of accountability and beneficial group payoffs, not-for-profit boards are more likely to engage in unethical conduct than their for-profit counterpart. According to studies, board members are susceptible to "situational pressures" in group settings.[123] These "situational pressures" are especially likely in contexts where people lack accountability for collective decision making.[124] Not-for-profit board members face collective incentives to make their organization the

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[121] Peggy Sasso, *Searching for Trust in the Not-for-Profit Boardroom: Looking beyond the Duty of Obedience to Ensure Accountability*, 50 UCLA L. REV. 1485, 1487–88 (2003); *but cf.* Lloyd H. Mayer, *Fragmented Oversight of Nonprofits in the United States: Does it Work? Can it Work?*, 91 CHI.-KENT L. REV. 937, 939 (2016) (describing the role of state attorneys general in enforcing corporate laws on nonprofits which is the only enforcement method nonprofit boards are susceptible too); *cf.* FISHMAN ET AL., *supra* note 12, at 204–08 (2016) (discussing the role of state attorneys general and their responsibility to oversee charitable trusts and corporations in order to protect the state and public interest).

[122] *See* Jeffery M. Kaplan, *Boards of Directors, Moral Hazard and Corporate Compliance Programs*, 16 FED. ETHICS REP. 1, 1 (2009) (acknowledging that shareholder boards may require directors to exceed the benchmark requirements for oversight duties, going above and beyond).

[123] *See* Deborah L. Rhode & Amanda K. Packel, *Ethics and Nonprofits*, STAN. SOC. INNOVATION REV. (Summer 2009), https://ssir.org/articles/entry/ethics_and_nonprofits ("Situational pressures" can be present in group setting or in situations when an employee feels that they have to comply with a superior's orders. When "situational pressures" are present, moral compasses of employees tend to go awry.); *see also* Kaplan, *supra* note 122. *But see* David M. Schizer, *Tax and Corporate Governance: The Influence of Tax on Managerial Agency Costs* 4, 5, 7 (Colum. Law Sch. Pub. Law & Legal Theory, Working Paper Grp., Paper No. 14-415, 2014) (Tax rules and board oversight works in theory, however in practice, it does not necessarily impede for-profit managers from their self-interest because tax rules and oversight are easy to avoid and managers can fool their boards.).

[124] *See* Rhode & Packel, *supra* note 123, at 31 (discussing an experiment by Scott Armstrong asked one group of people to play the role of board of directors for a pharmaceutical company and another group to give their moral opinions of their choices. Four-fifths of the pharmaceutical board of directors decided to keep marketing a drug that killed people, would likely be barred by regulation, and decided to take legal and political actions to prevent a ban. Meanwhile the other group, giving their moral opinions with similar business backgrounds, said that continuing to market the drug was "socially irresponsible.").

most profitable because it makes themselves more marketable for other corporate positions.[125] Because not-for-profit boards face collective incentives to maximize the organization's profits and are less accountable systematically, they are more vulnerable to moral blinders that cloud ethical judgment.

The Accordable Care Act does more harm than good—pummeling tax-exempt hospitals with additional regulations without much societal benefit. In 2010, the Affordable Care Act added four general requirements, listed in I.R.C. § 501(r) (2012), to encourage not-for-profit hospital charitable giving:

> (1) establish written financial assistance and emergency policies,
> (2) limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance policy,
> (3) make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual, and
> (4) conduct a Community Health Needs Assessment ("CHNA") and adopt an implementation strategy at least once every three years (effective after March 23, 2012).

Federal legislators intended to hold not-for-profit hospitals to a higher standard by implementing the additional requirements, forcing not-for-profit hospitals to focus more on community health needs.[126] However, these requirements have nothing to do with charitable giving. Instead, they aligned with the financial interest of not-for-profit hospitals to maximize profits. The first three requirements deal with information disclosure policies, while the fourth

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[125] *Cf.* Danne L. Johnson, *Seeking Meaningful Nonprofit Report in a Post Sarbanes-Oxley World*, 54 ST. LOUIS U. L.J. 187, 204–07 (2009) (Nonprofit board members are often selected for their wealth or work, perhaps having no prior governance or business experience. The list of a nonprofit board's responsibilities is long, and directors may have different motivations for serving on nonprofit boards, which changes both how they view their role and the expectations that the organization has of them.).

