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Non-Profit Charitable Tax Exempt Hospitals - Wolves In Sheep's Clothing: To Increase Fairness and Enhance Competition All Hospitals Should Be For Profit and Taxable

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Non-Profit Charitable Tax-Exempt Hospitals – Wolves in Sheep’s Clothing:*
To Increase Fairness and Enhance Competition in Health Care
All Hospitals Should Be For-Profit and Taxable

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I. INTRODUCTION

Most hospitals in the United States are not-for-profit tax exempt institutions.¹ Legally these hospitals are deemed to be charities² and are exempt from federal, state and local taxes,³

¹See John Carreyrou and Barbara Martinez, Grassley Targets Nonprofit Hospitals on Charity Care, WALL ST. J., Dec. 18, 2008 at A5 (noting that nonprofit hospitals account for the majority of hospitals in the U.S.) Id. at col. 1. See also, Cong. Budget Office Nonprofit Hospitals and the Provision of Community Benefits (3) at 3 (2006) (Non-profit hospitals account for sixty-eight percent of the 630,000 beds in Medicare-certified community hospitals.) Id. There are three types of modern hospitals; nonprofit, for-profit, and government facilities. Nonprofit hospitals are governed by a board of trustees and may not be owned by investors and may not distribute any profit to owners. Id. at 7; Vince Galloro, Profit or Loss? Do Gloomy Economics and the Coming Surge in Medicare Enrollment Signal Tough Times for Investor Owned Hospitals? Modern Healthcare, March 2, 2009 at p. 28 (“Over the past five decades, investor-owned hospitals have carved out a significant niche in an industry still dominated by not-for-profit providers.”) Id.

²The significance of being a charity is that various tax benefits are associated with the status. Thus, in this context the legally relevant definition of “charity” is found in the tax law. Generally, the federal tax code sets the standard because most states follow the federal definition. See Internal Revenue Code (IRC) §501 (c)(3)(2000) which generally exempts from federal income tax, “Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific testing for public safety, literary, or educational purposes or to foster … amateur sport competition… [or] the prevention of cruelty to children or animals.” Thus, the provision of healthcare in general or the running of a hospital are not per se tax exempt activities under IRC 501 (c)(3), they only become tax exempt if they are charitable, educational, or research focused. Tax exempt hospitals are made up of three distinct subgroups; the private nonprofit that must be “charitable” to be tax exempt, the government-owned nonprofit, which is not taxable as governmental entity (I.R.C. §115 (2000)), and the university-affiliated, teaching/research nonprofit, which would be tax exempt as an “educational” institution under § 501 (c)(3) and Treas. Reg. § 1.501 (c)(3) – 1(d)(3) (as amended in 1990), or as a scientific research organization under § 501 (c)(3) and classified as a public charity under § 509 (a)(1) via § 170 (b)(1)(A)(iii). Only private nonprofit hospitals must comply with the community benefit test to be “charitable” under 501 (c)(3). This article includes both private nonprofit hospitals and university affiliated teaching/research hospitals when referring to nonprofit, tax-exempt, or charitable hospitals. The current requirements that a hospital must meet to be considered charitable under 501(c)(3) are set out in Revenue Rulings 69-545 (which sets out the “Community Benefit Test”) and 83-157 (which refines the Community Benefit Test). See Rev. Rule 69-545, 1969-2 C.B. 117, Rev. Rule 83-157, 1983-2 C.B. 94, and infra notes 124-157 and accompanying text, where these matters are discussed in more detail.

raise money through tax exempt bond offerings\(^4\) and receive charitable contributions that are tax deductible to the donors.\(^5\) Today it is estimated that 47 million Americans lack access to healthcare.\(^5\) Moreover, even when the new Patient Protection and Affordable Care Act\(^5\) is fully operational, which is estimated to be around 2019, there will still be millions of Americans without health insurance and thus without reliable access to healthcare.\(^5\) Notwithstanding the millions of uninsured Americans charitable hospitals are not required, and nothing in the new Health Care Reform Law will require that they provide any charitable (that is, free) medical care in exchange for their tax benefits,\(^6\) and many in fact provide very little or no charitable care.\(^7\)

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\(^4\) Id. at 395.

\(^5\) Id. (the cost to the government, in terms of taxes forgone, as a result of tax exempt bonds and charitable deductions related to tax exempt hospitals for 2002 is estimated to be $3.6 billion).


\(^5\) See, Greg Hitt and Janet Adamy, *Historic Vote on Health: Deal on Abortion Wins Over Holdout Democrats; Biggest Change in Decades*. THE WALL STREET J., March 22, 2010 A-1 (noting that the Congressional Budget Office has Said that by 2019 the legislation would extend coverage to 32 million Americans or to 95% of legal U.S. residents up from 83% today). Id. at A5. Of course the CBO also estimates that the new healthcare entitlement will decrease the budget deficit by $143 billion over 10 years, (Id.) so of course the CBO could be overly optimistic on both counts. But, even if we use the most optimistic estimates, there still will be 15 million Americans without health insurance in 2019, and history suggests there may be many more. There was a popular belief that when Social Security was passed in the mid 1960’s that everyone would have access to healthcare, which did not happen. See discussion infra at notes 149-151 and accompanying text. Also, a number of states have brought legal challenges against the requirement in Obama Care that everyone purchase health insurance. See Laura Meckler and Great Hitt, *Obama Signs Landmark Health Bill: White House Ceremony Seals Big Political Victory but Republicans Aim to Tap Discontent Over Issue to Rouse Voters*, THE WALL ST, H, March 24, 2010 at A4 (noting that more than a dozen states filed suit on March 23, 2010 asserting that this mandate on individuals to buy insurance was unconstitutional). Id. If these suits are successful, the number of uninsured would increase.


\(^7\) See Thomas K. Hyatt & Bruce R. Hopkins, *The Law of Tax-Exempt Healthcare Organizations* 4 at 535 (2d.ed.2000)(in 1990 “57 percent of nonprofit hospitals provided less charitable care than the value of the tax exemption they received” (citing, Gov’t Accountability Office, Nonprofit Hospitals: Better Standards Needed for Tax Exemption (1990)); Cecilla M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J.CONTEMP. HEALTH L. & POL’Y 302,331 (2007) (some for-profit health organizations provide more charitable services than similar non-profit health organizations… yet these nonprofits are able to maintain their tax exempt status despite minimal charity care provided, even when the value of the tax exemption far exceeds the benefits returned to the community ([footnotes omitted])). One study indicated that
addition, some charitable hospitals charge uninsured patients exorbitant amounts that are much higher than the amounts insured patients are required to pay. Many also use harsh and even draconian collection tactics to collect these exorbitant charges from uninsured and/or indigent patients; the very people a charitable institution should be helping. Moreover, some “charitable” hospitals demand large cash payments upfront before they will even admit or schedule appointments for un/under-insured patients.

Under the traditional definition of charity, helping the poor and needy, most charitable hospitals fail miserably in accomplishing a charitable mission. Even under the modern


Some hospitals even use body attachment or civil arrest warrants to enforce their excessively high charges against the uninsured. See Nation, supra note 8 at 120 esp. nt. 131.

All definitions of charity from the very earliest to the present include helping the poor and needy, but modern definitions are not limited to this purpose. See infra notes 71-157 and accompanying text. For a general discussion of this idea, see Kelley supra note 6.

For examples, see infra notes 191-206 and accompanying text.

See infra notes 71-95 and accompanying text.

amorphous “public benefit” definition of charity, most charitable hospitals do not provide benefits equal to the value of the tax exemptions they receive. As noted, most charitable hospitals do very little to provide health care for the un- and under-insured. Thus, many commentators have called for changes in the law applicable to charitable hospitals.
Unfortunately, most of the proposed changes aim to make charitable hospitals more charitable (to “earn” their tax benefits)\(^\text{18}\) when what is needed is just the opposite.\(^\text{19}\)

the fact that the Senate Finance Committee was discussing eliminating the not-for-profit tax exemption in order to raise funds to pay for proposed healthcare system reform); Brooks supra note 3 at 424 (“… hospitals in America today are big business and, in many ways, charitable goals are secondary to other non-exempt purposes”); Colombo supra note 6 at 30 (community benefit test has been a failure, alternatives include conditioning tax exemption on certain explicit behavior e.g. charity-care); Jardon McGregor supra note 7 (advocating that non-profit healthcare organizations be required to provide a minimum amount of charity care); Larry F. Rosen & Christopher D. Scott, Back to the Future – Are Tax-Exempt Hospitals Headed for the Good Old Days? 39 Md. B.J. 35, 38 (2006) (predicting an inevitable change in federal and state governing tax-exempt hospitals); Harold L. Kaplan & Linda S. Moroney, Hospitals Face New Financial Threat of Legislation pertaining to tax-exempt hospitals); John D. Colombo, The Role of Tax Exemption in a Competitive Charity Care Legislation, 25 Am. Bankr. Inst. J. 28, 59 (2006) (predicting an inevitable change in federal and state legislation pertaining to tax-exempt hospitals); John D. Colombo, The Role of Tax Exemption in a Competitive Health Care Market, 31 J. Health Pol. Pol’y L. 623 (2006); Letter from Charles E. Grassley, Ranking Member, Senate Comm. On Fin., to David M. Walker, Comptroller Gen., U.S. Gov’t Accountability Office (Apr. 5, 2007), available at [http://www.senate.gov/finance/press/Gpress/2007/prg040507b.pdf](http://www.senate.gov/finance/press/Gpress/2007/prg040507b.pdf) (urging the GAO to “conduct additional work on uncompensated care and other community benefits provided by nonprofit hospitals”); Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before the S. Comm. On Fin. 109th Cong. (2006), available at [http://finance.senate.gov/hearings/statements/091306cg.pdf](http://finance.senate.gov/hearings/statements/091306cg.pdf) [hereinafter Hearing on Nonprofit Hospitals] (statement of Sen. Grassley, Chairman, S. Comm. Fin); Michael Bologna, Cook County to Raise Funds to Pay for Proposed Healthcare System Reform); Grimes supra note 1 at 404 (concluding that “the current federal tax exemption of nonprofit hospitals is neither explicable nor justifiable in terms of the logic or efficiency or reward for virtue but cautioning against abrupt change); Robert Charles Clark, Does the Nonprofit Form Fit the Hospital Industry, 93 Harv.L.Rev. 1416 (1980) (advocating no legal favoritism for the non-profit hospital); Id. at 1488; Melanie Evans, Special Report: Caution: More Scrutiny Ahead: Regardless of Federal Standards on What Constitutes Adequate Community Benefits, Hospitals Still Face A Close Look From The States, Modern Healthcare, Nov. 12, 2007 at 46; (discussing the lack of clarity regarding how much community benefit non-profits are required to provide and what counts as community benefit); See Hyman, supra note 13 (suggesting that the financial and philosophical bias in favor of not-for-profit hospitals is misplaced and the focus should be on behavior not organizational status); Gilbert supra note 15 (only hospitals that provide sufficient charity care may claim the exemption); David A. Hyman, The Comundrum of Charitability: Reassessing Tax Exemption for Hospitals, 16 Am. J.L.& Med. 327, 375-76 (1990) (special virtues reflected in charitable care which justifies tax exemption); A. Kay B. Roska, comment, Nonprofit Hospitals: The Relationship Between Charitable Tax Exemption and Medical Care for Indigents, 43 Sw.L.J. 759, 772 (1989) (suggesting that charity care be required as a prerequisite for tax exemption).

\(^\text{18}\) See, e.g., John Carreyrov and Barbara Martinez, Grassley Targets Nonprofit Hospitals on Charity Care, Wall St. J., December 18, 2008, at A5 (“Sen. Charles Grassley is weighing proposed legislation in early 2009 that would hold nonprofit hospitals more accountable for the billions of dollars in annual tax exemptions they enjoy… [by] require[ning] nonprofit hospitals to spend a minimum amount on free care for the poor also known as charity care, and set curbs on executive compensation and conflicts of interest…”); Folkerts supra note 17 (recommending the adoption of a minimum level of charity care for nonprofit hospitals); Kinney Helvin supra note 17 (same); Brooks supra note 3 (calling for legislation that requires increased charitable conduct in exchange for the exemption); Jardon McGregor supra note 7 (advocating a minimum amount of charity care to patients in need for nonprofit hospitals); Gabriel O. Aitsebaomo, The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify For Federal Tax Exemption, 26 Campbell L. Rev. 75 (2004) (same).

\(^\text{19}\) By opposite this article means the elimination of tax exempt status for all nonprofit hospitals (except free clinics. See infra notes 319-331 and accompanying text. An early advocate of a similar tax neutral approach was Professor Robert Clark. See generally, Clark supra note 17. Bloche supra note 16 at 391, reaches a similar conclusion: “in short the tax exemption of nonprofit hospitals lacks a convincing justification, either in its current form or as a benefit made conditional upon institutional behavior deemed socially desirable” Id. at 391. He bases this conclusion
That is, no hospitals should be tax exempt. Hospitals are not really charities, notwithstanding the current legal definition of charity, because they derive their income by charging and receiving payment from most if not all of their patients. Moreover, a hospital's ability to produce negative (to society) internalities such as excessive executive and doctor salaries or premium working conditions, or positive externalities, such as biomedical research, health education, free indigent care or other “community benefits” is the direct result of secretly overcharging paying patients. These “contributions” from paying patients, which have been estimated to exceed 30 percent of the hospital charges paid by patients, are in no sense voluntary. Today, non-profit hospitals are more akin to mini-governments imposing a tax on all of their patients who pay for the services they receive. Moreover, paying patients have no right to “vote” for these mini governments or even to have access to information regarding the amount of “tax” imposed or how the “taxes” are spent. In fact, it is this very lack of transparency or this camouflage, along with a lack of discipline imposed by financially interested investors/directors, in part on his findings that “the nonprofit form does not appear per se to engender the production of more research than the for-profit form.” (Id. at 316) and reaching a similar conclusion for medical education and uncompensated care for the poor Id. at 316-317. However, Bloche urges caution in changing the exemption because the costs of the change may exceed the benefit, (Id. at 392) and, in any event, Bloche believes that the political reality is such that the elimination of the exemption is very unlikely. Id at 391-392. A third approach is to continue the tax exemption for nonprofit hospitals but not base it entirely or at all on free or charitable care. In some ways this seems like a continuation to the current IRS Community Benefit approach which has been widely criticized. See supra note 17. However, those advocating this approach have in mind something more workable than the approach laid out in Rev.Rule 69-545. See, e.g., Goodman supra note 17 (advocating looking beyond uncompensated or charity care and citing Horwitz supra note 6 as identifying characteristics of nonprofits other than charity care that are beneficial such as the provision of unprofitable service like emergency room care, labor and delivery services, psychiatric emergency care, as well as a willingness to locate in impoverished communities and an ability to survive harsh economic climates; and using donative theory to justify nonprofit tax exemption). Id. at 727; Horwitz supra note 6 (suggesting that corporate form – i.e., not-for-profit status itself justifies the tax exemption because it is correlated with the offering of beneficial services and beneficial behavior/conduct). Cf. Bloche supra note 16 at 314-352 discounting similar observations of positive externalities.

20 See Bloche supra note 16 at 356 stating: In 1992, private payers paid an estimated 38% more on average than their patients’ costs, up from 25% in 1989. By 1992, cross-subsides from private payers were financing 14% of American hospital costs, up from 11% in 1989. Uncompensated care, defined as bad debt plus charity care less government subsidies to the poor, accounted for $11.9 billion of this cost-shift in 1992. Another $22.7 billion in cross-subsides financed the difference between costs and payments for government-sponsored programs, principally Medicare and Medicaid [notes omitted].

21 See Clarke supra note 17 at 1437-41.
and the increased (though often misplaced) trust the public places in non-profits, as well as the
tax exemption, that encourages hospitals to adopt the non-profit business model.\(^{22}\)

In addition, to the extent that the tax exemption given to non-profit hospitals is
characterized, at least in part, as a purchase by of the government of the positive externalities
mentioned supra, it is dramatically inefficient and a startlingly bad deal for taxpayers, paying
patients and the poor.\(^{23}\) Direct purchase by the government of the positive externalities it seeks

\(^{22}\) *Id.* at 1446-1447. Clark states:

> But why did physicians not simply organize hospitals as partnerships and *ensure* possession of the
> power that they can only have by the grace of trustees in a nonprofit hospital?

* ***

Surely the answer must be that, in the case of the hospital formed as a partnership of physicians,
the fact that the real controlling group is trying to produce economic profits and to distribute
residual earnings to itself, rather than rededicating them to some charitable purpose, is abundantly
clear to lawmakers, whereas in the case of the nonprofit hospital that fact – and it is a fact, if the
“physicians cooperative” model is believed – is hidden.

* ***

A fourth reason why physicians may prefer nonprofit hospitals is that a for-profit hospital may
scare some patients away. In other words, patients, and perhaps third-party payors, prefer the
nonprofit hospital because they believe it is somewhat less likely to exploit them – they “buy” the
fiduciary hypothesis – but physicians prefer the nonprofit hospital because patients prefer it, feel
more secure in it, and are thus more easily exploited. One inevitably thinks of wolves in sheep’s
clothing. Since this strategy of extremely vague, pervasive, and implicit misrepresentation is one
that is not readily controlled by general legal strictures against fraud, the purely exploitative
physician may plausibly conclude that it could advance her interest yet would create little risk of
adverse consequences.

In summary, the most convincing explanation of the supposed preference that, according
to the exploitation hypothesis, income-maximizing physicians have for the nonprofit form, as
opposed to a for-profit hospital owned by physicians, is that it conceals the true nature of what
they are doing from consumers and policymakers and misleads them into giving greater trust,
money, and tax exemptions. The essence of the model is fraud. [notes omitted]. *Id.*

See *Bloche supra* note 16 at 363-368. Bloch states:

Cross-subsidization from private payers is easy to criticize as a disingenuous product of the failure of our
political will.

* ***

Political visibility may further the ends of efficiency and moral honesty, but at the same time,
invite resistance from those asked to bear the cost.

* ***

The low visibility of hospital cost-shifting may suffice to explain the political viability of public
policies that encourage or require it [notes omitted] *Id.* at 362, 365.

\(^{23}\) *Bloche supra* note 16 at 258-259; *infra* notes 158-216B and accompanying text.
with the taxes that are forgone due to the exemption would be much more efficient.\textsuperscript{24} Achieving healthcare access for the poor by hidden cost transfers structured by non-profit hospital administrators and/or required by the government through below cost Medicare/Medicaid reimbursements,\textsuperscript{25} or requiring tax exempt hospitals to provide a set level of free care to the poor, is an inefficient, deceitful, non-democratic approach that undermines the basic foundations of our democracy.\textsuperscript{26} This discredited, disingenuous, and elitist approach springs from a basic distrust of the American people and/or a willful determination to thwart the democratic process on the part of those who support such a system.\textsuperscript{27} Moreover, such an approach does a disservice to the poor

\textsuperscript{24} See Bloche \textit{supra} note 16 at 369-372 (all of these mismatch problems (poorly targeted to the health needs of the poor (primarily care and prevention under provided), poorly targeted to the communities that need financial support to provide medical care to the poor, poorly targeted to individual patients in most need, if targeted to needy patients at all) could be ameliorated by public subsidies fashioned to confer health care purchasing power upon needy beneficiaries…” [notes omitted]). \textit{Id.} at 372.