[126] *See* Shefali Luthra, *Nonprofit hospitals focused more on community health needs under the ACA. That may change.*, WASH. POST (Mar. 14, 2017), https://www.washingtonpost.com/national/health-science/nonprofit- hospitals-focused-more-on-community-needs-under-the-aca-that-may-change/2017/03/14/4214f3fe-080c-11e7- b77c-0047d15a24e0_story.html.

requirement deals with CHNA and its implementation.[127] Hospitals first created CHNAs to determine the health needs of their local community so they could better cater their services to them.[128] Tax-exempt hospitals face profit-maximizing incentives to meet their community's specific health needs, providing enough supply to meet their community's specific demands. Because CHNAs align with the financial interest of hospitals and the other three requirements listed in 501(r) focus on information disclosure, the additional requirements do not change the behavioral incentives of tax-exempt hospitals.

Not-for-profit hospitals who fail to meet the Affordable Care Act's additional requirements are fined a $50,000 excise tax for any given taxable year and could lose their tax-exempt status.[129] Despite the plain meaning of the internal revenue code, the IRS will not strip not-for-profit hospitals of their tax-exempt statuses unless their noncompliance with the additional requirements is "willful or egregious."[130]As of September 2020, using the Westlaw database, neither the IRS nor a court has clarified the IRS's "willful or egregious" noncompliance standard. Thus, the IRS will not attack tax-exempt hospitals' statuses as long as they maintain good faith efforts to comply with the Affordable Care Act's additional requirements.

One study found hospitals responding to the Affordable Care Act's additional requirements and providing increased levels of charitable care; however, this study wrongly compares the expenses on charitable care to the entities' total expenses to determine whether hospitals are

[127] *See* 26 C.F.R. § 1.501(r)-4 (2016) (explaining how financial assistance policies ("FAP") should be created for emergency care services); *see* 26 C.F.R. § 1.501 (r)-5 (2016) (stating how to limit prices for FAP qualifying patients); *see* 26 C.F.R. § 1.501(r)-6 (2016) (requiring hospitals not to engage in extra ordinary bill collection actions); *see* 26 C.F.R. § 1.501(r)-3 (2015) (stating how to complete a community health needs assessment ("CHNA")).
[128] *See* Sara Heath, *How to Create, Conduct Community Health Needs Assessments*, PATIENT ENGAGEMENT HIT (Sept. 11, 2017), https://patientengagementhit.com/news/how-to-create-and-conduct-community-health-needs-assessments (stating that hospitals created CHNAs to help healthcare organizations uncover the health and social ills of a specific community; it is not an IRS created requirement).
[129] *See* 26 U.S.C. § 4959 (2012).
[130] *See* Rev. Proc. 2015-21, 2015-13 I.R.B. 818; IRS Notice 2015-46, 2015-2 C.B. 64.

responding.[131] The study should be comparing charity care in relation to the entities' revenue streams and profits. Entities that make more profits, in theory, should spend more on charitable care. The entity could exercise its market power and raise prices, make more profit, and neither change its charitable care expenditures nor operating expenses. The ratio would remain intact. Likewise, if a hospital effectuated a merger or acquisition, reducing their operating expenses via efficiency gains, and left charitable expenditures unaltered, then their charitable expenditures in relation to their total expenses would increase even though their nominal charitable spending remained stagnant. Thus, data using operating expenses as a comparable baseline is flawed.

C. Not-for-Profit Hospitals' Cooperatives with Managed Care Organizations

Managed Care Organizations ("MCOs") make healthcare worse. They disrupt traditional supply and demand market forces, serving as third-party intermediaries between the true supplier of healthcare services and its true consumer. Hospitals are the true suppliers of healthcare services, while the recipients of healthcare treatment are the true consumers. MCOs contract with true consumers, either directly or through their employer, for services rendered and then contract with hospitals for services provided. Because hospitals, the true supplier, and recipients of healthcare treatment, the true consumer, can only negotiate prices with MCOs and not with each other, MCOs impede traditional supply and demand market forces.