\textsuperscript{25} See Bloche \textit{supra} note 16 at 367-68 noting in 1995 that:

For the time being, however, the political appeal of public policies that rely on cross-subsidization to finance care for the uninsured appears undiminished. Indeed, in 1994, an ideologically diverse group of Congress members embraced a strategy for expanding access to insurance that would achieve federal budget neutrality through a large new cost-shift. This strategy entailed the financing of federal subsidies for the purchase of private insurance through reductions in the growth of Medicare payments to doctors and hospitals. [notes omitted].

Melanie Evans, \textit{Uncompensated Care Spikes by 8.3\%, AHA, Medicare Losses at General Hospitals Also up 20% to \$18.6 Billion Association Says}, Modern Healthcare, October 29, 2007, stating:

Medicare losses at U.S. general acute-care hospitals rose 20\% to \$18.6 billion in 2006, and unpaid costs on care for Medicaid patients climbed 15.3\% to \$11.3 billion. Uncompensated care- which includes two expenses, charity care and bad debt - climbed 8.3\% to \$31.2 billion. But as a percentage of overall expenses, uncompensated care remained fairly steady at 5.7\% compared with 5.6\% a year earlier, according to the Chicago-based trade group’s statistics.

* * *

“The magnitude of the Medicare and Medicaid shortfalls just keep rising,” said Caroline Steinberg, the AHA’s vice president of trends analysis, who argued such losses prove particularly troubling considering that the insurers account for roughly half of hospitals’ business. Last year marked the first time the AHA released losses on the pair of subsidized insurers.

Steinberg said private payers end up shouldering the costs as hospitals seek to offset losses from public plans. “The real question is how long is the private sector willing to cover the shortfalls from Medicare and Medicaid?” she said.

As of this writing the hidden cross-subsidization game goes on – still encouraged/required by government policy, especially Medicare/Medicaid reimbursement rates that are below hospital cost. Moreover, Obama Care provides for a significant expansion of Medicaid and a more modest expansion of Medicare, so the problem is likely to get worse. \textit{See Obama Care \textit{supra} note 5B at Title II.}

\textsuperscript{26} See Bloche \textit{supra} note 16 at 369 (noting the disadvantages of cross-subsidization in terms of “economic efficiency, distributive justice, and moral and political symbolism.”) \textit{Id.}

\textsuperscript{27} Essentially, those who support cross-subsidization believe that American voters will not support paying higher taxes to increase access to health care for the poor. In light of that belief, whether or not accurate, they decide to
by ultimately making their access to healthcare haphazard at best and dramatically inefficient.\textsuperscript{28}

This Machiavellian mess is enabled by the ill-conceived combining of health care creation and delivery (the business of health care) with the political/social goal of addressing the needs of the poor.\textsuperscript{29} A central theme of this article is that we must separate these two issues; the business of healthcare, and providing services for the poor, and keep them separate, in order to achieve our health care goals.

The primary issue related to health care is how to insure that America continues to develop the best healthcare possible – where best is defined as the ability to cure, treat, and manage the greatest number of diseases or other maladies while preserving patient autonomy.\textsuperscript{30}

\begin{footnotesize}
\begin{itemize}
\item[28] See Bloche\textsuperscript{\textit{supra}} note 16 at 368-379 (making the case against cross subsidization.)
\item[29] See infra notes 320-331 and accompanying text.
\item[30] It is now in intellectual fashion to say that America does not have the best healthcare system in the world only the most expensive. See, e.g., Ezekiel J. Emanuel, \textit{What Cannot Be Said on Television About Health Care}, 297 JAMA 2131 (2007) (There are three phrases that should and can no longer be said about the U.S. healthcare system without qualification, embarrassment, criticism, or even denunciation: “The United States has the best healthcare system in the world,” “Healthcare is special,” and New is better.”) Id. at 2131. However, if the word “system” is removed from the statement, few could seriously argue that America does not continue to develop and have available, for a price, the best healthcare in the world. We develop more new drugs and pioneer more new treatments than any other country in the world. See, e.g., Betsy McCaughey, \textit{Obama’s Health Rationer-in-Chief} \textit{WALL ST. J.}, August 27, 2009 at A15 (discussing Dr. Ezekiel Emanuel health adviser to President Obama, and noting that according to “…an August 2009 report from the National Bureau of Economic Research, patients, diagnosed with cancer in the U.S. have a better chance of surviving the disease than anywhere else”) Id.; See, infra, notes 217-318 and accompanying text.

This is due in large part to our free market approach to healthcare and our willingness to pay for new beneficial treatments. See, Craig S. Karpel, \textit{We Don’t Spend Enough on Health Care} \textit{WALL ST. J.}, August 17, 2009 at A11 (“The unprecedented advances expected to come out of American stem cell, nanotechnology and human genome research – which other countries’ constricted health sectors cannot support – will send these already impressive figures [medical and orthopedic equipment exports increased by 65.1% from 2004 through 2008, and pharmaceutical exports were up 74.6%] skyward.”) Id. The reason many argue that America does not have the best healthcare “system” in the world is because we lack universal coverage and obtaining access to healthcare is a financial burden for many Americans. See infra notes 265-318 and accompanying text. But in seeking to provide greater access to healthcare for poor Americans we must not destroy the free market in health care that has and will continue to produce the best healthcare in the world. Providing universal access to mediocre healthcare is not an acceptable solution. See Karpel\textsuperscript{\textit{supra}} (noting that a study by Deloitte LLP has found that more than 400,000 non-U.S. residents obtained medical care in the U.S. in 2008, with an annual increase of 3% expected, and that 3.5% of inpatient procedures at U.S. hospitals were performed on international patients, many of them escaping from Canada’s supposedly superior health system.) It is important to remember that today’s expensive new treatment often becomes tomorrows affordable standard of care.
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The only way to achieve this goal is to harness the most effective tool we have to achieve it which is free market competition. 31 Another problem with allowing a tax exemption for non-profit hospitals is that it gives the government more influence over tax exempt hospitals and as a result, contributes to the already great influence government has over the business aspects of health care which in turn interferes with the operation of free market competition. Government influence results in part from the dependence of charitable hospitals on their tax exemption. Moreover this dependency results in another problem; charitable hospitals focus too much of their attention on retaining their tax-exempt status at the expense of an exclusive focus on providing the highest quality healthcare at the lowest cost. 32 Government influence over the business of healthcare 33 also results in a different and somewhat less obvious but just as serious problem. The problem is that the government is subject to a strong temptation to limit access to (i.e., ration) healthcare, to eliminate patient autonomy, and to discourage the development of new

Simply put, providing universal access to healthcare has less to do with healthcare and more to do with whether as a society we are willing to pay for such access. The answer, of course depends on the cost – but bringing down the cost of U.S. healthcare by reducing patient autonomy or healthcare quality is not the proper answer. The question is are we willing to pay for universal access to the current quality/autonomous healthcare most Americans now have and want to keep? If we are not able to pay for “universal” access perhaps we are able to pay to increase access above current levels. See infra notes 320-331 and accompanying text where a tired medical insurance system is suggested. In addition, we may increase access by taking steps to develop a more vibrant economy and education system, both of which will reduce to cost of universal access by reducing the number of poor.

31 See discussion infra notes 206-216B and accompanying text.
32 See Bloche supra note 16 at 382-98 (1995) (discussing the lobbying efforts, internal accounting efforts, and determination of non-profits to maintain the exemption as well as the structural constraints that block its repeal); Hyatt supra note 7 at 2-4 and 14-15 noting generally that the tax-exempt organization laws influence every aspect of non-profit hospital management, and how much time and effort non-profits put into issues such as the definition of charity care and how to measure it in order to protect their tax exemption; Brooks, supra note 3 at 394, 410 discussing the value of the tax-exemption to non-profit hospitals, and noting that in spite of calls for its elimination or revision the exemption, thanks to extensive lobbying, survives. Again with the Obama Health Reform proposals in 2009 the issue of eliminating the exemption to help fund the reform has surfaced See, Joe Carlson, Taxation with Designations, Idea to Nix Not-For-Profit’s Tax Exemption Revisited, Modern Healthcare, May 25, 2009. Needless to say, with much effort by the non-profit hospital industry the exemption still survives.
33 This article argues that the government has an important role to play in healthcare, as in other parts of the economy, in facilitating the function of the free market in health care, and in ensuring the safety and efficacy of new drugs and equipment. However, direct participation in the healthcare market place is not an appropriate role for government. See, e.g., Scott Gottlieb, What Doctors and Patients Have to Lose Under Obama Care, WALL ST. J. December 24, 2009 at A19 (discussing the negative consequences of direct involvement of the government in the making decisions about what care will be available and to whom, as reflected in President Obama’s health plan – i.e., Senate Health-care bill Reid bill); Tom Coburn, The Health Bill Is Scary, WALL ST. J. December 17, 2009 A-27 (same).
medical technologies including new drugs and procedures in order to control the overall cost of health care. This results from, among other reasons, the high cost to the government of the Medicare and Medicaid programs, the political difficulty of cutting benefits, the popular (though erroneous) belief that the increasing cost of health care is a threat to the U.S. economy, and a desire of some in government to provide access to healthcare for all Americans by adopting a single payer government run health insurance system. The recent passage of Obama Care has made these problems even worse because it insures more government involvement in health care than ever before. The result of too much government influence over the business of healthcare is that the free market will be constrained and the development of the highest quality, lowest cost health care will be overwhelmed by a myopic focus on cost containment, which will lead to less individual patient autonomy, lower quality healthcare, and less available health care.

Finally, this article argues that the business of healthcare development and delivery is too important to be conducted under the not-for-profit tax exempt business model or to be run by the government. Moreover, the primary reason that the non-profit model has dominated the hospital industry is that it provides camouflage for the real profit seeking motives and/or elitist wealth transfer motives of those in defacto control, and it affords a tax deduction that enhances profits.

The most effective tool that exists for allocating scarce resources to produce the most abundant

34 See, e.g., Betsy McCaughey supra note 30: infra notes 265-318 and accompanying text. People’s wants and desires are unlimited. Thus, without the operation of the free market which limits what people can consume to what they can afford, consumption of healthcare will increase dramatically. As a result, the government will need to replace the limits on consumption provided by a free market with a system of rationing. The problem is that a government rationing system will be much less effective and efficient at producing the healthcare people want.

35 See, Colleen C. Denny, Ezekiel J. Emanuel and Steven D. Pearson, Why Well-Insured Patients Should Demand Value-Based Insurance Benefits, 297 JAMA 2515 (2007) (referring to the “perilous situation” of health care spending in the U.S., noting that in 1950 health care spending represented only 5% of gross national product, but by 2016 will account for 20% of the nation’s total output) Id. at 2515. Cf. Karpel, supra note 30 (arguing that maximizing social welfare in the U.S. will require the spending of 20% or more of GDP on health care). Id.

36 See, e.g. McCaughey, supra note 30 (arguing that the Obama administrations own health advisors believe that bringing down costs substantially will require rationing of medical resources, and discouraging the development of expensive new treatments and medicines); infra notes 265-318 and accompanying text.

37 See infra notes 207-216B and accompanying text.
supply of the goods and services society wants at the lowest cost is the free market, for-profit business model.\textsuperscript{38} The for-profit free market model will produce the high quality health care that Americans want at the lowest cost and preserve the individual autonomy that Americans value. This article argues that for-profit taxable hospitals play a very important role in ensuring a freely competitive health care market, and provide a critical counter balance to the increase government involvement in the business of healthcare that will occur in the near future as Obama Care becomes operational.\textsuperscript{38A} Thus, hospitals should be encouraged, by amending the legal definition of charity, to adopt the for-profit model. Federal and state tax codes should be amended to provide that a healthcare provider must provide service free to all patients with no expectation of or request for payment in order to be considered charitable and thus tax exempt. As a result of this change only free clinics will qualify as tax exempt.

This article begins with a historical overview of the non-profit tax exempt hospital. Next the development of the current state of law regarding charitable hospitals is reviewed. The problems associated with the current law are then discussed. Part V proposes a solution that will help to address these problems and Part VI concludes.

### II. HISTORICAL OVERVIEW OF CHARITY

In the United States the modern non-profit tax exempt hospital is the result of a historical anomaly. The first hospitals provided a refuge for poor people who were very sick; the poor were housed in large wards, cared for themselves to the extent they could or relied on volunteers, and

\textsuperscript{38} See, \underline{______} \textit{Into the Red: Annual Survey of Hospital Systems Shows Not-For-Profits Posted An Overall Net Loss in 2008; For-Profit Chains Bucked the Trend}, MODERN HEALTHCARE, June 8, 2009 (arguing that part of reason for profits showed a profit while not-for-profits lost money was superior management (lower debt, lower costs, less bad debt) due in part to responsiveness to investors); Vince Galloro, \textit{Profit or Loss? Do Gloomy Economics and the Coming Surge in Medicare Enrollment Signal Tough Times for Investor Owned Hospitals?} MODERN HEALTHCARE, March 2, 2009 (for-profits are better managed in part due to pressure from investors).

\textsuperscript{38A} See \textit{infra} notes 215-217 and accompanying text.
were not expected to recover. A hospital fulfilled a welfare function, it was where the sick poor went to die, not a place to treat the sick. When people with money became ill they were treated in their homes by doctors under whatever terms were agreed with the doctor. Early hospitals or “alms houses” were supported solely by donations and staffed by volunteers – there was no expectation of payment from patients.

In the late 19th and early 20th centuries, as medical care improved due to scientific discovery, especially the development of anesthesia which allowed for more advanced surgical procedures that could only be performed in the hospital, hospitals changed. Instead of charitable places for the sick poor to die, hospitals became places for the affluent to receive treatment for illness in exchange for payment. For example, according to one study, in 1880 no hospital permitted physicians to charge fees for services rendered to patients at the hospital. By 1905, 47 of 52 New England hospitals surveyed permitted physicians to charge for services to

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39 See, Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 270 (Utah 1985). Voluntary hospitals housed and tended to those who were both sick and poor; these patients were housed in large wards, largely cared for themselves, and often were not expected to recover. Id. Because hospitals at this time performed no medical treatment and because they were institutions for the poor, the nonpoor who needed medical treatment and their private physicians avoided them. Id. n. 7.

40 See Jardon McGregor, supra note 7 at 305 (noting that early hospitals often served more of a welfare function rather than a medical function, assisting patients through religious and moralistic approaches; Paul Starr, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 145, 149, 158 (1982) (noting the paternalistic, communal social structures of early voluntary hospitals, and that patients received more moralistic and religious assistance than medical treatment. Id.

41 See Utah County supra note 39 at 270 n. 7 (the nonpoor in need of medical treatment and their treating private physicians overwhelmingly avoided them).

42 See Paul Starr supra note 40 at 149-158 (discussing the transition of hospitals from institutions treating the poor for the sake of charity to treating the rich for the sake of revenue). Starr also notes that around the early 20th century the practice of not permitting physicians to charge private patients for their services in hospitals changed. Id. at 163-64. By 1922 paying patients provided 65% of hospital revenues, from close to zero around 1880. Id. at 161.

43 See Utah County supra note 39 at 279 n. 9 (“[H]ospitals ceased being custodial holding institutions for the poor and instead became centers of medical treatment especially surgery, attractive for the first time, to private physicians and paying patients.”) Id.

44 Id.; Rosemary Stevens, IN SICKNESS AND IN WEALTH 17-51 (Basic Books 1989) (describing the history of healthcare in America and the transformation undertaken by hospitals in the late 19th and early 20th centuries from institutions to ease (though not necessarily treat) the suffering of the poor to “modern scientific” organizations whose specialized treatments would become symbols of social status for the wealthier classes that could afford them).

45 Paul Starr supra note 40 at 163-64 (noting that in 1880 no hospital in this study permitted physician fees, but by 1905 47 of 52 New England hospitals surveyed permitted physicians to charge for services to private patients). Id.
patients. Hospital architecture also changed from large wards to private rooms to accommodate paying patients. By 1922, 65 percent of hospital revenues were generated by private payments; public appropriations provided 18 percent, endowments 3.6 percent and donations 5.7 percent.

It was also during this time that interest in health insurance arose. Health insurance began during the Great Depression at a Texas hospital that sold hospital insurance to the city’s school teachers. Other hospitals joined together to offer this insurance and the network eventually became Blue Cross insurance. As a result of these changes, the poor began to have difficulty accessing hospital/medical care. In addition, as hospitals began to rely on payments from patients they also began to be affected by tax laws. American law, like its British antecedents, exempted charitable organizations from taxes. For example, the Tariff Act of 1894 exempted “… corporations, companies or associations organized and conducted solely for charitable, religious, or educational purposes.” The Tariff Act of 1909 provided that the tax exemption only applied if the organization had no earnings inuring to the benefit of any private stockholders or individuals. In 1913 the federal income tax law exempted “any corporation or association organized and operated exclusively for religious, charitable, scientific or educational

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46 Id.
47 Id. at 159 (also the composition of hospital patients changed during this time (1880-1905) from exclusively poor to being similar to the population at large) Id.
48 Id. at 161.
49 See Jardon McGregor supra note 7 at 307.
50 Id.
51 Id. (noting that as insurance developed, direct payment was reduced and private philanthropy as a means of financing hospitals also reduced resulting in problems with cost and access); See Melissa A. Thomasson, From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance, 39 Explorations Econ. Hist. 233, 240-41 (2002) (discussing employer’s use of health benefits to attract and retain workers during the wage and price controls of World War II, and the codification of tax deductibility for employer contributions to health plans in the Internal Revenue Code of 1954). Id.
52 See generally, Kelley, supra note 6.
purposes. Thus, hospitals could be tax exempt if they were organized exclusively for charitable purposes and no earnings accrued to the benefit of private shareholders or individuals.

Congress used the tax law as well as other programs to encourage these early-modern hospitals to provide charitable (free) care to the poor. For example, in order for these early-modern hospitals to be considered charities they were required to provide charitable (free) care to the poor. Also, the government set up programs like Hill-Burton which provided construction loans and grants for government-owned and nonprofit hospitals. In exchange for these loans and grants hospitals were required to provide a reasonable amount of uncompensated service to the poor. Since hospitals at this time no longer focused exclusively or even primarily on the poor, requiring charitable hospitals to provide a certain amount of charitable (free) care to the poor was thought necessary to justify treating these early-modern hospitals as charities.

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57 Until 1969 the Internal Revenue Code required, indirectly, that tax exempt hospitals be operated “exclusively” for the relief of the poor. See Treas. Reg. § 39.101(b)-1(b) (1939 Code)(“Corporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor.”) Id. However, the word “exclusively” was interpreted to be satisfied as long as the hospital was operated “to the extent of its financial ability” for those unable to pay for the services rendered, and not exclusively for those who were able and expected to pay. See Rev. Rule 56-185 (21 Fed. Reg. 460, 464 Jan. 21, 1956). See discussion supra notes 124-157 and accompanying text.
59 Id.
60 Id.
61 See, e.g., H.R. 1860, 75th Cong. (3d Sess. 1938) ([t]he exemption from taxation of property devoted to charity and other purposes is based upon the theory that the government is compensated for loss of revenue by its relief from financial burden which would otherwise have been met by appropriations from public funds, and by the benefits resulting from promotion of the general welfare.) Id.; Hopkins supra note 53 at 16 (discussing the language quoted above); St. Louis Union Trust Co. v. United States, 374 F. 2d 427, 432 (8th Cir. 1967) (“[o]ne stated reason for …
The rationale for the early-modern charitable hospital’s tax exemption was that in exchange for the tax exemption the hospital would provide a quid pro quo or return benefit in the form of uncompensated medical care to the poor. Since providing for the poor was a government function, one that tax revenues were used to meet, it seemed to make sense to allow a charity, in this case a hospital, to keep the money it would have otherwise paid in taxes so long as an amount equal to or greater than the taxes forgiven was used by the hospital to provide uncompensated medical care to the poor. In short, a charitable tax exempt hospital, in exchange for freedom from taxation had an obligation to fulfill. That obligation was the relief of poverty via providing free medical care to the poor. As discussed in the next section, the definition of charity under the U.S. tax code has changed greatly in the last 40 years. The contemporary definition no longer focuses exclusively on the relief of poverty. Today any activity that benefits the public may be considered charitable.

It is important to note that when the first hospitals arose their function was not critical or fundamental either to the economy nor to most people in society. These early, alms house hospitals provided services exclusively to the poor, thus it is understandable that these organizations were set up as non-profit charities. To the extent that these institutions were operated and managed like a business, which was likely very little at best and not at all in most

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[an exemption of this kind is that the favored entity performs a public service and benefits the public or relieves it of a burden which otherwise belongs to it") quoting Duffy v. Birmingham, 190 F.2d 738, 740 (8th Cir. 1951); Harding Hosp., Inc. v. United States, 505 F.2d 1068, 1071 (6th Cir. 1974) (Therefore if the government would have otherwise provided the service, it is more prudent and less expensive to forgo the tax rather than incur the entire cost of rendering the charitable services to the community).

62 See supra notes 57-61 and accompanying text.
63 Id.
64 See, Eastern Kentucky supra note 56 at 1280 (noting that under Rev.Rule 56-185 a hospital to be considered a “charity” had to be operated to the extent of its financial ability for those who could not pay for the services rendered, but that the definition of “charity” was modified by the I.R.S. in Rev. Rule 69-545 in terms of community benefit, and as a result the provision of free care or below cost care is no longer essential for a hospital to qualify as a tax exempt organization). Id.
65 See the discussion of Rev. Rule 69-545 infra at notes 124-157 and accompanying text.
66 See supra notes 207-216B and accompanying text.
67 See supra notes 207-216B and accompanying text.
cases, the non-profit business model was sufficient. This form makes it less likely that wealthy donors will be defrauded; as noted none of the profits of a non-profit entity may be distributed.\(^6\) The non-profit form of business likely had less to do with running an efficient hospital than with keeping the rich from being bilked.\(^6\) That is, to prevent money given to benefit the poor from being taken by those in control of the hospital for their own benefit.\(^7\) Today by contrast the services provided by hospitals are critical to the economy and very important to virtually all members of society. However, as a result of the desire to maximize profit and secrecy many hospitals have continued to operate under the non-profit charitable business model. As discussed infra this is a problem that must be addressed.

III. CURRENT LEGAL REQUIREMENTS APPLICABLE TO NON PROFIT TAX EXEMPT HOSPITALS

A. The Expanding Definition of Charitable Hospital

The definition of charity has changed greatly over time.\(^7\) Early definitions focused on providing care for the poor and needy. For example, the Code of Hammurabi admonished care for the poor, widowed and orphaned.\(^8\) The Anglo-American concept of charity has its roots in Judeo-Christian religious tradition.\(^9\) This religious based charity was also focused on aiding the

\(^6\) Id.
\(^7\) Id.
\(^8\) See Kelley supra note 6 at 2440-2462, (tracing the concept of charity from ancient Egyptian civilizations in 1300 BC to present day).
\(^9\) Id. at 2441.
Prior to the Protestant Reformation being poor was not considered a moral failing, but simply part of God’s plan. There was no attempt to distinguish the deserving poor from the undeserving or to eliminate poverty. The focus of charity at this time was primarily on the giver not the recipient of the alms. The concept of charity changed after the Protestant Reformation. As the law developed as an institution and the Church of Rome lost influence in England the focus of charity began to change. Legislative efforts were focused on controlling begging and preventing vagrancy. In fact, legislation at this time discouraged private giving to the poor or “promiscuous alms” for fear it would encourage sloth and licentiousness. In addition, the first attempts were made to weed out the so called “sturdy” beggars who could work from the deserving poor who could not.

In England in 1536 with the establishment of the Church of England the Catholic monasteries that had been the center of poor relief were thrown into disarray. Also, as the move from feudal society to mercantile capitalism occurred the number of poor and displaced rose dramatically. The legislative response was again aimed at controlling the “problem of the poor,” and to a greater extent than Roman Catholicism, Protestantism focused on self-reliance, the primary of work and the belief that poverty was a sign of God’s disfavor. The upshot of all of this on the definition of charity was that now the deserving poor were the focus of charity.

74 Id.
75 Id. at 2442.
76 Id.
77 Id.
78 Id. at 2443-2444.
79 Id.
80 Id.
81 Id.
82 Id. at 2444-2445.
83 Id.
84 Id. at 2445-2446.
while the sturdy poor were put to work.\textsuperscript{85} Moreover, the goal of state sponsored charity took on a social engineering focus, to solve the problems of begging and vagrancy rather than its traditional purpose of demonstrating religious obedience and faith.\textsuperscript{86} In addition, the deserving poor were to be provided for through taxes.\textsuperscript{87} Thus, aiding the poor (the deserving poor) was the states obligation and taxes were levied to meet this obligation.\textsuperscript{88} Aiding the poor was no longer just a voluntary religious act – though this practice still continued.\textsuperscript{89}

The culmination of these shifts in religion and society is reflected in the English Statute of Charitable Uses passed in 1601.\textsuperscript{90} The preamble of the statute listed the activities or uses the law defined as charitable.\textsuperscript{91} The poor were certainly included, with provision made to help; the poor, aged, sick, and maimed soldiers and mariners, orphans, houses of correction and prisoners or captives.\textsuperscript{92} But also included in the preamble’s definition of charitable uses or activities were the building of bridges, roads, ports, causeways, churches, sea-banks, and highways as well as support for schools of learning, free schools and scholars in universities.\textsuperscript{93} This represented a new expanded definition of charity that had been developing for some time in England,\textsuperscript{94} the definition clearly and specifically included the old one – help for the poor and needy – but now

\textsuperscript{85} Id. at 2446-2448.
\textsuperscript{86} Id.
\textsuperscript{87} Id.
\textsuperscript{88} Id.
\textsuperscript{89} Id. at 2449-2450 (noting that Elizabeth’s Act Concerning Poverty of 1521 and the Poor Laws represented a view that had developed over the preceding centuries in England “that poverty was caused by immortality and sloth, and that it could be addressed by requiring the poor to work”). \textit{Id.} at 2450. “The Reformation and the various legislative acts of late medieval England secularized charity and reformed it into a mechanism for controlling poverty and pauperism, but charity never completely shed its compassionate, spiritual underpinnings.” \textit{Id.}
\textsuperscript{90} 43 Eliz., C4 (1601) (Eng.).
\textsuperscript{91} Id.
\textsuperscript{92} Id.
\textsuperscript{93} Id.
\textsuperscript{94} See Kelley \textit{supra} note 6 at 2446-2450.
also included activities that were not focused on the poor and needy but instead offered a public benefit.\(^{95}\)

### B. Modern Definition of Charity Under U.S. Tax Law

With the advent of income taxes the focus of charity law in the United States became the federal tax code. The relevant section of the Internal Revenue Code (IRC) is 501(c)(3) which provides the following: \(^{96}\)

\[\text{§501. Exemption from tax on corporations, certain trusts, etc.}\]

(a) Exemption from taxation. An organization described in subsection (c) or (d) or section 401(a) [IRC Sec. 401(a)] shall be exempt from taxation under subtitle [IRC Sections 1 et seq.] unless such exemption is denied under section 502 or 503 [IRC Sec. 502 or 503].

* * *

(3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. \(^{97}\)

From the time Congress first passed the charitable tax exemption it has used the word charity to mean “relief of the poor” not the broader “public benefit.” \(^{98}\) This is clear from the regulations

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\(^{95}\) Id. (noting that, “…by 1601 charity had turned sharply toward social engineering.”) Id. at 2450. Kelley goes on to conclude: “Charity had evolved from a spiritually charged activity to a more secular one, defined most broadly by the “public benefit.” Id. at 2450-2451.

\(^{96}\) Internal Revenue Code (I.R.C.) § 501(a) (2004).

\(^{97}\) Id.

\(^{98}\) See Eastern Kentucky supra note 56 at 1286-88. The D.C. Circuit Court reversed the decision of the district court which had enjoined the I.R.S. from granting tax exempt status to hospitals unless they complied with Rev. Rule 56-
that define “charity” as “relief of the poor”\textsuperscript{99} and the structure of the exemption itself which lists charitable separately from other tax-exempt purposes.\textsuperscript{100} There would be no need to list the additional purposes if the word charity was meant in its broad public benefit sense.\textsuperscript{101} However Congress did use the broader public benefit approach to create its list of tax exempt purposes.\textsuperscript{102}

Historically charities have been exempt from the obligation to pay taxes under the quid pro quo theory discussed supra.\textsuperscript{103} That is, because the charity performed a function, traditionally the alleviation of poverty, that the government would otherwise be obliged to perform, it made sense to let the charity keep the money it would otherwise pay to the government as taxes to

\textsuperscript{99} See E. Ky. Welfare Rights Org. v. Shultz, 370 F. Supp. 325, 326-27 (D.D.C. 1973). The Supreme Court held the case to be non justiciable due to lack of standing by the original plaintiffs, but the court’s opinion seems to accept the validity of Rev. Rule 69-545 notwithstanding its effect on indigents. See Simon, 426 U.S. at 42 n. 23. Another case, Lugo v. Miller 640 F. 2d 823 (6th Cir. 12981), also challenged Rev. Rule 69-545 but was rejected by the court for reasons similar to Simon. \textit{Id.} at 831.

The Circuit Court in Eastern Kentucky \textit{supra} note 56 stated: “Prior to 1959, Treasury Regulations generally defined charitable organizations as those operated for relief of the poor.” \textit{Id.} 1287 n. 13 (citing: Treas. Reg. § 39.101b – l(b) (1939 Code, and 1923 I.R.S. Commissioner ruling (I.T. 1800, II-2 Cum. Bull. 152 (1923) holding that the term “charitable” in predecessor of Section 501(c)(3) was used in the restrictive sense of relief of the poor, rather, than its broader legal sense in the law of charities. \textit{Id.}

\textsuperscript{100} If term “charitable” were intended to be used in IRC § 501(c)(3) in its broad charitable trust sense there would be no need to separately list purposes such as religious, scientific educational etc., because the term “charitable” would include in its broad definition all of these purposes. Thus, the structure of 501(c)(3) consistently with contemporaries regulations, must use the term in its limited “relief of the poor” meaning. See Hopkins, \textit{supra} note 53 at 90.

\textsuperscript{101} Bob Jones Univ. v. United States, 461 U.S. 574, 592 (1983) (“Charitable exemptions are justified on the basis that the exempt entity confers a public benefit – a benefit which the society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues.”). Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985) (“The basis for the tax exemption is a quid pro quo: ‘private charities perform functions that the state would be required to undertake and tax exemption is granted as a quid pro quo for the performance of these functions and services.’”) (quoting \textit{EDITH L. FISCH, DORIS JONAS FREED & ESTHER R. SCHACTER, CHARITIES AND CHARITABLE FOUNDATIONS} § 787, at 602 (1974)); IHC Health Plans, Inc. v. Comm’r. 325 F.3d 1188, 1195 (10th Cir. 2003) (“The public-benefit requirement highlights the \textit{quid pro quo} nature of tax exemptions: the public is willing to relieve an organization from the burden of taxation in exchange for the public benefit it provides.” (citing Geisinger Health Plan v. Comm’r. 985 F.2d 1210, 1215 (3d Cir. 1993)).
further its charitable purpose.\textsuperscript{104} As noted supra, the IRC requires that a business entity meet certain requirements in order to qualify as a tax exempt charity.\textsuperscript{105} The first requirement is often called the operational test.\textsuperscript{106} Under this test, a business’s organizational document must provide that the business will be operated exclusively for one or more tax exempt purposes.\textsuperscript{107} As noted, the list of tax exempt purposes recognized by the IRC includes, inter alia, the following: charitable, scientific, educational, religious or literary.\textsuperscript{108} However, the word “exclusive” in the statute, has been interpreted to mean primarily or substantially.\textsuperscript{109} Thus, the business may not engage in activities that are not in furtherance of its tax exempt purpose, unless such non-tax exempt activities constitute an “insubstantial” part of the businesses overall activities.\textsuperscript{110} Finally, under the operational test, no profits may inure to the benefit of private parties, and upon dissolution of the organization its assets must be distributed in furtherance of its tax exempt purpose.\textsuperscript{111} It is important to note that the payment of salaries and other expenses by a tax exempt entity is permitted from profits and is not considered the distribution of profits to private parties.\textsuperscript{112}

In addition, Congress and the courts have developed other doctrines applicable to businesses that claim to be tax exempt. These doctrines include the commerciality doctrine\textsuperscript{113}

\textsuperscript{104}See \textit{supra} note 103.
\textsuperscript{105}See \textit{supra} notes 96-105 and accompanying text.
\textsuperscript{106}See \textit{Kelley supra} note 6 at 2473-2477 esp. nt. 226 (“See Treas. Reg. 1.501(c)(3)-1(a)-(b). Aspiring charities must also pass the IRS’s “organizational test,” which is, in essence, a “magic words” test. The applying organization merely must show that certain clauses – promising to eschew lobbying and political activity and all private inurement, for example – have been included in the organization’s founding documents. \textit{Id.”}).
\textsuperscript{107}Id. at 2473-2477.
\textsuperscript{108}See I.R.C. § 501(c) (3) quoted \textit{supra} in the text at note 97.
\textsuperscript{109}See \textit{Kelley supra} note 6 at 2473.
\textsuperscript{110}Id.
\textsuperscript{111}Id.
\textsuperscript{112}It is incorrect to think of non-profit organizations in general, especially hospitals, as organizations where no individual “profits” from the organization’s activities or as organizations unconcerned with maximizing profit. See Clarke \textit{supra} note 17 at 1436-1437 (explaining the “exploitation hypothesis of non-profit preference in terms of it allowing doctors, “residual owners” to maximize their net income”).
\textsuperscript{113}See \textit{Kelley supra} note 6 at 2476-2483.
and the Unrelated Business Income Tax.\textsuperscript{114} The commerciality doctrine is a court fashioned doctrine that holds that a tax exempt business may lose its exemption if it engages in too much commercial activity.\textsuperscript{115} Commercial activity is activity that has a direct counterpart in or is conducted in the same way as in the for-profit business environment. Needless to say the commerciality doctrine is less than clear in its requirements and is often redundant with the operational test.\textsuperscript{116} Moreover, the application of the doctrine by the courts has been less than consistent.\textsuperscript{117} Adding to the confusion is the Unrelated Business Income Tax (UBIT) that was passed by Congress in 1950\textsuperscript{118} and was based in part on the concern that, notwithstanding the operational test and commerciality doctrine, charities were free to engage in too much commercial activity and this resulted in unfair competition to taxable businesses.\textsuperscript{119} In theory, the UBIT seems to sanction commercial activity by a tax exempt business that is unrelated to its tax exempt purpose as long as the entity pays tax on the profits from the unrelated commercial activity.\textsuperscript{120} However, in practice too much unrelated commercial activity can run afoul of the operational test and the commerciality doctrine and place the organizations tax exempt status in jeopardy.\textsuperscript{121} A full discussion of these topics is beyond the scope of this article. Suffice it to say that when it comes to the permissible level of commercial activity by charities there is currently no clear standard to apply.\textsuperscript{122} Part of the reason for this is that the definition of what is charitable

\textsuperscript{114} Id. at 2483-2486.
\textsuperscript{115} Id. at 2476.
\textsuperscript{116} Id. (“The commerciality doctrine is so vague and malleable that it strains the bounds of legal rhetoric to call it a doctrine.”) \textit{Id.}
\textsuperscript{117} Id. at 2477-2483 (discussing cases).
\textsuperscript{118} See I.R.C. 513 (a)(2000); Treas. Reg. 1.513-1(a) (as amended in 1983).
\textsuperscript{119} See Kelley \textit{supra} note 6 at 2483.
\textsuperscript{120} Id.
\textsuperscript{121} Id. at 2484.
\textsuperscript{122} Id.
is itself is unclear.\textsuperscript{123} The effect of this uncertainty is that charities, including (perhaps especially) tax exempt hospitals spend a great deal of effort attempting to navigate these uncertain tax laws in order to maintain their tax exemption.

C. Current Requirements for Tax Exempt Hospitals

Hospitals have never been expressly categorized as tax exempt organizations and have achieved that status only by qualifying as “charitable” organizations under the IRC.\textsuperscript{124} Prior to 1959, when the regulations explaining the IRC of 1954 were adopted,\textsuperscript{125} Treasury Regulations generally defined charitable organizations as those operated for the relief of the poor.\textsuperscript{126}

Thus, under IRS policy hospitals qualified as tax exempt under 501(c)(3) only if they were charitable, that is provided free or below cost service to those unable to pay. This policy was expressed in Revenue Ruling 56-185\textsuperscript{127} which stated that a hospital could qualify for tax exempt status only if it was “operated to the extent of its financial ability for those not able to

\textsuperscript{123} Id. at 2472 (“Lacking a specific, workable definition of charity, federal tax law has developed a series of tests and doctrines to help it determine which activities and organizations should qualify for charitable tax exemption and which should not.”) Id. (Later suggesting that these tests and doctrines constitute a “murky legal swamp”). Id. at 2473.

\textsuperscript{124} See, e.g., Eastern Kentucky supra note 56 at 1280 where the court states:

Hospitals and other health organizations have never been expressly categorized as tax exempt organizations and have achieved that status only by qualifying as “charitable” organizations under the Code. Long established Internal Revenue Service (I.R.S.) policy held that hospitals qualified as charitable organizations under 501(c)(3) only if they provided free or below cost service to those unable to pay. This policy was articulated in Revenue Ruling 56-185, which held that a hospital could qualify for tax exempt status only if it was “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.” [notes omitted] Id. at 1280.

\textsuperscript{125} Id. at 1286 (“Prior to 1959 Treasury Regulations generally defined charitable organizations as those operated for the relief of the poor” (citing Treasury Regulations to the 1939 I.R.C.). Id.; See also; Kelley supra note 6 at 2471 (noting that with each revision of the I.R.C. the regulations that accompanied the acts consistently defined charity as “relief of the poor.”) Id.

\textsuperscript{126} See supra note 125.

\textsuperscript{127} Rev. Rule 56-185, 1956-1 C.B. 202; See also Eastern Kentucky Welfare Rights Organization 506 F.2d. 1278, 1280 (D.C. Cir. 1974) (“This policy was articulated in Revenue Ruling 56-185, which held that a hospital could qualify for tax exempt status only if it was “operated to the extent of its financial ability for those not able to pay for the services and not exclusively for those who are able and expected to pay.” [notes omitted]) Id.
pay for the services rendered and not exclusively for those who are able and expected to pay.”