Consumers do not have real choices in either the market for healthcare insurance or in the market for healthcare services. Employers negotiate the price of their employee's healthcare insurance, while their healthcare insurer negotiates the prices of the employee's treatment. In addition, consumers with employer-sponsored health insurance face little incentive to shop for unsponsored coverage because employers incorporate the price of healthcare coverage into their

[131] Susannah C. Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 61, 73, 85 (2014) (concluding that hospitals are responding to the Affordable Care Act's requirements and giving out more charitable care, comparing expenses on charitable care in relation to total expenses).

employees' wages.[132] Due to employers passing on the costs, employees would suffer an indirect pay cut when they decline an employer-sponsored healthcare plan for another healthcare insurance provider.[133] Thus, employees would be worse off purchasing a private healthcare plan in lieu of an employer-sponsored healthcare plan. Because employees are worse off denying employer-sponsored healthcare plans and have no ability to negotiate prices, in a third-party payor system, consumers act as price-takers and take whatever coverage their employer provides.[134]

Although it could be argued that MCOs reduce the cost of providing healthcare by reducing transaction costs, MCOs face no incentives to pass those efficiency gains to consumers. Instead, MCOs disrupt the price setting mechanisms of healthcare, serving as a third-party intermediary between the provider and ultimate purchaser of goods. Because there is a disconnect between consumers and the prices paid to service providers, consumers cannot internalize the true cost of their healthcare services. Thus, consumers are unable to compare prices of healthcare services and rely on their employers, who have unaligned financial incentives, to negotiate deals on their behalf.[135]

In a market where prices are not the "central nervous system," the only way for hospitals to gain patients is through HMOs or other insurance providers.[136] As a result, hospitals face incentives to join HMOs to increase their consumer base.[137] This form of market allocation pressures hospitals to contract the price of their services as high as possible to HMOs and other insurance providers,

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[132] *See* Havighurst, *supra* note 34, at 37, 38.
[133] *See* Inland Steel Co. v. NLRB, 170 F.2d 247, 251 (7th Cir. 1948) (treating employee pension and welfare benefits as wages purchased with an employee's labor).
[134] *See Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND. (Feb. 18, 2018, 3:51 PM), https://www.kff.org/other/state-indicator/total-population/ (stating that in 2019, 49 percent of Americans received their insurance through their employers).
[135] *Id.*
[136] *Id.*; *see also* Sloan, *supra* note 101, at 235–36 (1998); *cf.* United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 244 (1940) (stating that prices are the very essence of competition).
[137] Benjamin Stone, *The Art of Negotiation: Hospitals and Managed Care*, CHI. POL'Y REV. (Sept. 5, 2013), http://chicagopolicyreview.org/2013/09/05/the-art-of-negotiation-hospitals-and-managed-care/.

who will then reimburse the hospital for the services rendered to their patients, to maintain their profits. Likewise, HMOs face incentives to contract the price of the hospital services as low as possible to maintain their profits. In the end, the hospital or the HMO with more relative market power will extract the most profit from the transaction.

Legal scholars explored the difficulties of altruistic giving and determined that altruistic markets cannot operate where intermediaries capture available economic surplus.[138] A third-party payor system creates too many intermediaries in a healthcare transaction. All of the intermediaries face incentives to make profits and grow their operations. As a result, any tax benefits we grant these institutions are unlikely to trickle down to its intended beneficiary—taxpayers. Given this literature, as applied to the healthcare industry, the question then becomes: can we trust charitable healthcare entities to engage in altruistic behavior when they face incentives to reap the economic surplus themselves?

D. Market Power of Not-for-Profit Hospitals & Managed Care Organizations

Market power is an instrumental negotiation tool for healthcare entities and is a key part of this Article's assessment of not-for-profit healthcare organizations. Market power refers to the ability of a firm, or a group of firms acting jointly, to raise prices above competitive levels without losing so many sales that the price increase is unprofitable and must be rescinded.[139] In a third-party payor system, market power is the primary factor determining the prices healthcare firms charge consumers for services and upstream suppliers for goods.[140] Today, healthcare firms use it as a bargaining chip to sell their goods or services at higher prices, or alternatively, negotiate lower

[138] *See* Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163, 197 (2000) (describing how an altruistic market for human tissue would only work when none of the entities in a distribution chain acts to capture the available economic surplus by selling the tissue); *see generally* Stephen J. Choi et al., *Altruism Exchanges and the Kidney Shortage*, 77 LAW & CONTEMP. PROBS. 289 (2014); *see generally* Julia D. Mahoney, *Altruism, Markets, and Organ Procurement*, 72 LAW & CONTEMP. PROBS. 17 (2009).
[139] William M. Landes & Richard A. Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937, 939 (1981).
[140] *See, e.g.*, Ge Bai & Gerard F. Anderson, *supra* note 18, at 1662–63 (2016) (showing hospitals marking up the prices of medical consumables 2–28 times greater than the costs to purchase them).

prices for purchased goods.