Revenue Ruling 56-185 is very consistent with the quid pro quo rational of the charitable tax exemption. That is, as long as the hospital is “to the extent of its financial ability” fulfilling the government’s obligation of providing medical care for the poor, then the government will forgo the hospital’s obligation to pay its tax. The definition of “to the extent of its financial ability” meant that essentially all of the hospital’s revenues over and above its expenses had to go to providing indigent care.

Essentially, charitable hospitals received a tax exemption “because they were dedicated to the relief of poverty.”

Proposed regulations to the 1954 Code were initially issued in 1956, and these were consistent with Revenue Ruling 56-185 in that they adopted a “relief of the poor” definition of charity. However, these were withdrawn for more extensive study. A comprehensive set of regulations was proposed in early 1959 and, after public hearings, final regulations were issued. The 1959 regulations interpreting §501(c)(3), and the definition of charity contained in these regulations reflected a far different view of the meaning of charity than had ever previously been adopted under the federal tax law.

These regulations stated:

(2) Charitable defined. The term ‘charitable’ is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by

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128 See supra note 127.
129 See supra notes 103-105 and accompanying text.
130 See Supra notes 103-105 and accompanying text.
131 See Hyatt, supra note 7 at 5 (noting that under Rev. Rule 56-185 that “… for the most part all of your revenues over and above expenses had to go to providing indigent care, because it was though the relief of poverty that you qualified for exempt status.” Id.; See also, Colombo supra note 6 at 30 (“while the IRS never took an official position regarding how much charity care was “enough” …, if a hospital lacked a substantial charity care program, auditing agents almost always recommended denial or revocation of exempt status” [notes omitted]). Id.
132 See supra notes 127-131 and accompanying text.
133 See 21 Fed. Reg. 460, 464 Jan. 21, 1956; see also, Eastern Kentucky supra note 56 at 1287 nt. 14 discussing the proposed regulations.
134 See Eastern Kentucky supra note 56 at nt. 14.
137 See Kelley supra note 6 at 2472 (noting that in the 1959 regulations “… the IRS, without the approval of Congress had vastly expanded the federal tax definition of charitable.”) Id.
the separate enumeration in section 501(c)(3) of other tax exempt purposes which may fall within the broad outlines of ‘charity’ as developed by judicial decisions. Such term includes: Relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human rights secured by law; or (iv) to combat community deterioration and juvenile delinquency.”

Thus, these regulations made clear that the Internal Revenue Service at least, if not Congress, was adopting a new broad public benefit definition of “charitable” for the tax code. As noted this broad definition had been in the law since at least 1601 as reflected in the English Statute of Charitable Uses. However, this was the first time the broad public benefit definition of charity was adopted for purposes of the IRC.

Ten years later in 1969 the IRS applied this new broad definition of charity specifically to tax exempt hospitals in Revenue Ruling 69-545 which provided that a tax exempt hospital must promote the health of a class of persons broad enough to benefit the community and must be operated to serve the public rather than a private interest. This new standard is commonly referred to as the Community Benefit Standard and specifically replaced the relief of poverty/care of the indigent standard reflected in 56-185 as the basis of the tax exemption. Free care to the poor continued to be an acceptable basis for the exemption, as a type of community benefit, but relief of the poor was not considered the only activity that provided a

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139 See supra note 137.
140 See Kelley supra note 6 at 2472 (“Suddenly with the issuance of this language, it appeared that aiding the poor was only one meaning of charitable”). Id.
141 See supra notes ______ - ______ and accompanying text.
143 See Colombo supra note 6 at 31 (discussing Rev. Rule 69-545’s “community benefit” standard).
144 Id.
community benefit, nor a necessary activity (beyond maintaining an emergency room open to all regardless of ability to pay) for a charitable hospital.\textsuperscript{145}

In fact, under ruling 69-545 a tax exempt hospital did not have to provide any free care to the poor so long as it maintained an emergency room open to all regardless of ability to pay, accepted Medicare and Medicaid patients, and had an independent governing body comprised of community leaders.\textsuperscript{146} The IRS had decided that the “promotion of health” was an inherently charitable purpose even if the cost is borne by patients and third party payors.\textsuperscript{147} It is important to note, that the change from a relief of poverty standard to a promotion of health/community benefit standard was not the result of a change in the law – rather it resulted solely from a change by the IRS in the regulations interpreting the law.\textsuperscript{148} The validity of this change has however, withstood repeated court challenge.\textsuperscript{149} It appears that part of the reason for the approach taken by Revenue Ruling 69-545 was the passage of Medicare and Medicaid four years before in 1965.\textsuperscript{150} The IRS evidently believed that this new legislation would provide adequate access to medical care for the poor and indigent.\textsuperscript{151} In fact, this sentiment was echoed by the Court of Appeals for the DC Circuit in 1974 in its opinion in \textit{Eastern Kentucky Welfare Rights Org. v. Simon}\textsuperscript{152} in which the validity of Rev. Rule 69-545 was unsuccessfully challenged on behalf of the poor and indigent.\textsuperscript{153} The court stated:

\textsuperscript{145} See supra notes 137-141 and accompanying text.
\textsuperscript{147} Id.
\textsuperscript{148} See supra note 137.
\textsuperscript{149} See, \textit{e.g.}, Eastern Kentucky supra note 56 (discussed \textit{supra} at notes 64-134 and accompanying text; Cf. Colombo \textit{supra} note 6 (arguing that the courts and the IRS increasingly look to uncompensated care as the touchstone of the tax exemption for health care providers.).
\textsuperscript{151} See Hyatt \textit{supra} note 7 at 11-12 (quoting a press release by Senator Charles Grassley referring to the I.R.S. and the Treasury as “hoodwinked” into believing that, as a result of Medicare/Medicaid, the inability to afford medical care was a problem of the past). Hyatt, it should be noted, disagrees with the Senator’s characterization. \textit{Id.}
\textsuperscript{152} Eastern Kentucky \textit{supra} note 56.
\textsuperscript{153} For a discussion of this case see \textit{supra} note 98.
The institution of Medicare and Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring free or below cost hospital services. …Thus it appears that the rational upon which the limited definition of “charitable” [limited to relief of the poor] was predicated has largely disappeared. To continue to base the “charitable” status of a hospital strictly on the relief it provides for the poor fails to account for these changes in the area of healthcare. (notes omitted)\textsuperscript{154}

With the advantage of hindsight it’s clear that both the IRS and the Court were far too optimistic. Today, access to adequate healthcare for the nation’s 47 million poor uninsured as well as for the under-insured is a major problem. One that is creating irresistible pressure to return to the more limited definition of charity, providing relief for the poor, especially in the hospital context.\textsuperscript{155}

At least under Revenue Ruling 69-545 a charitable hospital had to maintain an emergency room open to all regardless of ability to pay. However in 1983 this requirement was modified by another Revenue Ruling, 83-157.\textsuperscript{156} This ruling eliminated the “emergency room open to all regardless of ability to pay” requirement of Rev. Rule 69-545.\textsuperscript{157} Thus, today a hospital may qualify as charitable and tax-exempt under the IRC even though it provides no free or below cost care to the poor and needy.

IV. PROBLEMS WITH CURRENT LAW

A. The Current System Works Well For No One

The law today allows a hospital to claim a charitable tax exemption even though it provides no free or below cost care to the poor.\textsuperscript{158} Moreover, nothing in the new Health Care Reform law changes this fact. Not only do many so called charitable hospitals provide no

\begin{footnotesize}\begin{enumerate}
\item[\textsuperscript{154}] Eastern Kentucky \textit{supra} note 56 at 1288-89.
\item[\textsuperscript{155}] See \textit{supra} notes 17-18 and accompanying text.
\item[\textsuperscript{157}] This ruling was given to a specialty hospital. The ruling stated that specialty hospitals, such as cancer treatment hospitals, generally could qualify for the tax exemption under the community benefit text even though they did not operate an emergency facilities.
\item[\textsuperscript{158}] See \textit{supra} notes 124-157 and accompanying text.
\end{enumerate}\end{footnotesize}
charitable (free) care, they also treat the poor very harshly, often charging them rates for services
that are many times higher than the amount they accept as full payment from the insured,
denying the un or underinsured treatment unless they pay first, or if treatment was provided
before payment, suing them for the treatment they received if the hospitals exorbitant bill is not
paid on time and in full.\textsuperscript{159} Also, today there are approximately 47 million Americans that have
no health insurance and often no access to health care and even under the most optimistic
assumptions associated with Obama Care that number would fall to a still large 15 million
Americans by 2019.\textsuperscript{160} The law applicable to tax exempt hospitals has developed to the point
where it is a losing situation for all involved; paying patients, the poor, and society overall. This
would be surprising if it weren’t for the fact that the government has been in charge of the
development of these laws.\textsuperscript{161} The taxpayers lose because they effectively pay twice for the same
service; foregoing billions of dollars in taxes supposedly for the benefit of the poor and needy,
and at the same time, tax payers pay more (30\%) for the medical care they receive in order to
fund the unreimbursed care hospitals do provide.\textsuperscript{162} The poor lose because if these taxes were

\textsuperscript{159} See infra notes 168-206 and accompanying text.
\textsuperscript{160} See supra note 5C.
\textsuperscript{161} Those who advocate a government run single payor healthcare system incorrectly assume that the government is
capable of efficiently running such a system. That is, even if a single payor system was the best solution, and it
clearly is not, the government has proven itself, time and again, to be incapable of properly running such a system.
For example, Medicare and Medicaid fail to reimburse hospitals fully for the cost of care provided forcing hospitals
to overcharge other patients to cover the short fall. Moreover, Obama Care will make this problem worse by
increasing the number of people on Medicare and Medicaid. In 2002 Medicare paid ninety-five percent of a
hospitals actual costs for covered procedures. See Allen Dobson et al., The Cost-Shift Payment “Hydraulic”:n
Foundation, History and Implications, 25 Health Aff. 22, 25 (2006). Medicaid reimburses hospitals 92 percent of
cost. Id. Social Security is not on a fiscally sound footing and we seem to lack the political will to make it sound.
The military and space programs work well but one could hardly accuse them of being efficient. Stories of $600
hammers and $1,200 toilet seats are legion. If the reader doubts the veracity of this point let me suggest a trip to
your local DMV or a perusal of the IRC to confirm the point. The reason the government is not efficient is because it
does not have to be – there is no immediate threat of failure – governments can raise taxes and run deficits.
Medicare’s unfunded liabilities are already about 2.6 times larger than the entire U.S. economy in 2008. See,
\textsuperscript{162} See supra notes 20-29 and accompanying text discussing hidden taxes levied by hospitals to cover unreimbursed
care such as Medicare, Medicaid and charity care. See Dobson et al., supra note 161. This double payment under
the guise of charity allows hospitals to maximize profits. See supra notes 20-22 and accompanying text. As
discussed above a non-profit entity can’t distribute these profits to investors but, that does not mean there is no
collected they could be used to increase their access to medical care. But, most important, everyone loses because new and better medical care that could be available (more diseases cured, more treatments available etc.) is not, because tax exempt hospitals are not focused exclusively on the development of the best medical care at the lowest cost. Rather non-profit hospitals spend a lot of time and effort on compliance with ambiguous and unclear tax laws. Moreover, tax

incentive to, or benefit from maximizing profits in the context of a non-profit. As noted, salaries are not considered distributions to investors, and while there are limits, at least in theory, in how high salaries can be, non-profit salaries are usually every bit as high as salaries in the private sector. See, Joe Carlson, Some Hefty Paydays, Modern Healthcare, April 27, 2009 (noting that executives at healthcare associations [non-profits] saw their total compensation increase 10% in 2007 to an average of $712,000 – quoting Ken Berger of Charity Navigator “Healthcare is the 800-pound gorilla in the not-for-profit room; [t]he sheer amount of money involved is staggering.”); Melanie Evans and Joe Carlson On the HOT Seat: As the Recession grows, an IRS Report Shows Enviable Salaries and Uneven Community Benefits Provided by Tax-Exempt Hospitals, Modern Healthcare February 16, 2009 (similar); Melanie Evans, We Just Don’t See a Slowdown; Not-For-Profit Execs. Still See Wage Gains as Tax-Reporting Changes Loom, Modern Healthcare, July 28, 2008 (similar). See also, Clarke, supra note 17 at 1443 (discussing the benefits of the non-profit form to doctors who wish to withdraw all of their earnings from the hospital on a current basis). While total compensation is lower, because of the inability to receive stock based compensation, there are other ways to extract value. Remember doctors, the defacto owners of non-profit hospitals, usually bill separately for services rendered to patients in the hospital. Thus, having the hospital spend money to attract more privately insured patients for more profitable procedures redounds to the financial benefit of doctors. Also, doctors and administrators can take out excess profits in kind though, relaxed, less regulated less pressured and more physically comfortable work environments. See Clarke supra note 17 at 1436 (non-profit form means doctors don’t have to “contend with strong countervailing force toward monitoring and economizing that would be provided by profit-oriented top management.”)

Another reason for forming non-profit hospitals is that this form allows the entity to force patients to contribute money to further the secret unexpressed social goals of those in control of the entity. See Clarke supra note 17 at 1439 where he states

… under the elitist view, those who control the nonprofit hospital exploit the vulnerability of consumers as potential taxpayers. They charge for hospital services at rates that allow some funds to be directed toward research, teaching, favored patients, and favored departments of the hospital; they do not advertise or fully disclose this practice; and they do not give consumers any choice in the matter. They exclude consumers from decisionmaking by disenfranchising them with respect to hospital governance and not permitting them to purchase hospital services while avoiding the tax. None of this is to suggest that the elitist controlling group is acting selfishly in furtherance of its own interest or to deny that minigovernmental goals, perhaps good and noble ones, are being sincerely pursued. The point is simply that the controlling group constitutes an undemocratic ruling class with respect to the hospital’s minigovernmental functions.

In short, the essence of the non-profit hospital model is fraud. See Clarke supra note 17 at 1446-47. The non-profit form allows the maximization of profits by hiding the entities true agenda, (whether that agenda is personal accumulation of wealth or the pursuit of secret social goals or both), and the availability of the tax exemption increases those profits.

See supra notes 20-28 and accompanying text. Providing healthcare to the poor via cross-subsidization results in lower quality and less available healthcare for the poor than spending the same amount to confer health care purchasing power directly upon needy beneficiaries by, for example, providing health care vouchers. Id.

See supra notes 124-157 and accompanying text discussing tax laws applicable to non-profit hospitals.
exempt hospitals are run less efficiently than for-profit hospitals. Everyone suffers from this because today’s expensive new treatment often becomes tomorrow’s affordable care. In sum, the current federal tax law requirements for charitable tax exempt hospitals are unfair, based on erroneous historical assumptions, likely result in higher cost lower quality health care, and allow/encourage too much government involvement with the business of health care which is

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165 See Clark *supra* note 17 at 1459-1462. Clarke states:

*Kenneth Clarkson has analyzed various sets of data to determine the effects of attenuation of property rights in non-profit hospital management. [Kenneth Clarkson, *Some Implications of Property Rights in Hospital Management*, 15 J.L. & Econ. 363 (1972).] His conclusions support the notion that nonprofit hospitals are less efficient than for-profit hospitals. The nonprofit hospital administrators seem more likely than for-profit managers to avoid unpleasant but efficiency-relevant tasks. For example, they spend less of their time supervising employees and acting as night supervisors. Nonprofit managers also tend to use information that, while easier to obtain, is more crudely calibrated to performance than other information. For example, in hiring new personnel they rely more heavily on the candidates’ formal education degrees; and they are more likely to grant automatic rather than merit-based salary increases. Suppliers believe that non-profit administrators are less price conscious. For example, they are less likely to press bill collection efforts or to engage in disputes with the Blue Cross companies. Furthermore, governmental and private nonprofit hospitals considered together, in contrast to for-profit hospitals, exhibit a greater variance in their selection of inputs, suggesting that they have a freedom uncharacteristic of producers in competitive markets, and may be straying from optimality. Even after size adjustments are made, nonprofit hospitals have more numerous and complex written rules, which may suggest that the absence of discipline that would be exerted by managers whose compensation personally was linked to profits forces the hospital trustees to rely instead on a more cumbersome system of controls. Overall, Clarkson’s picture is one of administrators trying to minimize conflict and unpleasantness, at the cost of some organizational inefficiency. Because the economic rent obtained by taking advantage of the vulnerability of third-party payors cannot all be taken out as dividends or profit-related managerial compensation, as in a for-profit hospital, the managers follow a second-best strategy and take out some of the benefits in kind, such as by increasing on-the-job satisfaction and institutional prestige.

Clarkson’s work provides some evidence of managerial slack in the nonprofit hospital, which in turn implies a degree of exploitation of the hospitals’ market power over consumers. In most examples, such as the alleged failure of nonprofit purchasing agents to be as price conscious as their for-profit counterparts, any exploitation comes mainly at the expense of payors. But in some cases, such as the distaste for supervision, it might detract from the quality of patient care. [notes omitted]. Id. at 1460-61.

See also, Rexford E. Santerre & John A. Vernon, Hospital Ownership Mix Efficiency in the U.S.: An Explanatory Study (National Bureau of Econ. Research, Working Paper No. 11192, 2005) (noting that nonprofits suffer from inefficient production of services due to the lack of oversight from shareholders with financial interests, but suggesting that this inefficiency may be overcome by competition with for-profits) Id. at 3-5; Joe Carlson and Vince Galloro, *Into the Red: Annual Survey of Hospital Systems Shows Not-for-Profits Posted an Overall Net Loss in 2008; For Profit Chains Bucked the Trend*, MODERN HEALTHCARE June 8, 2009 (noting that some see the superior performance of for-profits in the recent market turmoil as validation of the for-profit model in terms of efficiency). Id.

166 For example, new drugs are often very expensive, but once they go off patent and are made by generic suppliers the price drops dramatically. This reflects the fact that once the cost of development has been recouped, the price falls.
likely to result in rationed care and the adoption of policies that discourage the development of new and beneficial healthcare.\textsuperscript{167}

B. The Current Law is Unfair

The current tax law is unfair because overall charitable hospitals receive much more from their tax exemptions than they give back to the community.\textsuperscript{168} This is true whether one looks at the amount of free care provided to the poor or the cost of the community benefit provided or both.\textsuperscript{169} Simply put, granting a tax exemption to charitable hospitals is a bad deal for taxpayers.

The current tax law applicable to charitable hospitals is the result of two historical errors. First, as hospitals changed from refugees for the sick poor to die peacefully to institutions that sold treatment for the sick, rich and poor, the decision was made to continue to treat hospitals like charities (even though they were now businesses) as long as they were set up as non-profits and provided free care to the poor “to the extent of their financial ability.”\textsuperscript{170} This solution never “fit” very well as the confusing law applicable to charitable hospitals demonstrates.\textsuperscript{171} The second error occurred after the passage of Medicare and Medicaid, when the conclusion was

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\textsuperscript{167} See infra notes 265-318 and accompanying text.
\textsuperscript{169} See supra note 168.
\textsuperscript{170} See supra notes 96-157 and accompanying text.
\textsuperscript{171} See supra notes 124-157 and accompanying text.
\end{flushright}
reached that it would no longer be necessary to provide free or below cost care to the poor.\textsuperscript{172}

Not only was this assumption incorrect, but again the decision was made to continue to treat hospitals as charities – though all of their patients would presumably pay for their treatment.\textsuperscript{173}

This error in judgment is reflected in Revenue Rules 69-545\textsuperscript{174} and 83-157.\textsuperscript{175} As a result of these errors, the law today is in the untenable position of providing a charitable tax exemption to hospitals that provide no charitable care.

Given the inconsistency between many tax-exempt hospitals’ status as charitable organizations and their insignificant levels of charitable care, it’s not surprising that charitable hospitals are facing a number of problems. Some members of Congress have suggested legislation to require tax-exempt hospitals to spend a minimum amount on free care for the poor, set curbs on executive compensation and to restrict conflicts of interest with for-profit businesses.\textsuperscript{176} States, who control the exemptions from state and local (real estate) taxes are not required to follow the federal tax exemption rules, but most do.\textsuperscript{177} However, a few states have begun to set their own standards that a charitable hospital must meet to receive state and local tax

\textsuperscript{172} See supra notes 71-157 and accompanying text.
\textsuperscript{173} See Colombo supra note 6 at 30-31:

Concurrent with Congressional consideration of the Medicare and Medicaid legislation in the mid-1960s, however, exempt hospitals began pushing the IRS for reconsideration of exemption standards. The common complaint (almost hilarious, in retrospect, for its inaccuracy) was that between private medical insurance and the “new” Medicare and Medicaid programs, there simply would not be enough of a demand for charity care to satisfy the IRS, and hence exemption standards should become more flexible in order to maintain exempt status for hospitals. One wonders, of course, why the most appropriate response to these arguments was not ‘well, if there isn’t any need for charity care, then there isn’t any need for exemption,” but a young staff attorney with the IRS, Robert Bromberg, apparently took the complaints of the hospital industry seriously and began work on a new exemption standard. [notes omitted] Id.

\textsuperscript{174} See supra notes 124-157 and accompanying text.
\textsuperscript{175} See supra notes 124-157 and accompanying text.
\textsuperscript{176} See, e.g., Discussion Draft supra note 168 at 16-17 (recommending \textit{iter alia} that tax exempt hospitals be required to meet minimum charity care requirements and conduct all joint ventures with non-501(c)(3) entities according to 501(c)(3) standards). Id. For a fuller discussion of these proposals see Folkerts supra note 17 at 619-626; See also, supra notes 17 and 18.
\textsuperscript{177} See Kathryn J. Jervis, \textit{A Review of State Legislation and a State Legislator Survey Related to Not-for-Profit Hospital Tax Exemption and Health Care for the Indigent}, 32 J. Health Care Fin. 36 (2005) (about half of the states automatically grant tax exemption to organizations that have obtained federal income tax exemption status) Id. at 38.
exemptions. Also, in recent years some charitable hospitals have been stripped of their state tax exemptions for providing too little charitable care. While some charitable hospitals continue to provide significant levels of charity care in some of the poorest urban neighborhoods, many more charitable hospitals have merged to create huge charitable hospital systems, have abandoned facilities in poor urban areas while building expensive new hospitals in more affluent suburbs, and amassing billions of dollars in reserves and revenues. And, there is nothing in the law to prevent all charitable hospitals from following suit. Even though these huge charitable hospital systems are technically non-profit – many follow a very for-profit approach of closing money – losing facilities (usually in poor areas where many patients are uninsured) and building new hospitals in affluent areas (where most patients have private insurance). While these non-profit systems provide very little charity care they make substantial profits! Moreover, net income or profit is clearly the number one priority for many of these large systems, and they do not use their size to offer more charity care. For example, Ascension Health, the country’s largest nonprofit hospital system had net income of $1.2 billion in 2007 (a 300 percent increase

178 See, e.g., Tex. Tax Code Ann. § 11.1801 (Vernon 2008) (requiring a specific percentage of hospital revenue be used for charity care and community benefit); Leah Snyder Batchis, Can Lawsuits Help the Uninsured Access Affordable Hospital Care?: Potential Theories for Uninsured Patient Plaintiffs, 78 Temp. L. Rev. 493 (2005) (noting that Pennsylvania, Utah and West Virginia have similar requirements) Id. at 511. In addition, some states, e.g., California, Indiana, Idaho and New York require that non-profit hospitals conduct a community needs assessment and planned response to those needs. Id. See also, Colombo supra note 6 at 37-40 (discussing state statutes.

179 See Lucette Lagrado, Hospital Found “Not Charitable” Loses Its Status as Tax Exempt, WALL ST. J. Feb. 19, 2004 at B-1 (discussing the revocation of property tax exemption for Provena-Covenant hospital in Urbana, Illinois by the Illinois Department of Revenue). See also, Colombo supra note 6 at 37-40 (discussing other cases); Suzanne Sataline, Illinois High Court Rules Nonprofit Hospitals Can Be Taxed, THE WALL ST. J. March 19, 2010 at B-4 col. 3 (noting that the Illinois Supreme Court ruled that the state was correct when it decided in 2002 that the charity care provided by Provena Covenant Medical Center was too small to qualify for tax exemption.)


181 Id. Discussing Assension’s closing of its subsidiary, Riverview Hospital located in Detroit on the poor east side, while planning to open a new $224 million hospital 30 miles away in an affluent suburb.

182 Id. (noting that non-profit hospital systems have closed facilities in poor urban areas while spending billions on suburban expansions, and this is occurring at the same time that large nonprofit chains are enjoying some of their most prosperous times ever).
since 2004).\textsuperscript{183} In 2008 Ascension’s 67 hospitals had net income of $351 million.\textsuperscript{184} The fall off in net income came as a result of struggling financial markets – not because the bad economy produced more poor and uninsured patients, though it did – but because Ascension’s investments gains were dramatically lower!\textsuperscript{185}

Ascension, who is affiliated with the Roman Catholic Church, says that it can’t use its more profitable subsidiaries to subsidize those that are struggling. An Ascension spokesperson says “such an approach would mean that needs in other communities may not be met.”\textsuperscript{186} Ascension requires that its 38 subsidiaries be self sustaining and it bases how much capital it allocates each subsidiary, in part, on its profitability.\textsuperscript{187} Clearly profit is more important at Ascension than charity, and of course the charitable tax exemption increases profit.\textsuperscript{188} However Ascension’s charity care at 2.5 percent of its patient revenue for 2008 gave it the highest percentage among the nation’s five largest nonprofit hospital systems.\textsuperscript{189} Nonetheless Ascension recently closed an unprofitable hospital in Detroit, a city that had 42 hospitals in 1960 and now has only four, even though or likely because the number of city residents without health insurance continues to increase.\textsuperscript{190}

Another example of less than charitable conduct by a charitable hospital concerns M.D. Anderson Cancer Center in Houston. The non-profit hospital refuses to admit or even schedule appointments for uninsured or even under-insured patients until it receives payment.\textsuperscript{191}

According to John Tietjens, vice president for patient financial services at Anderson, asking

\textsuperscript{183} Id.
\textsuperscript{184} Id.
\textsuperscript{185} Id.
\textsuperscript{186} Id.
\textsuperscript{187} Id.
\textsuperscript{188} Id.
\textsuperscript{189} Id.
\textsuperscript{190} Id.
\textsuperscript{191} See Barbara Martinez, \textit{Hospitals Demand Cash Upfront from Patients} \textit{WALL ST. J.} April 28, 2009 A-1 (col. 6).
patients to pay after they’ve received treatment is “like asking someone to pay for the car after they’ve driven it off the lot.” He goes on to say “The time that the patient is most receptive is before the care is delivered.” Remember M.D. Anderson is a cancer center, the patients are faced with cancer, indeed Mr. Tietjens’ patients would not likely be more receptive if a loaded gun was pointed at their heads. The amounts these hospitals demand can be huge. M.D. Anderson for example, demanded $105,000 up front from a patient with leukemia because she was under-insured. M.D. Anderson even sends representatives from its business office into exam rooms with doctors to encourage payment. The hospital calls this a “coordinated teamwork approach” another name might be violation of patient privacy or harassment.

UCLA Medical Center also a nonprofit tax exempt hospital that is part of the University of California system demanded $375,000 from a 17 year old cancer patient who needed a liver transplant after his health insurer refused to pay for the operation. For-profit hospitals like Tenet Healthcare and HCA also demand payment before admitting patients – but these hospitals are not calling themselves charities; nor are they receiving billions of dollars in tax exemptions.

In some cases for profit hospitals actually provide more charitable care than their non-profit tax-exempt colleagues. Consider the for-profit hospital run by Tenet Health Systems, it provided $5.9 million in charity care during 2001 or 2.6 percent of its operating revenue. Tenet also paid $13.1 million in sales, property and income taxes for the same year or 2.5 percent

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192 Id.
193 Id.
194 Id.
195 Id.
196 Id.
197 Id.
198 Id. Noting that, according to the American Hospital Directory, 77 percent of nonprofit hospitals are in the black compared to 61 percent of for profit hospitals. Id. Moreover, many nonprofit hospitals are using their growing surpluses to reward their executives with rich pay packages, build new wings and accumulate large cash boards. Id.
of its operating revenues.\textsuperscript{200} That same year a St. Louis area non-profit health care organization provided only $476,000 in charity care or just 22/100ths of one percent of its operating revenue, and because it was tax exempt it paid no sales, property or income tax.\textsuperscript{201} If this organization were not tax exempt it would have faced $5.4 million tax bill.\textsuperscript{202} Moreover, evidence suggests that nonprofit hospitals provided community benefits equal to only eighty-three percent of the uncompensated care and taxes paid by for-profit hospitals.\textsuperscript{203} The many instances in which non-profit hospitals seem to place the pursuit of profit over charity care has led the Commissioner of the IRS to observe that there is now very little difference between for-profit hospitals and not-for-profit hospitals.\textsuperscript{204}

While there may be very little difference between for profit and charitable hospitals in their levels of charity care or even some of their business practices there are important differences in the competitive landscape caused by the fact that the majority of hospitals are non-profit. M.D. Anderson for example, discussed above for demanding payment before treatment and sending business representatives to exam rooms to badger patients for money, says that its goal is to cure cancer, and justifies its up-front payment policy for under/uninsured patients because its increasing bad debt load threatens its mission.\textsuperscript{205} The question addressed in the next section is whether the law should encourage M.D. Anderson to focus on its mission or force it to split its focus between curing cancer and further an ever-changing social agenda?

The point made here is that under current law we have the worst of both possibilities. That is, Anderson’s attention is diverted from its mission by its desire/need to maintain its tax

\textsuperscript{200} \textit{Id.}
\textsuperscript{201} \textit{Id.}
\textsuperscript{202} \textit{Id.}
\textsuperscript{203} See Community Benefits \textit{supra} note 7 at 3.
\textsuperscript{204} See Hyatt \textit{supra} note 7 at 3.
\textsuperscript{205} See Barbara Martinez \textit{supra} note 191.
exemption (something that is likely to require even more attention in the near future)\textsuperscript{206} yet Anderson is not required to provide any free care to the poor. If the solution argued for here is adopted, some of the very practices that the previous paragraphs criticize tax exempt charitable hospitals for (focus on profit, refusal to give free care, etc.) may be adopted by all hospitals. However, this article is not arguing that all of these practices are per se unfair; rather, they are unfair when practiced by institutions that purport to be charities and that receive a charitable tax exemption.

C. The Non-Profit Tax Exempt Business Model is Not as Appropriate for Hospitals

The practice of medicine may be an art, but the provision of medical services like: time with doctors, time in operating rooms, drugs, imaging tests, lab tests and the development of new drugs and treatments is a business.\textsuperscript{207} Modern hospitals, like it or not, are first and foremost, involved in a business; the business of developing and providing health care services. In a competitive market the mission of a hospital run like a business is to produce a profit by providing the best health care at the lowest cost, where best is determined by its customers. In the best case, the mission of a modern tax-exempt hospital is to keep their tax exemption and

\textsuperscript{206} We seem to have reached a tipping point – the status quo (non-profit hospitals receiving a tax deduction but providing no or very little charitable care) is unlikely to be tolerated much longer. This article notwithstanding, the odds now favor a legislative requirement for more charitable care and more reporting requirements. As a result, charitable hospitals will spend even more time to find the cheapest way to comply with these likely new requirements.

\textsuperscript{207} To say that healthcare is a business is relevant because it means that the laws of economics apply. They apply, like gravity, because that’s the way the world works – not because someone makes them apply. A colleague once remarked that he did not see why there should be any profit in healthcare – why should a profit be taken for restoring someone’s health? I would agree with my colleagues assessment had he qualified profit with exorbitant or large or, ideally higher than what a freely competitive market would allow. In a competitive market profit is really a cost; why would I work as a doctor if I was not compensated for my effort, why would an investor give money to be used to build the hospital if he were not paid for the use of his money? Profit is necessary because most people can’t afford to do something for nothing. The main point though is that the best way to avoid high profits is a freely competitive market.
then provide the best health care at the lowest cost. In the worst case, a non-profit tax-exempt hospital’s mission is to keep its tax exemption in order to maximize profits and use their non-profit structure as camouflage to hide both their profit maximizing activities on behalf of doctors and administrators and/or their elitist, secretive (perhaps fraudulent) cross-subsidization of certain types of healthcare and wealth redistribution. This article argues that all hospitals should focus solely on delivering the best health care at the lowest cost, and that the way to accomplish this is to increase competition in the health care system. That is, to increase competition between hospitals, healthcare insurers, doctors and all of the other participants in the health care system. This article argues that having hospitals adopt a for profit taxable business model, and thus be held accountable to investors is one important step in increasing competition in the health care system.

The goal our society should adopt with regard to healthcare is to cure or prevent as many diseases/injuries/discomforts as possible at the lowest cost. In short, the best healthcare at the lowest price. The non-profit charitable model is not appropriate for this mission.

Consider other necessities, for example, food or shelter. Soup kitchens, while performing a

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208 If a provider’s (doctor, hospital, etc.) costs are too high and someone else can provide the same quality service for a lower cost, this competitor will open for business (ease of entrance and exit from the market is a hallmark of a freely competitive marketplace) and drive the high cost provider out of business.

209 See Clarke *supra* note 17 at 1436-37 (explaining the “exploitation hypothesis” of non-profit hospitals and elitist view of non-profit entities); Hyman *supra* note 13 at 758 (“If nonprofits underwrite their “charity” care by overcharging everyone else, should such conduct even count as community benefit?”) *Id.; See* Bloche *supra* note 16 at 355 (The imagery of charity rings hollow when it comes to hospitals…the free care provided by nonprofit hospitals is framed largely by private payers, who are hardly inspired by donative benevolence.”) *Id.; Melanie Evans, Health Care Hot Seat; Report On Tax-Exempt Hospitals Finds High Salaries, Limited Benefits to Communities*, Crain’s Detroit Business March 2, 2009 (discussing an IRS report on executive pay at not-for-profit hospitals that found six-figure salaries and uneven charity care); Melanie Evans and Joe Carlson, *On the Hot Seat: As the Recession Grows, an IRS Report Shows Envyable Salaries and Uneven Community Benefits Provided by Tax-Exempt Hospitals*, Modern Healthcare, February 16, 2009 (same). This type of behavior is evidence of a non-competitive market. As discussed *infra* an important role that government can play is that of insuring the conditions necessary for a freely competitive market such as; sufficient supply (more medical schools/scholarships for medical school) ease of entry into the market for new hospitals, insurers requiring that accurate information on price and quality of medical care be available to consumers, vouchers to help the deserving poor purchase medical insurance in the market place, etc.

210 See *supra* note 165.
vital and noble function, do not produce the best food nor would one expect them to. Public/low income housing, again while very important, does not produce the best housing. As a society we strive to provide every person with adequate food and shelter. We do not believe that everyone should have the best housing or food. In fact, getting better housing or food is an important incentive for people to succeed in the economic system. In the case of healthcare, however, an important question is whether we should strive to provide access to the best available healthcare to everyone or provide adequate necessary healthcare to everyone, and the best healthcare only to those who can afford it? The point of this article is not to answer this question (though it suggests the later answer is the correct one), but to recognize that the answer to this question is separate and distinct from the answer to the question of how to create the best available healthcare.

The issue of how to provide services; food, shelter, healthcare etc. to the poor is separate and distinct from the business of food production, homebuilding or healthcare. These businesses should be, like any other business, focused on providing the best product/service at the lowest cost (where best is determined by the market place). A competitive market will insure this focus. Poverty must be addressed either by eliminating the causes of poverty or by giving money, goods, or services directly to the poor. For example, stimulating the economy to provide more jobs and motivating able workers to develop the skills needed for available jobs will eliminate the main cause of poverty for the able poor. That is, the Victorian conclusion that the proper response to the poverty of able people is work, is still correct today. Where poverty can’t be eliminated, then it must be

211 See Adam Smith, AN INQUIRY INTO THE NATURE AND CAUSES OF THE WEALTH OF NATIONS (R.H. Campbell et al., eds., Clarendon Press 1976) ("...it is not from the benevolence of the butcher, the brewer, or the baker, that we expect our dinner, but from their regard to their own interest.") Id. 26-27.

212 See supra notes 39-70 and accompanying text.
addressed by providing money to the deserving poor to purchase necessary goods and services in the marketplace.\textsuperscript{213} The point is, addressing the needs of the poor is a complex and distinct undertaking and one that is the proper province of the government. While private parties may choose to get involved in this effort, it is a mistake to create laws that force businesses to adopt government social engineering objectives. Hospitals and other healthcare providers should be free to focus on providing the best healthcare at the lowest cost – a daunting task by itself – they should not also be burdened with the obligation of fulfilling the government's obligation to provide services to the deserving poor.

The most effective tool we have for creating the “best” of anything at the lowest cost is the free market. Because non-profit charitable hospitals have had to compete with for-profit hospitals their businesses have been more efficient then they would have been without this competition.\textsuperscript{214} However, the presence of so many non-profit tax exempt hospitals has reduced overall competition and efficiency. In addition, we have reached a point where the laws applicable to non-profit tax-exempt hospitals are likely to change dramatically.\textsuperscript{215} As noted, most of the current proposals for change call for requiring more free care from tax

\textsuperscript{213} This is much better than providing the goods or services directly to the poor via the government because it keeps the government out of the marketplace. The government’s role in the facilitation of the free market is analogous to that of an umpire or referee, and just as these officials must avoid participating in the game so the government must avoid participating directly in the market.

\textsuperscript{214} See, e.g., Rexford E. Santerre and John A. Vernon, Hospital Ownership Mix Efficiency in the U.S.: An Exploratory Study (Nat’l Bureau of Econ. Research, Working Paper No. 11192, 2005) (competition from cost-conscious for-profit hospitals causes non-profit hospitals to implement cost-effective strategies to remain competitive) \textit{Id.} at 3-S. The same working paper also notes that for-profits may increase the quality of their care in order to compete with non-profits that the public perceives as more “trustworthy” due to their less obvious interest in profits. \textit{Id.} The effect noted, has nothing necessarily to do with the non-profit status of the hospitals, if any other hospitals (for profit or non-profit) were perceived to offer superior quality – a properly functioning free market would force other participants to either improve their quality or lower their price.

\textsuperscript{215} See \textit{infra} notes 265-318 and accompanying text.
These changes will make tax-exempt hospitals even less efficient at the business of health care as the amount of effort required to comply with new tax exemption requirements increases.

Moreover, as discussed in the next section, the likely change in government regulation of tax exempt hospitals will come in addition to the implementation of Obama Care which provides for increased government regulation of health insurance and health care in general. This is likely to result in an unprecedented drive to reduce the overall cost of healthcare. Tax exempt hospitals, because of their dependency on their tax exemption, will be much more sensitive to government pressure to reduce cost by slowing the development of new expensive treatments, and rationing care which will make these hospitals even less effective in achieving the goal of providing the best healthcare at the lowest cost.