Not-for-profit hospitals and MCOs face the same incentives to maximize profits.[141] Not-for-profit hospitals face incentives to negotiate higher prices with MCOs for medical services and negotiate lower prices with upstream suppliers for medical equipment and consumables.[142] MCOs, on the other hand, face incentives to negotiate low prices with hospitals for medical services provided and negotiate high prices with employers and individuals for their insurance coverage.[143] In essence, the relative market power between hospitals and MCOs will determine how these firms split profits. The firm with more market power will extract as much economic surplus as possible before agreeing to contractual terms. Because price negotiations between not-for-profit hospitals and MCOs occur behind closed doors, without consumer participation, consumers are unable to extract some of the economic surplus and reduce their total cost for healthcare.

Conclusion

The 501(c)(3) tax-exempt status departs from its original purpose to benefit local communities and relieve the government from allocating funds to combat economic and social ills. Under the IRS's interpretation of "charitable," tax-exempt hospitals need not give free care to the poor or provide emergency care services despite large government tax expenditures. Instead, tax- exempt hospitals are growing in scale, market concentration, and profit—charging taxpayers higher prices—without increasing charitable distribution. Accordingly, this result explains why the

[141] *See* Robert E. McDonald, *An Investigation of Innovation in Nonprofit Organizations: The Role of Organizational Mission*, 36 NONPROFIT & VOLUNTARY SECTOR Q. 256, 263–64, 268 (2007); *see also* Lori Timmins, *How do Hospitals Respond to Financial Pain? Evidence from Hospital Market in Texas*, VANCOUVER SCH. ECON. 1, 4 (2014) (finding that hospitals are strategically targeting specific procedures and patients to augment revenue).
[142] Stone, *supra* note 137; *see also* Martha C. White, *Hospitals made $21B on Wall Street last year, but are patients seeing those profits?*, NBC NEWS (Feb. 7, 2018), https://www.nbcnews.com/business/business-news/hospitals-made-21b-wall-street-last-year-are-patients-seeing- n845176 ("Health economists describe the current dynamic as a sort of arms race, with health care providers and insurers each trying to gain market share to get more negotiating leverage.").
[143] *See* Stone, *supra* note 137.

government's tax expenditures are increasing while charitable giving is waning. In addition, the government suffers direct harm as a market participant—paying higher prices to not-for-profit hospitals through Medicaid and Medicare programs.

The Affordable Care Act exacerbates the injustice and should be repealed. It does not solve the fundamental problems with not-for-profit hospitals in a third-party payor system. Instead, it increases administrative costs—compounding inefficiencies on inefficiencies. The Affordable Care Act's first three additional requirements do not relate to charitable giving, focusing on information disclosure instead. The fourth requirement aligns with not-for-profit hospitals' financial interest to maximize profits instead of promoting charitable giving as intended. This legislation forced 20 million consumers into the healthcare market, leaving not-for-profit healthcare entities salivating at the market growth. Consumers already subsidize the inefficient healthcare system; why should they be forced to buy healthcare insurance and further increase the profits of tax-exempt hospitals and managed care organizations? All they get in return are increased prices.

The 501(c)(3) tax-exempt status should be reformed, requiring tax-exempt organizations to distribute their profits. This solution is politically palatable by both adherents of wealth redistribution and free market principles. It also has the potential to stimulate community values in an economy where wealth inequality is growing. A distribution requirement would not stop these organizations from charging higher prices, but it would require them to distribute more profits in proportion to their revenue growth. In theory, their "charitable" distributions should equal the tax breaks not-for-profit hospitals are receiving at the federal and state level. If this theory held true in practice, then tax-exempt organizations would not have pecuniary advantages over their for-profit counterparts. Furthermore, although tax-exempt institutions would still have more discretion in their business endeavors, facing less regulation and a lack of shareholder accountability, more discretion only poses a relatively higher risk of unethical collective behavior.