Even before passage of Health Care Reform the United States had a government dominated healthcare system. The government is currently responsible for more than 50% of all medical spending. As the major provisions of Obama Care become operational, between 2014 and 2019, this domination will increase. In order to maintain an effective free market in medical care there must be a free market counter-balance to the government. The free market counter balance can and must come from a vibrant, freely competitive, independent and for profit hospital sector. The hospital sector must be strong enough, and independent enough to negotiate with private medical insurers to create a viable market for medical insurance policies that offer real alternatives to the coverage, co-pays, waiting periods etc. offered under government policies so that Americans who desire and can afford different levels of coverage may obtain them.

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216 See supra notes 17-18.
216A See generally, Hitt and Adamy supra note 8 discussing the major provisions of Obama Care; Meckler and Hitt supra note 8 (same).
216B See infra note 229.
Private insurance companies will only be able to offer real alternatives to government dictated policies, if hospitals and doctors are strong and independent enough to contract with private insurers free from government influence. The hospital sector must be strong and independent enough to be able to refuse to accept Medicare, Medicaid or other government insured patients if reimbursement rates or policies are not fair. As long as the majority of hospitals are organized as non-profits and are dependent on the government for their tax exemption they will not be strong enough or independent enough to act as a free market counter balance to the government. Thus, all hospitals should be encouraged to adopt the for profit taxable business model.

D. Patient Autonomy: Who Should Decide? The Danger of Too Much Government Involvement

The fundamental question we are facing today regarding healthcare is who should decide what constitutes “quality” health care, and who should decide how much money we spend on healthcare. It is easy to get support for the proposition that only quality healthcare should be supported, but what does quality mean and more importantly, who decides? It seems very obvious that in America – under a free-market system – the answer to both questions should be the people through the functioning of the market place. For example, should a new cancer drug that on average extends life by two months at a cost of $100,000 per patient be supported? Rather than the government deciding based on some arbitrary number like $35,000 per month for the value of life,\textsuperscript{217} patients should be able to choose in consultation with their doctors based on facts of their specific case.\textsuperscript{218} Patients should also be able to choose the healthcare they want access to by being able to choose the health insurance coverage they want based on what they

\textsuperscript{217} For example in the United Kingdom they have a rationing body – the National Institute for Health and Clinical Excellence (NICE) – that is designed to slow the adoption of new medications and set limits on how much will be paid to lengthen a life. See Betsy McCaughey, Obama’s Health Rationer-in-Chief, WALL ST. J. Aug. 27, 2009, A15.

\textsuperscript{218} See infra notes _____ - _____ and accompanying text,
can afford and what benefits matter to them. Moreover, whether the United States spends 10 percent or 20 percent of its GDP on healthcare should be left to market to decide.\textsuperscript{219} Simply put, patients will choose (if the government allows them to) to spend an amount equal to the value they believe they receive from their healthcare, and they will spend it on the healthcare they decide is of the highest value to them.\textsuperscript{220} In this way the market will achieve the appropriate allocation of resources to healthcare, and those resources will be spent on the highest quality healthcare (where quality is defined by patients).

Clearly patients should be able to decide what healthcare they purchase because this will lead to the best allocation of resources. But there is a more fundamental point here that the public health advocates\textsuperscript{221} don’t get – the right to decide is itself a fundamental part of “quality” for Americans.\textsuperscript{222} As discussed infra, without patient autonomy there is not “quality” healthcare.\textsuperscript{223}

\textsuperscript{219} See Craig S. Karpel supra note 30 (suggesting that after food, shelter and clothing, health care becomes one of the economy’s most important outputs).

\textsuperscript{220} Some estimates suggest 30 percent of GDP by mid-century as optional. Id. (citing work by Robert E. Hall and Charles I. Jones).

\textsuperscript{221} By “public health advocates” I am referring to those who base their analysis primarily on data from clinical studies that provide averages based on the populations studied. I do not mean to imply that such research is not valuable or relevant, it is both. But, the problem is that such research is also limited because average results often do not apply to individual patients. Clinical studies routinely exclude patients with more than one medical condition and often the elderly or people taking more than one medication. See Jerome Groopman and Pamela Hertzband, \textit{Sorting Fact From Fiction on Health Care} THE WALL ST. J., August 31, 2009 at A13. In addition medical research is dynamic and what appears to work at one point in time can be completely refuted a short time later. Id. (citing an Ottawa Health Research Institute study indicating that 15 conclusions out of 100 derived from clinical studies about drugs, devices and procedures had to be reversed within one year, and after 5 years one half of the conclusions were contradicted). Id.

The “Public Health” approach becomes a problem when it is used to eliminate patient autonomy and create cookie-cutter-one-size-fits-all medicine. In certain medical contexts strict protocols are necessary because the patient can’t be involved in decision making and/or time is of the essence. For example, during surgery strict protocols help reduce infection and errors, or in the emergency room when a patient in the midst of a heart attack is brought in strict protocols are very valuable. But in most medical contexts the patient can and should play a decision making role. Id. (noting “This is how doctors and patients make shared decisions – by considering expert guidelines, and then customizing the therapy to the individual). Id. Another way of saying this is that patient autonomy is an important part of quality healthcare.

\textsuperscript{222} See supra note 221.

\textsuperscript{223} See infra notes 235-255 and accompanying text.
Some argue that healthcare is a special good and that, therefore leaving its development and distribution to the market is not appropriate. As a result, these folks believe that the state has a central role in the business of healthcare. That is, the government should participate directly in the healthcare market by deciding what healthcare is to be available, and paying for all of it or a large portion of it. I argue here that this view is mistaken. Healthcare is no more special than food, clothing, shelter and many other goods. Moreover, the realities of the market can’t be avoided, at the risk of sounding trite, there is no free lunch no matter who pays, nor how special the good! Production requires capital and labor. A free market simply allows for the most efficient allocation of these resources. Rather, what is special and a non-market activity is providing services for the poor. But in this regard, as discussed supra, healthcare is no different than food, shelter, and all of the other goods and services the poor need but lack. The fact that

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224 See, e.g., Jeffrey W. Stempel, Adam, Martin and John: Iconography, Infrastructure and America’s Pathological Inconsistency About Medical Insurance, 14 Conn. Ins. L.J. 229 (Spring 2008) (concluding: “realistic assessment of the lay citizenry should appreciate that people are on average normally not sufficiently rational, informed, or disciplined to be able (sic) make the type of consistently intelligent medical treatment decisions upon which the consumer-driven model depends…”). Id. at 299.; Jill R. Horwitz supra note 6 at 1387 (“Because we cannot observe some crucial measures of quality and access to care – for example, medical treatment outcomes, doctor skill, or patient comfort – we cannot contract for them.”) Id.; Timothy Stolzfus Jost, Is Health Insurance a Bad Idea? The Consumer-Driven Perspective, 14.2 Conn. Ins. L.J. 377 (2008) (similar); Wendy K. Mariner, Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts, 69 Brook. L. Rev. 485 (2003) (similar).

225 See, e.g, Stemple supra note 224 at 304 (“Without doubt, a government-administered public insurance plan is the optimal route.”) Id.; Mary Anne Bobinski, The Health Insurance Debate in Canada: Lessons For the United States? 14.2 Conn. Ins. L.J. 341 (2008) (“In the aggregate, the result is that Canadians fare better than Americans “noting that Americans” are one third less likely to have regular medical doctors, are a fourth more likely to have unmet health care needs, and more than twice as likely to forgo necessary medicines.” (Citing Karen E. Lasser, et al., Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey, 96 Amer. J. Pub. Health 1300, 1303 (2008); Deborah Stone, Health Law Symposium: The False Promise of Consumer Choice,51 St. Louis U. L.J. 475 (2007) (consumer choice sounds good but does not work) Id. at 475.

226 Various iterations of the healthcare proposals leading up to the passage of Obama Care had included a “public option” provision that would have involved government even further in the business of health care. The public option refers to government offered health insurance beyond Medicare and Medicaid. The final version of Obama Care does not contain a “public option,” though some are still pushing for it.


228 See supra notes 207-216B and accompanying text.
the poor lack necessary services and goods is no reason to involve the state in the business of healthcare.

The more healthcare the government is responsible to pay for the greater the governments influence on the market place, and thus the greater the governments say in deciding what constitutes quality healthcare, and how much money is spent on healthcare.\(^{229}\) The government, however, for a number of reasons including that it is the payor but not the recipient of the healthcare serves, is too focused on reducing the cost of healthcare rather than on increasing the quality of healthcare. As the amount of healthcare the government is responsible to pay for increases as it will under the Obama Care the focus on cost containment will also increase. The government is driving concern will become the amount of healthcare the government can afford to pay for, rather than the highest quality healthcare the market can provide to patients. Private insurance companies also merely pay for healthcare, and do not directly receive the healthcare service – thus, their incentive to reduce costs is similar to the governments. But, there is a very important difference; these private companies must compete for customers and this forces them to balance quality with cost in the same way their customers do.\(^{230}\) Moreover, these private companies can raise the cost of insurance for those willing to pay for increased medical care without having to raise the price for everyone.\(^{231}\) Thus, private companies are limited by the

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\(^{229}\) It is estimated that the Government is now responsible for paying for more than 50 percent of U.S. healthcare via various programs, principally Medicare and Medicaid. See, Editorial, *Change Nobody Believes In*, WALL ST. J. December 21, 2009, (quoting Harvard Medical School Dean Jeffrey Flier “our capacity to innovate and develop new therapies would suffer most of all “due to Governments involvement in the business of health care under Obama care). This editorial also notes that “The White House was able to persuade the likes of the AMA and hospital lobbies [to support Obama care] because the federal government will control 55 percent of total U.S. health spending under Obama care, according to the Administration’s own Medicare actuaries.”) Id.

\(^{230}\) Moreover, the best way to insure the best quality health insurance at the lowest cost is to increase competition between insurance companies. Certainly allowing interstate competition between companies and setting up insurance exchanges would help. Also, the government could require a certain disclosure format to help consumers compare various policies.

\(^{231}\) While the government might design a basic “high-value” insurance policy and require each company to offer it (see supra notes 217-230 and accompanying text), there must be choice for consumers. The one-size-fits-all
market in their efforts to cut costs. The government, however, does not have to compete and as a result is not subject to this limitation. The government is subject to the ballot box limitation, but this is very inefficient because elections are only held at certain times and issues are comingled.

Under a government dominated health insurance system the government will be forced to focus more and more on containing the cost of healthcare and it will have no choice (as discussed *infra*) but to institute a system of rationing, and to discourage the development of experimental/new treatments (drugs, procedures, etc.) because this is the only way to significantly reduce the current cost of healthcare, and to keep it from growing.\textsuperscript{232} The net result of this will be lower quality healthcare and this will hurt everyone, rich and poor.\textsuperscript{233} Diseases that could have been cured, treatments and drugs that could have been developed won’t be because we will have, through the government, squandered the money that could have been used to pay for them. Moreover, as noted above, today’s expensive new cure often become tomorrow’s affordable standard treatment. As noted supra, the increased government involvement in the business of healthcare must be balanced by non-governmental market participants. Hospitals can be one of the most important of these non-governmental participants if they are for profit institutions. Thus, in order to balance increased government involvement in healthcare, hospitals should be encouraged to adopt a for-profit taxable business model and increase the competition between hospitals and health insurers. This will increase patient autonomy by increasing patient bargaining power because the patient will be able to shop one hospital against another either

\footnotesize{\textsuperscript{232} See *infra* notes 274-297 and accompanying text.}

\footnotesize{\textsuperscript{233} See *infra* notes 298-318 and accompanying text.}
himself or through his insurance company. Hospitals in order to attract patients will be forced to be responsive to patient not government preferences.

E. Is Patient Autonomy Practical? Are Patients Capable Of Being Intelligent Healthcare Consumers?

1. The Information Problem.

Human health and illness is complex, our current level of medical knowledge is only partial and most patients are not conversant in the technical language of medicine or accustomed to questioning their doctors’ judgments and medical conclusions. In short, there is a great deal of ignorance and confusion regarding healthcare in general and quality healthcare in particular. Thus, many medical decisions are too complex to be left to patients alone. For example, it would be very difficult for patients to judge for themselves whether new drugs or procedures are safe and effective. In addition, it is sometimes argued that many patients are too emotional to be able to properly decide when to cease life support for a parent, or when to refuse treatment for themselves, or for their children; even when the experts think that the best approach is to do nothing. In short, some argue that because of this information problem patients are just not capable of being intelligent healthcare consumers. Generally, those who make these arguments tend to view medical care from a “public health” perspective and are

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234 Also, with the help of the government as referee – not player – consumers will also be able to shop one insurance company against another.
235 See Clarke supra note 17 at 1419-1421 (noting that there is a great deal of ignorance and uncertainty about the quality and various forms of health care); Stempel supra note 224 at 242-251 (suggesting that the patients do not know what is best for them regarding medical care and insurance coverage.) Id.
236 See supra note 235 and note 221 (noting that 50 percent of conclusions based on clinical studies were contradicted within five years; 15 percent were contradicted within one year).
237 The government does properly play an important role in this regard with agencies such as the Food and Drug Administration. This governmental role is that of a referee not market participant.
238 See, e.g., Anna Wilde Mathews, When the Best Rx is No Rx, WALL ST. J. Feb. 16, 2010 at D1 (discussing the division between parents and doctors over whether to prescribe antibiotics for ear infections – some prefer to wait to see if it will heal itself – in part to avoid the development of virulent bacteria from antibiotic over use.)
239 See, e.g., Stemple supra note 224 at 242-251.
driven by numbers; specifically data based calculated averages. They tend to ignore individual patients and individual differences and preferences and think and act in terms of the “average” patient. Moreover, they often do not see the doctor/patient relationship as a good substitute for government control.

Because of the information problem patients cannot independently determine the quality nor therefore the value of the medical care they are purchasing, but this does not have to lead to government run healthcare. If provided with the relevant information by his doctor and by other health information providers, concerning his medical condition, available treatments and their likely consequences and costs, a rational patient could assess the value of the various alternatives. Moreover, the government can and should play an important role in ensuring that

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240 See, e.g., Colleen C. Denny, Ezekiel J. Emanuel, Steven D. Pearson, Why Well-Insured Patients Should Demand Value-Based Insurance Benefits, 297 JAMA 2515 (2007) (citing an example of a schizophrenia medication that is 3 to 9 times more expensive than existing antipsychotics but was no more clinically effective on average than the cheaper earlier drugs – and suggesting that insurers should not be allowed to reimburse for the new drug – but admitting that “The clinical features of a particular patient with schizophrenia, for example, could make a second-generation antipsychotic agent [the more expensive one] substantially more beneficial and valuable than for the average patient.”) Id. at 2517.

241 Id. See also, Stemple supra note 224 at nt. 20 making the point that when deciding whether something like health care is better, it depends on the perspective one takes:

Considering costs and benefits in totality, I operate with the premise that the quality of care increases if, on the whole, a higher quantum of competent medical service is provided throughout society. Thus, I would consider a system “better” if it served all people with B+ level care and eliminated noncoverage and reduced substandard care even if some persons who formerly received A+ or gold-plated care with shorter waiting times would have preferred the current system. Taking this broad view, there is almost no question that the Canadian and Western European systems are “better” than that of the U.S.

Cf., Karpel supra note 30 (referring to the 400,000 non-U.S. residents that obtained medical care in the U.S. in 2008 and that this number will increase at an expected annual rate of three percent; this “inbound medical tourism” driven by the search for high-quality care without extensive waiting periods, many of these patients are escaping from Canada’s supposedly superior health system).

242 See, e.g., Ezekiel J. Emanuel, The Perfect Storm of Overutilization, 299 JAMA 2789 (2008) (criticizing the Hippocratic Oath for encouraging doctors to only be concerned with their patients welfare not cost) Id. at 2790; Groopman and Hartzband supra note 221, noting that notwithstanding President Obama’s promise that “No government bureaucrat will come between you and your doctor” Obama care will in fact do just that in order to force doctors to bring down cost). Id.

243 See, e.g., Clarke supra note 17 at 1420 (“If given full and exact information by his physician about probable consequences of available treatment alternatives, a rational patient could assess the value of the various choices). Id.; Keith T. Peters What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care, 10 J. HEALTH CARE L. & POL’Y 363 (2007) at 364 (with proper information healthcare consumers can make rational choices). Id.
patients have access to the relevant information. But, having government regulate the provision of information to patients and even the safety and efficiency of drugs, devices and procedures is not the same as having the government directly involved in the business of healthcare. A useful analogy is investing. The various laws and regulations relating to investments require that companies who wish to sell stock or bonds to the public provide potential investors with the information that they need to evaluate for themselves the appropriateness of available investments. The government requires and enforces the disclosure, but does not choose the individual investments for investors. The same approach has worked and can continue to work well for healthcare. Consumers are quite capable of deciding what is best for themselves and their families when given access to the relevant information.

In addition, patients do not and should not make medical decisions alone, rather they are made in consultation with the patient’s doctor. The value of this relationship should not be underestimated. It is the most important relationship in healthcare, and the one that holds out the most hope for the future of healthcare in the U.S. because it is a natural and fundamental part of a free market approach to healthcare. Those who take a public health approach undervalue the doctor patient relationship. However, this relationship is most effective when there is a high level of competition between doctors. Thus, the government can help by adopting policies to increase the number of medical schools and financing medical education. When doctors and hospitals, and health insurers compete patients benefit.

2. Healthcare and liberty

244 See, e.g., Peters supra note 243 at 386-90 (calling for an SEC of healthcare).
245 Id.
246 For example, many medications require a prescription from a doctor as do imaging studies and non-emergency hospital admission.
247 Obama care takes this view. See, e.g., Scott Gottlieb, What Doctors and Patients Have to Lose Under Obama Care, THE WALL ST. J. Dec. 24, 2009 at A19 (noting the government premise that doctors often make wasteful treatment decisions, and that Obama Care will subject doctors to a mix of financial penalties and regulations to constrain their use of costly clinical options).
There is a more fundamental difference between those who take a public health view and those who take a private or individual view of healthcare. This difference concerns freedom and liberty. This conflict is not new, but it does seem to be getting more frequent and more severe. For example, there has always been some disagreement regarding whether to require that all children receive various vaccinations. Some parents refuse to get themselves or their children vaccinated because they do not believe that the benefits outweigh the risk for themselves or their child, even though the data show that the benefit does outweigh the risk for the average patient. Others refuse vaccinations because they don’t believe the vaccine is necessary – that is they believe they will likely recover from the disease if they every contract it, and will be left with some beneficial immunity to boot. Others may be philosophically or religiously opposed to vaccinations.

The question is whether, in America, a citizen should be free to refuse to do something even though reasonable people would agree that doing the thing would benefit the individual directly and the rest of society indirectly? Put another way, is each citizen required to act for the greater good by acting for his own benefit, or does each citizen have the right to refuse to act, (assuming such refusal does not directly harm anyone else) even if such refusal will make him worse off in some way. Are we free to be illogical, unreasonable, and inefficient if the only direct negative effects of our being so fall on ourselves?

The current debate regarding whether the government may/should require each citizen to have health insurance is a good example of this old conflict and a good illustration of greater severity of this conflict today. Having health insurance is certainly prudent and it would be

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248 The recent controversy over whether to get the new swine (H1N1) flu vaccination is a good illustration. Childhood DPT shots, especially the pertussis component is another example.

249 See David B. Rikin Jr. and Lee A. Casey, Mandatory Insurance is Unconstitutional, THE WALL ST. J., Sept. 18, 2009 at A23 (discussing the health insurance mandate that is part of Obama Care).
difficult to argue that it’s reasonable to choose not to have it if one could afford it. But does this mean the government can/should require each person to have insurance? Moreover, those concerned by such a requirement wonder whether, if the government can require a person to have health insurance, it can also require him to use it.  

Generally the American legal tradition presumes that citizens have a right to freedom and liberty and that the government has a right to limit that freedom and liberty only when it has a good reason for imposing the limitation. Moreover, the federal government must have a Constitutional grant of power over an area before it can exercise any authority. The health of citizens has usually been considered a state not a federal matter. In addition, our American presumption of freedom and liberty has also traditionally required personal responsibility. That is, the fact that individuals are generally free to do what they want means that they are responsible for what they do. In other words, if you choose to smoke and refuse to pay for medical insurance and you get sick, no one else is responsible for bailing you out – you’re on your own both in making the decisions regarding smoking and purchasing medical insurance and in dealing with the consequences of these decisions.

The point is, as our healthcare goal moves toward government provided coverage it represents a necessary movement away from personal responsibility and therefore a move away

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250 If the government may force citizens to buy health insurance for their own good, may it require citizens to take medication to lower their blood pressure, insulin to control diabetes, or to stop smoking for their overall health? The metaphor of the slippery slope comes to mind.

251 Our founding documents make this principal clear. The Declaration of Independence makes clear that the governments power is limited and emanates from the consent of the governed. The Constitution speaks of “securing the blessings of liberty to ourselves and our posterity.” The Bill of Rights creates a federal government of limited powers and sets up the people as the repository of rights. See U.S. Constitution Amendment IV. These documents make clear that our country was founded on the premise of individual liberty – and that liberty was to be constrained only for good reason.

252 See U.S. Constitution.
from individual freedom and liberty. I submit that it is impossible to move in the direction of
government sponsored universal healthcare without restricting personal freedom and liberty
because resources are limited. If the government agrees to pay for everyone’s healthcare the
government will find itself, as discussed below, focused on controlling the cost of its
commitment to healthcare. This is because the government has limited resources, other
expenses in addition to healthcare, and because no one else in the system other than the
government would have any incentive to control costs (healthcare at the margin would be free).
As discussed below, to control costs the government has limited options; ration care, reduce the
development of new expensive care, and/or reduce the need for care. As discussed infra all of
these options, if pursued by the government will result in a loss of personal freedom.

3. The Third Party Payor Problem: Can Patients Become Value Based Consumers of
Healthcare?

In addition to the information problem discussed above, which effects both patients and
insurers, insurers face another problem; patients have no incentive to seek value in the medical
services they purchase if those sources are fully or close to fully covered by insurance. Patients
always have incentive to purchase the highest quality medical services (the quality of the care
effects them directly), but the concept of value requires consideration of cost as well as quality.
For example, consider the drug Cetuximab, a treatment for metastatic colorectal cancer that costs
about $40,000 for an average course of therapy, cures no one, but extends life by an average of

253 If the government pays for everyone’s medical care, then the government will end up telling everyone what
medical care they may have and when they may have it.
254 See, e.g., Karpel supra note 30 (noting that Obama Care is biased toward bean-counting rather than designed to
maximize American physical and mental wellbeing) Id.; Groopman and Hartzband supra note 221 (discussing the
fact that Obama Care rewards doctors and hospitals for complying with government mandated treatment measures
and penalizing hospitals and doctors who do not comply, and concluding that “bureaucrats could well write
regulations mandating treatment measures that violate patient autonomy”) Id.; McCaughey, supra note 217
(discussing the governments likely rationing of healthcare under Obama Care). Id.
255 See, infra notes 265-318 and accompanying text.
1.7 months. A patient who has insurance that will pay all or most of the cost of this treatment has no reason to consider cost in his decision regarding whether to purchase this treatment. He must obviously consider the quality of the treatment, the likely benefit to him of the treatment and the likely side effects that the treatment may have on him – but cost is simply not relevant to his decision. If, however, the patient were paying directly for the treatment, then he would have incentive to consider the cost of the treatment along with the likely benefits and side effects.

For example, if he is convinced that the treatment will work and his life will be extended by 1.7 months at a cost of $40,000, then he must decide whether he would rather be able to give that amount to his surviving spouse, children or grandchildren or purchase the treatment. It is the point of this article that each patient should be able to make that decision for himself – patients should have autonomy when purchasing medical care and medical insurance.

The problem is how to provide medical insurance but still give patients incentive to consider cost and look for value in their medical care purchases. First, it is important to recognize that this problem, like the information problem can be solved without resorting to government or insurance company based rationing of medical care. Second, the existence of independent competitive for-profit hospitals plays an important part in solving this problem.

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256 See, Denny, Emanuel and Pearson supra note 240 at 2515 (citing Schrag D. The Price Tax on Progress – Chemotherapy for Colorectal Cancer, 351 N. ENGL J. MED. 317 (2004); Cunningham D., Humblet Y., Siena S., et al., Cetuximab Monotherapy and Cetuximab Plus Irinotecan in Irinotecan-Refractory Metastatic Colorectal Cancer, 351 N. ENGL J. MED. 337 (2004)).

257 The point made here is that the patient should consider cost and the patient – NOT THE GOVERNMENT – or some government established committee – should decide whether to incur the cost. And, this can be done by using the free market approach. See, e.g., John F. Cogan, Glenn Hubbard and Daniel Kessler, A Better Way to Reform Health Care, THE WALL ST. J. Feb. 25, 2010 p. A13 (noting that “$5 out of every $6 of health-care spending is paid for by someone other than the person receiving care – insurance companies, employers or the government,” and suggesting elimination of the tax code’s bias in favor of health insurance over out-of-pocket spending; removal of state government barriers to purchasing and providing health services; and reforming medical malpractice laws.) Id.; Jeffrey S. Flier and David Goldhill, Reviving the Health-Care Debate THE WALL ST. J. Feb. 19, 2010 at A-15 (recommending encouraging the purchase of high-deductible insurance coupled with putting money away in health savings accounts, as a way to create an incentive for patients to focus on the cost of their care); See supra notes and accompanying text.

258 See suggestions in note 257 supra.
The best way to solve this problem is to create a freely competitive market for health insurance.\(^{259}\) Moreover, the government can play an important facilitating role here, similar to its role in addressing the information problem. The government can provide an environment where private insurers can compete nationwide for customers. This competition, which could be facilitated through a government sponsored on-line insurance marketplace,\(^{260}\) will result in the types and levels of insurance that people wish to purchase. For example, some insurance companies may offer policies that provide the insured access to a set dollar amount that may be used to purchase certain types of low value care (high value\(^{261}\) care might be covered 100%) with the provision that a certain percentage of the unspent balance of this amount would become part of the patients estate. Thus, if the patient chose to forgo certain low-value treatment, he could leave more money to his heirs. Other insurance companies may offer\(^ {262}\) various levels of co-pay percentages tied to low-value care. For example, 100 percent of the first $1,000, 20% for $1,000-$20 k; 5% from 30K to 100K, etc. Most important this approach leaves the patient, not the government, and not the insurance company, in charge of his own healthcare.\(^ {263}\) In order for a free market to function, we need free competition on both sides of the transaction. The seller’s side consists of hospitals and doctors. Thus, freely competitive for-profit hospitals are crucial to developing a value based healthcare market.\(^ {264}\)

\(^{259}\) One important step would be to allow insurance companies to offer policies nationally.

\(^{260}\) Such a system is part of Obama Care, but will not be fully implemented until 2019. See supra note 5C. Also, Obama Care envisions a one size fits all health insurance policy, which effectively destroys real competition. See Obama Care supra note 5B at Title II.

\(^{261}\) High value care is care that the public health people find significantly extends life or improves quality of life for the average patient. See Denny, Emanuel, and Pearson, supra note 240 at 1518 (suggesting a system of financial incentives within health insurance to “promote the use of high-value interventions but discourage – but not prohibit – the use of low-value, marginal interventions.”) Id.

\(^{262}\) Id.

\(^{263}\) Id.

\(^{264}\) See Stempel, supra note 224 at 277-279 (relating a personal experience with a hospital, in which the hospital would not allow Mr. Stempel’s wife to stay in the hospital following the birth by Caesarian section (after 20 hours of labor) longer than 48 hours notwithstanding Mr. Stempel’s offer to pay the hospitals bill out of personal funds – because insurance at the time only covered a 48 hour stay.) Id. Mr. Stempel does not say, but I feel fairly certain that
F. Do Rising Healthcare Costs Pose Serious Threats to the U.S. Economy?

1. U.S. healthcare costs are high

Many argue that the primary problem with U.S. healthcare is its high cost and especially the high rate at which its costs increase.\textsuperscript{265} Those that share this view argue that the high and ever increasing cost of healthcare is the reason the U.S. currently has 47 million people without health insurance.\textsuperscript{266} Moreover, as costs continue to rise, the number of un and under insured Americans increases.\textsuperscript{267} Also, as the U.S. puts an ever increasing percentage of its GDP to healthcare we pay an ever increasing opportunity cost illustrated by short changing other important public projects such as education and public construction.\textsuperscript{268} That is, just as man does not live by bread alone neither does he live by healthcare alone. Additionally, a moral argument is offered for reducing the rate of increase for healthcare costs. Rising healthcare costs fall hardest on the poor resulting in their inability to access necessary healthcare services and furthering what some see as the inequitable income and resource disparity in U.S. society.\textsuperscript{269}

\textsuperscript{265} See, e.g., Cogan, Hubbard and Kessler supra note 257 (noting that the critical problem is rising costs); Flier and Goldhill, supra note 257 (ballooning costs put health care out of reach, and also crowds out other goods and threatens growth in living standards); Ezekiel J. Emanuel, The Cost-Coverage Trade-Off, 299(8) \textit{JAMA} 947 at 948 (2008) (noting that uninsured and lack of coverage are just symptoms of the real problem which is rising health care costs); Emanuel and Fuchs, supra note242 (U.S. spends more on healthcare per person than any other country); Denny, Emanuel and Pearson, (Why Well-Insured) (discussing the “perilous situation of health care costs in the United States”) \textit{Id.} at 2515. \textit{Cf.}, Karpel supra note 30 (health care costs more because it’s better – we should spend more on it not less).

\textsuperscript{266} See supra note 5A; Emanuel \textit{supra} note 265 at 947-948 (estimating that “for every 10 percent increase in the average family health insurance premium, the rates of the uninsured younger than 65 years increases by .55 percent”) \textit{Id.} at 947-948.

\textsuperscript{267} Id.

\textsuperscript{268} See Denny, Emanuel and Pearson, \textit{supra} note 35 at 2516 (noting that increasing health care costs lead to reduced spending for programs that affect other aspects of patient’s lives). \textit{Id.}

\textsuperscript{269} Id.
It is important to note that not everyone agrees with this assessment. Some argue that the reason healthcare costs more now than in the past is because healthcare today is better. For example, today doctors can cure more diseases, successfully manage conditions that in the past would have resulted in death, alleviate more discomfort, avoid unnecessary surgery through advanced imaging, and provide safer and less invasive surgery when necessary. If these are the reasons healthcare costs more than higher costs are to be applauded not attacked.

It is useful to examine the reasons offered by the cost-is-the-problem group for the high and quickly increasing cost of healthcare and their suggestions for reducing the cost and rate of cost increase. The first reason this is useful is because there is a fair amount of agreement between both groups (those who believe higher costs should be attacked v. those who think they should be applauded) as to the real reasons for the high cost of U.S. healthcare. Second, these real reasons are not the ones most often cited by the press or politicians. Finally, examining these reasons and offered solutions reveals that the fundamental disagreement between these two

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270 See e.g., Karpel, supra note 30 (noting that we are “Confronted for the first time in history with a constant stream of medical innovations that are marvelously effective but tend to be very expensive” and suggesting that we choose life over money – and spend more on healthcare.) It is interesting to note that Dr. Emanuel and colleagues agree with the assessment above regarding the constant stream of medical innovations but see this as an important part of the problem not the solution. See Denny, Emanuel and Pearson, supra note 35 at 2515 (noting that with respect to quickly rising health care costs, “the major contributor is the constant introduction of expensive new medical technologies, including new drugs, devices and procedures.”) Id. But, where they disagree is in their evaluation of the new innovations with Karpel seeing them as “marvelously effect” and the others seeing them as marginally effective at best.

271 See Karpel supra note 30; See also, Clifford Asness, Notable & Quotable, THE WALL ST. J. July 18/19 2009 at A-14

In fact, nobody in the U.S. really wants 1950s health care (or even 1990s health care). They just want to pay 1950 prices for 2009 health care. They want the latest pills, techniques, therapies, general genius discoveries, and highly skilled labor that would make today’s health care seems like science fiction a few years ago. But alas, successful science fiction is expensive....

Health care today is a combination of stuff that has existed for a while and a set of entirely new things that look like (and really are) miracles form the lens of even a few years ago. We spend more on health care because it’s better. Say it with me again, slowly – this is a good thing, not a bad thing....

In summary, if one more person cites soaring health care costs as an indictment of the free market, when it is in fact a staggering achievement of the free market, I’m going to rupture their appendix and send them to a queue in the U.K. to get it fixed. Last we’ll see of them.

272 See supra note 271.

273 See infra notes 265-272 and accompanying text.
groups concerns the definition of what constitutes quality or cost appropriate healthcare and the importance of personal freedom.

2. Why are costs so high: Better healthcare or too much healthcare?

The main reasons for high U.S. healthcare costs are; the constant introduction of expensive new medical technologies, including drugs, devices and procedures; the policy of both public and private health insurers to pay for any beneficial new technology without regard to cost; and a high utilization of selective and expensive medical services such as MRI’s and new drugs by U.S. patients.\(^{274}\)

The United States spends more per person on health care than any other country;\(^{275}\) for 2005 $6,401 per person\(^{276}\) while the next highest, Norway, was $4,364.\(^{277}\) Overall, the United States spends 2.4 times the average of all developed countries ($2,759 per person) on healthcare.\(^{278}\) Those who see cost as the problem usually follow these statistics with the observation that U.S. healthcare is no better than the healthcare in other developed countries it just costs a lot more.\(^{279}\) Others, however, argue that U.S. healthcare costs more because it is better.\(^{280}\)

Again it’s not so much that the two groups disagree on the facts (though they do to some extent) rather it’s the definition of “better” that causes most of the disagreement.\(^{281}\) For example, one reason cited for high U.S. healthcare costs is the “abundance of amenities” in U.S. health

\(^{274}\) See Denny, Emanuel and Pearson supra note 35 at 2515 (the authors characterize the high utilization of selective and expensive medical services as “a systemic overutilization”).

\(^{275}\) See Emanuel and Fuchs supra note 242 at 2789.

\(^{276}\) Id.

\(^{277}\) Id.

\(^{278}\) Id.

\(^{279}\) Id. (stating that “U.S. health outcomes are the same as or worse than those in other countries.) Id.

\(^{280}\) See supra note 271.

\(^{281}\) See, e.g., supra note 270.
care. That is, U.S. hospitals offer more things like privacy, comfort and auxiliary services in hospital rooms than do other countries. In addition, physicians’ offices are more attractively decorated, their waiting rooms more comfortable and, their location more convenient than in other countries. But, is this just a waste of money or should it be considered part of quality?

Consider the fact that the World Health Organization ranks the U.S. 37th in the World in quality. This statistic alone certainly seems to support the argument that U.S. healthcare is not better it just costs more. However, the U.S. was ranked number one among all countries in “responsiveness” by the same organization. Our overall score fell to 37 primarily because the U.S. lacks universal coverage and care is a financial burden for many citizens. Responsiveness, the category where the U.S. ranked at the very top, has two components; respect for the person (including dignity, confidentiality, and autonomy of individuals and families to make decisions about their own care), and client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of provider).

Some argue that “responsiveness” is what most Americans rightly understand as a very important part of quality care. If this is correct, then paying for “responsiveness” may represent good value to the American patient.

The biggest driver of U.S. healthcare costs, however, is overutilization. This overutilization is not across the board, but is focused on new and expensive medical services. For example, the hospitalization rate in the U.S. at 121 per 1000 is lower than most developed

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282 See, Emanuel and Fuchs supra note 242 at 2789 (noting that hospital rooms in the United States offer more privacy, comfort, and auxiliary services than do hospital rooms in other countries.) Id.
283 See Groopman and Hartzband supra note 221.
284 Id.
285 Id.
286 Id.
287 Id. (“This is what Americans rightly understand as quality care and worry will be lost in the upheaval of reform.”) Id.
288 See Emanuel and Fuchs supra note 242 at 2789.
289 Id. at 2790.
countries (the average from the Organization for Economic Co-operation and Development (OECD) is 163 out of 1000). The U.S. ranks 21st out of 30 OECD countries for hospitalization. Doctor visits in the U.S. tell a similar story; U.S. patients have an average of 3.8 annual visits, while the OECD average is 6.8. However the U.S. has more than 2.5 times the number of MRI scanners as the OECD average and U.S. patients receive many more cardiac revascularization procedures (coronary artery bypass grafts, angioplasties and stents) than patients in other countries. With regard to pharmaceuticals, the U.S. not only has a higher per person use rate than most OECD countries (fourth highest), U.S. patients also use more new drugs (drugs that have been available for less than 5 years) that are more expensive than older drugs. Thus, the U.S. spends $752 per person on drugs while the next highest country, France, spends $425.

Finally, in the U.S. both public and private health insurers cover and pay; with only limited exceptions, for any beneficial new medical treatments without considering the cost of the treatment in relation to the amount of benefit provided. The combination of the constant introduction of new medical technologies, the apparent preference among U.S. patients (or their doctors) for these expensive new technologies, and the coverage for such services by most U.S. health insurers has resulted in the ever increasing cost of U.S. healthcare. But, as noted, it’s not about the facts that Americans disagree, rather it’s the interpretation of these facts. To many these facts show a broken and unsustainable healthcare system; to others, these same facts show

290 Id.
291 Id.
292 Id.
293 Id.
294 Id.
295 Id.
296 See Denny, Emanuel and Pearson, supra note 35 at 2515 (noting that with very few exceptions both public and private insurers pay for any beneficial new technology without considering its cost in relation to its benefit). Id.
297 See, Emanuel and Fuchs supra note 35 at 2789 (noting that overutilization of new and expensive drugs and treatments is the most important contributor to the high cost of U.S. health care.) Id.
a properly working system that is, or should be, the envy of the world, and that is at most in need of slight improvement in certain areas.

3. Controlling the rate of increase in U.S. healthcare costs

Popular methods of cost control often cited by politicians such as reducing waste, adoption of digital medical records and tort reform, while important for reasons beyond just cost control and helpful in reducing costs somewhat, would not significantly reduce the costs of U.S. healthcare because they do not address the fundamental reasons for the high cost of U.S. healthcare discussed above. In fact, these popular methods of cost control have been referred to as merely “lip stick cost control.” There is only one way to meaningfully reduce the rate of healthcare cost increase and that is for Americans to use less and especially less expensive healthcare. As noted, many consider this myopic focus on cost to be fundamentally mistaken and risky. The risk is that the pursuit of cost reduction will break a system that is currently working well for most Americans. These folks are in favor of reducing waste in healthcare – those very efforts that are derided as “lip-stick” cost control – but are not in favor of forcing Americans to use less healthcare.

Again, the disagreement comes down to the definition of the word “better.” The cost-is-the-problem group argues that more health care or more expensive healthcare is not necessarily better healthcare. Thus, they see a way to control cost; that is, have Americans use less and especially less expensive healthcare while still maintaining the same quality of the healthcare

[298] See, Emanuel, supra note 265 at 949.
[299] Id. (characterizing such methods as cutting waste, enhancing prevention and wellness, installing electronic medical records, and improving quality as “lipstick” cost control, more for show and public relations than for true change”) Id.
[300] See, Emanuel and Fuchs supra note 35 at 2789-2790 (to bring down costs Americans must use less and especially less expensive health care).
[301] See supra note 271.
they receive.\textsuperscript{302} The idea is that many of the new drugs, imaging technologies, devices and procedures provide only a marginal benefit at a very high cost, and by discouraging or eliminating these services the rate of increase in healthcare costs would be permanently slowed while the overall quality of healthcare would on average remain the same.\textsuperscript{303} For example, one commentator in the area cites the following:

Several examples illustrate this unacknowledged disconnect that often occurs between the marginal benefits and the costs of new technologies. A recent long-term study of schizophrenia medications indicated that second-generation antipsychotics, despite costing 3 to 9 times more than existing antipsychotics, were no more clinically efficacious on average than their predecessors. Cetuximab, a treatment for metastatic colorectal cancer, costs approximately $40,000 for an average course of therapy that cures no one and extends median survival by only 1.7 months. Similarly, bevacizumab, also used to treat metastatic colon cancer, extends median survival for an additional 2 to 5 months at a cost of approximately $50,000 for an average course of therapy. Despite their marginal value, these treatments are routinely covered by health insurance companies.\textsuperscript{304}

The disagreement of the meaning of “better,” or in this iteration of the argument “marginal value,” concerns two questions; better for whom, the specific patient involved or a hypothetical average patient?\textsuperscript{305} And, who decides how many dollars a particular benefit is worth? For example, the commentator cited above seems to conclude that the two to five months of extra life is not worth $50,000. Thus, he seems to value life at some amount less than the range of $333/$833 per day. Shouldn’t this determination be left to the patient and his doctor? Moreover, in the same article the commentator acknowledges that the “clinical features of a particular patient with schizophrenia could make a second-generation antipsychotic agent substantially more beneficial and valuable than for the average patient.”\textsuperscript{306}

\begin{footnotesize}
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\item[302] See, Denny, Emanuel and Pearson supra note 35 (suggesting that the U.S. create a system or group to judge the clinical, cost, and comparative effectiveness of new technologies and suggesting altering how insurance pays for medical services).
\item[303] Id. at 2516-2517.
\item[304] Id. at 2515.
\item[305] Id. at 2517 (noting that averages may not apply to a particular individual). See supra note 241.
\item[306] See, Denny, Emanuel and Pearson supra note 35 at 2517.
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concerned with be the benefit to the individual patient and shouldn’t that individual patient be the one to decide how much that benefit is worth? If so, then we are back to the World Health Organization’s term “responsiveness” – the autonomy of individuals and families to make decisions about their own care.\textsuperscript{307} Responsiveness or patient autonomy is an important part of what Americans mean by quality healthcare.

To reduce the cost of U.S. healthcare some advocate a so-called value based or quality based healthcare system.\textsuperscript{308} Such a system could be implemented in many different ways. One extreme would be a socialized healthcare system in which the government paid for all healthcare, and a government committee decided which new medical services would be available to whom based on the government’s budget and the committee’s definition of quality.\textsuperscript{309} This is a straight rationing system. The other extreme would leave the value/quality decision to the patient and his doctor. This is the system most Americans have now. There is a problem with this system; if the government or other third parties pay for healthcare through government or private health insurance then there is no cost consciousness on the part of patients and thus no cost control.\textsuperscript{310} However, it is possible to reach a compromise that would control costs and allow significant medical insurance coverage for those that currently have no coverage, while maintaining freedom of choice or “responsiveness” for most Americans.

Let’s assume for a moment that the reason for rising healthcare costs is that Americans are receiving too much high cost/low value healthcare. That is, it’s not that Americans are

\textsuperscript{307} See supra notes 265-273 and accompanying text.
\textsuperscript{308} See, e.g., Denny, Emanuel and Pearson supra note 35 at 2515 (discussing the need for “value-based insurance, in which health benefits are designed to reflect the underlying relation of associated costs and benefits for the services covered.”). \textit{Id.}
\textsuperscript{309} \textit{Id.} (calling for the U.S. to adopt “a trustworthy process to determine the value of health technologies and to integrate these findings into the design of health insurance benefits.”) \textit{Id.} at 2516. See supra note 217 noting that the United Kingdom has a committee to do this called the National Institute for Health and Clinical Effectiveness or “NICE.”
\textsuperscript{310} This problem is sometimes referred to as “moral hazard,” the tendency of health care consumption to increase if the recipient of the care does not pay at least a substantial price for the care.
receiving treatments that are not beneficial, rather the argument is that Americans receive too many healthcare services that are not beneficial enough to justify their cost.\(^{311}\) Thus, to meaningfully reduce costs Americans overall must receive fewer high cost/low benefit services.\(^{312}\) In order to accomplish this we must first decide which healthcare services are beneficial enough and to whom, to justify their cost. As noted this decision could be made either by the government via a “Quality Medical Care Committee”\(^{313}\) or it could be made by the market via patients deciding in consultation with their doctor which health care services provide good value for them. Once cost appropriate medical services (the value of the service equals or exceeds the cost to the patient – as determined by either the patient or the government) and cost inappropriate services are identified, then the use of the later can be reduced by a medical care rationing system imposed by the government on those who can’t afford private insurance and by allowing the free market to function for those with private health insurance.

This system envisions a tiered health insurance system with at least two levels of health insurance, one that covers only “high-value” healthcare and one that covers “high-value” and “low-value” healthcare. The later insurance would cost more and have higher deductibles than the former. Even if the classification of healthcare as either high-value or low-value was done by a panel of experts set up by the government and based on the “average” patient, Americans could still have access to low-value care through private insurance. For those with private insurance, the choice of what healthcare to purchase is left to the patient and his doctor. How to pay for the service selected and/or the “low value” insurance coverage is the patient’s problem, but this

\(^{311}\) See, e.g., Denny, Emanuel and Pearson supra note 35 at 2515 (noting that some new medical interventions may not be superior in any way to existing options or may produce only small, marginal improvements but with very few exceptions both public and private insurers in the U.S. pay for any beneficial new treatment without considering its cost in relation to the degree of additional benefit). Id.

\(^{312}\) Id. at 2518 (noting that most of the escalation of health care costs is attributable to spending on expensive new technologies, not wastefulness.) Id. at 2518.

\(^{313}\) See, e.g., NICE supra note 217. Obama Care has no direct counterpart to NICE but has a similar group known as The Patient-Centered Outcomes Research Institute. See Obama Care supra note 5B at Title 6.
represents a big difference from a rationing system that prohibits a patient from receiving a service even if he can pay for it. This system like a free market system allows anyone to have the service they choose as long as they can pay for it. Moreover, this system would allow many who can’t afford access to health care now, to have access at least to high-value health care.  

As discussed above, the biggest disagreement concerns who decide which healthcare services represent good value; the decision could be made by the government, based on a hypothetical average patient and a calculated average value of life, or it could be made by each individual patient based on his or her own circumstances. A tiered medical insurance system allows for both. For all other necessities such as food, clothing, housing, and for things like transportation we have chosen a combined government/free market approach. One possible exception is free public education, but even here we have a defacto tiered system with many parents who can afford it sending their children to private school. While this approach for healthcare will result in a tiered system – with the rich receiving more healthcare than the poor, it seems preferable to either a single payer government run system which would remove patient autonomy for all patients, or the current system that is extremely ineffective and inefficient at providing healthcare for the poor. The government now pays for more than half of the health care in the U.S., it could adopt a reimbursement model that would cover only cost appropriate healthcare “high value health care” under Medicaid and Medicare, thus eliminating government reimbursement for high cost/low value care, while allowing the rest of the market to

314 One source of funds for this would be the billions in taxes that are forgone each year because of the tax deduction given to charitable non-profit hospitals. Another would be the savings from amending government insurance, Medicaid and Medicare to cover only high-value health care.
315 See supra notes 217-234 and accompanying text.
316 See supra notes 158-216B and accompanying text.
317 One could argue that this is not appropriate for Medicare – that it should continue to cover both high and low value health care. But, given Medicare’s precarious financial position changing its reimbursement policy to cover only high value care even though it would require those covered by it to buy a supplemental policy to cover low-value care if this was desired, seems to be a good idea.
function freely. Patients who want access to any and all beneficial medical care could choose to buy more expensive health insurance that would cover both high and low value healthcare. Moreover, as discussed above, a private competitive health insurance market will be able to create insurance policies that make the price of medical care relevant to patients when they are purchasing medical care. Hospitals would play an important part in this process and for a free market approach to work we need for profit taxable hospitals.\textsuperscript{318}

As discussed, non profit tax exempt hospitals do not function well in a free-market based system because they are too dependent on the government for their tax exemption and not responsive enough to individual patients. For profit hospitals are especially important if we are to maintain individual patient freedom and autonomy at least for patients who are not limited to the government’s high-value-only health insurance. Individual freedom and autonomy will only be provided when there is freedom and competition on both sides of the transaction. Hospitals along with doctors represent the bulk of the seller’s side of the healthcare market. Thus, there must be freedom and competition among hospitals, doctors and insurers.

V. PROPOSED SOLUTION

A. Amend the Definition of Charity for Hospitals

Tax law, federal and state, should be amended to provide that a healthcare provider will be deemed charitable only if it offers its services to all members of the public without any demand for or expectation of payment. Taxable healthcare providers should be allowed a tax

\textsuperscript{318} The government will continue to exert great influence over health care even if all hospitals become taxable, because the new government pays for more than half of U.S. health care. While in theory the governments conduct of paying for health care or of providing insurance directly should be stopped, practically this is not going to happen. Perhaps the level of the government’s involvement could be scaled back somewhat or at least future growth could be eliminated. The government is and will remain a significant force in the health care market. It is important to balance that government influence with a strong competitive market of private for-profit hospitals, doctors and insurers and well informed consumers.
deduction for the marginal cost of unreimbursed charity care they provide. Charity care for purposes of this deduction should be defined as the marginal cost (no overhead costs) of care provided to the poor or needy, (those deemed poor or needy would be defined by the provider, without demand for or the expectation of payment or reimbursement from the patient or any third party or entity at any time. Contributions made to taxable healthcare organizations will be considered charitable contributions to the donor only if they are made to a trust established by the healthcare provider for the sole purpose of reimbursing the healthcare provider for the cost of charitable care as defined above. Obviously free care that is so reimbursed would not be tax deductible by the provider. This proposed solution should be phased in so as not to unduly upset the non-profit tax exempt healthcare industry. For example, tax exempt bonds could no longer be issued but those outstanding would need to be dealt with in a reasonable manner.

B. Developing the Best Medical Care and Providing the Poor with Access to Medical Care

No matter what general definition of charity one adopts – whether community benefit or helping the poor, in the context of necessary medical care, the only reasonable definition of charity is free care. Once a person is ill and needs medical care the decision that must be made is whether to treat that person even if he can’t pay for the treatment. I submit that the goal of our health care system should be to provide access to basic/high-value medical care to every person regardless of their ability to pay, while allowing those who can afford it, to purchase access to what some (e.g., the government sponsored committee) may define as low-value medical care. The question then becomes how we achieve that goal? The answer is in two parts. The first part

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319 See Jordon McGregor supra note 7 at 337 (noting the need to allow hospitals to define eligibility for free or reduced rate care based on regional variations in cost of living and citing examples at nt. 174).
320 See generally, Kelley supra note 6 (reviewing the history of the two threads of the definition), and discussion supra notes 39-70 and accompanying text.
321 See supra notes 311 – 315 and accompanying text.
has to do with having the best high-value medical care available in the first place. That is, we need a policy that will ensure that we continue to develop new medicines and treatments to cure diseases we can’t cure today. We need to attract capital to medical research and stimulate innovation in the development and administration of medical care. We must remember that today’s expensive new treatment (low-value care) often becomes tomorrow’s affordable (high-value) standard care. This article argues that the best way to accomplish this goal is to use the free market because this is the most effective tool the world knows for encouraging innovation, productivity and cost control.\(^{322}\) Moreover, this is much more efficient than the cross-subsidization model now in use.\(^{323}\) Specifically, all hospitals, with the exception of free clinics, should be taxable hospitals and competition among hospitals and in medicine in general\(^{324}\) should be increased. Barriers to entry in the hospital industry, and government regulation of the business aspects of medicine, must be reduced. More medical and nursing colleges should be encouraged and student tuition subsidized to increase the supply of medical professionals. In addition, the government should act to encourage the availability of the information patients need to be well informed medical consumers.\(^{325}\)

The second part of the answer concerns how to pay for access to basic/high value medical care for those who can’t pay for it themselves. This article does not purport to answer this question, but argues that the issue of how to pay for medical care for the poor while it is not

\(^{322}\) See supra notes 207-216B and accompanying text.

\(^{323}\) See supra notes 158-206 and accompanying text.

\(^{324}\) Competition should be increased between health insurers and doctors.

\(^{325}\) See supra notes 235-247 and accompanying text. Consumers with good information may choose not to purchase low-value care even if they can afford insurance that would cover it. Obama Care does make some provision for this. See Obama Care supra note 5B at Title III Improving the Quality and Efficiency of Health Care (providing for investment to support research to inform consumers about patient outcomes resulting from different approaches to treatment).
completely unrelated, is best treated as separate and distinct from the issue of how to develop
the best medical care at the lowest cost. More importantly this article argues that these issues
should be kept separate and distinct, because if they are mixed together – by for example, having
a government run healthcare system, the goal of developing and providing the best medical care
at the lowest cost will be all but abandon, and as a result all Americans rich, middle class, and
poor will suffer. With regard to the issue of how to pay for medical care for the poor this
article offers several observations. First, the goal of providing the same healthcare access for all
Americans should be abandoned, because it is not realistic and hinders progress. We should
embrace a system of multi-tiered access to health care. Our goal should be to provide the poor
with access to high-value/basic health care, while allowing/encouraging those who can afford it
to purchase access to more health care which would include various levels of low/value/non-
basic health care. Second, the taxes collected from previously tax-exempt hospitals can be
used to help pay for access to basic care for the poor. Encouraging or allowing a tax deduction
for the provision of community benefit when poor people are going without necessary medical
care is not appropriate or fair. Finally, for those who can’t afford private insurance, the preferred
solution would be for the government to provide medical insurance vouchers, similar to food
stamps that could be used to purchase basic/high-value health insurance in the private market.

326 For example, the government can’t provide health care (drugs, treatments) to the poor or anyone else if the health
care does not exist.
327 See supra notes 320-331 and accompanying text.
328 As a practical matter our inability to move forward with some version of universal access leaves the poor with, in
many cases, no or very limited access. The tiered approach may at least move us forward toward providing
basic/high value health care to everyone, and as noted such an approach is similar to the approach we use for other
necessities such as food and shelter.
329 With proper information provided to the public, these policies will likely develop to cover premium services that
people are willing to pay for like shorter or no waiting periods, generous coverage (though obviously at a price) so
that in the immediate context of a medical decision money is not a relevant concern. Of course many will not be
able to afford this luxury or will not be willing to pay for it even if they can – but for those who want it and can pay
for it the market will and should provide it. By analogy, to avoid the airport security hassle one may charter a plane
or purchase one outright – though in reality most people can’t afford it and many that can do not see sufficient value
in doing so.
However, given the realities of Medicare and Medicaid a more likely alternative would be to embrace a tiered medical insurance system. Under this system government insurance as well as bottom of the line private insurance would cover only high-value medical care. This change would also provide additional funds to help provide access to basic medical care for the poor because government insurance (Medicare/Medicaid) would no longer cover low-value medical care. As noted, more expensive private insurance would be available for most Americans that would cover various amounts of low-value health care with various co-pays and deductibles.

VI. CONCLUSION

Forty-seven million Americans are currently without health insurance and under the most optimistic assumptions 15 million will still lack coverage in 2019 when Obama Care is fully implemented. Yet, notwithstanding this fact, under current law tax-exempt charitable hospitals are not required to provide any free or low cost care to the poor and nothing in the new Healthcare Reform law changes this. Moreover, many tax-exempt charitable hospitals treat the poor very harshly in terms of the prices charged, the collection tactics used, and the upfront cash payments often required. To be clear, this conduct is engaged in by hospitals that purport to be charities and that receive the benefit of being tax exempt. As a result of this anomalous situation there is irresistible pressure building to change the rules applicable to tax exempt charitable hospitals. The question that must be considered very carefully is nature and direction that this change should take. One option with respect to hospitals is to revise the rules to require

330 The government now purchases more than 50 percent of health care in the U.S. See, Flier and Goldhill supra note 257 (government outlays already account for the majority of the nation’s health spending). Id.
331 The free market will allow consumers to buy what they want in terms of benefits, assuming of course that they can afford them. See supra note 329.
332 See supra notes 5A-5C and accompanying text.
333 See supra notes 124-157 and accompanying text.
334 See supra notes 168-206 and accompanying text.
335 See supra notes 158-167 and accompanying text.
charitable hospitals to provide more free care to the poor and indigent, in essence to be more charitable, and commentators and politicians have called for this sort of change. This solution would correct the error made after the passage of Medicare and Medicaid and move the law back in the direction of Rev. Rule 56-185. This article argues in favor of another option that is to stop treating all modern hospitals as charities. An exception would be made for hospitals that provide 100 percent free care to all patients (e.g., free clinics), but under this proposal essentially all modern hospitals would be for profit, taxable institutions. The argument presented here is that the later solution is the best one because it will result in the highest quality health care (where quality is determined by patients) at the lowest possible cost, and is the only solution that will preserve patient autonomy in making healthcare decisions. In addition, this solution will produce tax revenue that can be used to increase the access of the poor and indigent to healthcare. No claim is made however that these new revenues will be adequate to provide sufficient access to healthcare for the poor. However, this article argues that the question of how to provide services (including healthcare) to the poor should be kept separate and distinct from the question of how to provide the best health care for all Americans at the lowest cost. In order to keep these issues separate it is important to balance the government’s involvement with and influence over the business aspects of healthcare. For profit taxable hospitals are very important in providing that balance. Moreover, a tiered insurance system under which government health insurance would cover only high-value care would help control costs and increase access to basic healthcare for the poor. Moreover, the government has an important

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336 See supra notes 1-19 and accompanying text.
337 See supra notes 124-157 and accompanying text.
338 See supra notes 217-255 and accompanying text.
339 See supra notes 320-331 and accompanying text.
340 See supra notes 319-331 and accompanying text.
341 See supra notes 207-216B and accompanying text.
342 See supra notes 320-331 and accompanying text.
role to play in facilitating the flow of medical information to patients; this is similar to the role the government plays in the investment area, so that patients can become informed consumers of medical services. Finally, the government should continue to regulate the safety and effectiveness of healthcare.

\[343\text{ See supra notes 235-247 and accompanying text.}\]