Provisions of Uncompensated Care in American Hospitals: The Role of the Tax Code, the Federal Courts, Catholic Health Care Facilities, and Local Governments in Defining the Problem of Access for the Poor

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I. Introduction

Material deprivation seriously compounds such sufferings of the spirit and heart. To see a loved one sick is bad enough, but to have no possibility of obtaining health care is worse.¹

Despite the promises of Medicare² and Medicaid,³ despite the in-
crease in employment-related private insurance, and despite the increased public awareness of the problem of inadequate access to health care facilities for many indigent citizens, a huge percentage of our population—at least ten percent—is unable to receive the health care they desperately need. This problem is exacerbated by the fact that fewer hospitals provide charity care as the economic pressures of the health care market become more acute and large numbers of hospitals are sold to for-profit chains. Religiously-affiliated hospitals, particularly Catholic hospitals, have directly contributed to the problem of indigent access by transferring indigent patients to public hospitals, and by reducing the volume of charity care they provide.

However, private nonprofit hospitals, including Catholic hospitals, do not deserve all the blame. The Internal Revenue Service (“IRS”), by weakening the charity care standards a hospital must meet to remain tax-exempt, and the courts, by denying standing to indigent plaintiffs who seek to challenge the IRS’s interpretation of the tax code, must also share a portion of the responsibility for the horror stories to which we have grown accustomed.


[[In 1985, fewer private hospitals served the poor because they preferred to transfer the patients to public facilities.” National Health Law Program, Health Care for the Poor in 1985, 19 CLEARINGHOUSE REV. 946, 952-53 (1986).]]

It is estimated that thirty percent of the acute care hospitals in the United States will be run for profit by 1990. Dallek & Lowe, The For-Profit Hospital Juggernaut, 13 S. EXPOSURE 78, 79 (1985). In 1983, the two largest for-profit chains, Hospital Corporation of America and Humana, Inc., had 339 and 86 hospitals, respectively. Id. at 79.

Telephone conversation with health policy analyst at the U.S. Catholic Conference (Feb. 19, 1986).

See infra notes 129-143 and accompanying text.

See infra notes 50-61 and accompanying text.

See infra notes 62-81 and accompanying text.

In Tennessee, an 18-year-old boy, burns covering nearly half his body, was denied a transfer to the Vanderbilt Hospital Burn Unit because he was uninsured. Forced to travel to a United States Army hospital 1000 miles away, he had to have his leg amputated. In California, an uninsured man with a stab wound in his temple died after two neurosurgeons on
This Article will discuss the issue of uncompensated care provided by American hospitals. First, it will discuss the historical background of public, nonprofit, and proprietary (or for-profit) hospitals. Three federal programs designed to increase health care access for the poor—the Hill-Burton Act, Medicare, and Medicaid—will be briefly described. Changes in the interpretation of the Internal Revenue Code (the “Code”) by the IRS, through the revenue rulings that were issued in 1956, 1969, and 1983, will be reflected upon. Implications of the federal tax code will be discussed in light of the decisions that denied indigent plaintiffs their day in court based on their lack of standing to bring suit.

This Article will then address the relationship between the existing IRS stance toward nonprofit hospitals and the state ad valorem tax exemption statutes, including consideration of the fiscal stress placed on local governments by the shift in governmental responsibility created by the IRS's new view of the Code. Finally, this Article will outline the current problem indigents have in achieving access to hospital care and will describe the current makeup of for-profit, nonprofit, and public hospitals. The role of Catholic hospitals in contributing to the problem of indigent access will be explained. In addition, the question of what can be done to promote a renewed emphasis on charity care shall be addressed, focusing on Catholic hospitals, which are slowly implementing procedures to increase the volume of uncompensated care they provide, and on local governments, which are beginning to exert legal muscle against nonprofit hospitals that continually transfer indigent patients to public hospitals. It will be suggested that this legal trend will help the indigent population achieve better access to nonprofit hospitals.

the staff of a private hospital and two public hospitals in surrounding counties refused to accept him. In South Carolina, two children with meningitis were denied a transfer to a regional medical center because they were uninsured and lived outside the country. See Dallek, supra note 5, at 10-11. In Texas, an uninsured laborer with third-degree burns was transferred to Parkland Memorial Hospital in Dallas, with an intravenous tube in place, after three for-profit hospitals refused to treat him. Also, in California, a woman in labor lost her child when a hospital denied her care, even though tests showed that her baby was in distress. See Dallek & Waxman, "Patient Dumping": A Crisis in Emergency Medical Care for the Indigent, 19 CLEARINGHOUSE REV. 1413, 1414 (1986).

The phrase “nonprofits” is used in this article to refer to voluntary nonprofit hospitals, including religiously-affiliated hospitals.


See infra notes 50-61 and accompanying text.
II. CHANGES IN THINKING ABOUT CHARITY CARE: A HISTORICAL OVERVIEW

The early image of the nonprofit hospital as primarily concerned with free care to indigent persons is no longer applicable to the modern hospital.¹⁸

A. The History of Hospitals

Early public hospitals evolved out of almshouses as welfare institutions for the dependent poor.¹⁹ These early hospitals provided sanctuary for indigents,²⁰ criminals, the incurable, the infectious, the terminally ill, and the physically and mentally handicapped.²¹ These hospitals did not serve a medical function, and they were often dirty and crowded. Moreover, there was a stigma attached to those individuals who needed to turn to public institutions for help; thus the nonpoor overwhelmingly avoided early public hospitals. However, it became the policy of public hospitals to accept all patients who sought treatment. Funded through the taxes collected under the authority of local governments, these institutions remained essentially unchanged until the late nineteenth century.

Similarly, early voluntary, or nonprofit, hospitals also performed more of a welfare function than a medical function. Often affiliated with religious organizations and run with a religious mission to care for the poor, voluntary hospitals in the eighteenth and nineteenth centuries cared for the sick poor who had no place else to turn for custodial care. Supported by charitable donations, and by charging the few paying patients in excess of the cost of their care, voluntary hospitals housed the poor in large wards, largely expected the poor to treat themselves, and offered more moral guidance and religious help than medical attention.²²

The function and status of hospitals changed through the late nineteenth century and early twentieth century as a result of several factors.

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¹⁹ The discussion in this section draws on Bromberg, Financing Health Care, supra note 18; SECURING ACCESS, supra note 4; Bromberg, The Charitable Hospital, 20 CATH. U.L. REV. 237 (1970) (hereinafter Bromberg, Charitable Hospital); and STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).
²¹ “Meanwhile, the public hospitals became the providers of last resort, meeting the needs of those who could not find care in the private sector.” 1 SECURING ACCESS, supra note 4, at 140.
²² See STARR, supra note 19, at 148-51. “Early voluntary hospitals had a fundamentally paternalistic social structure; their patients entered at the sufferance of their benefactors had the moral status of children.” Id. at 149.
First, the professions of nursing and medicine became more scientific and more reliable. The advanced education of both professions largely took place in public hospitals, thereby enhancing the reputation of these facilities. Second, medical science and technology—in the forms of better hygiene, anesthesia, clinical laboratories, and x-rays—transformed public hospitals from welfare institutions into community health centers where the limited supply of advanced equipment and technology was centralized. Third, these changes attracted the nonpoor patient who needed the specialized services a hospital could offer, and who was able to pay for the increasingly expensive treatment. As a result, the social composition of hospitals changed until they resembled the population at large, and the hospitals responded by replacing the large wards which housed the poor with private rooms more suitable for their new clientele. Finally, physicians realized that they could make money in the new hospitals and began collecting fees directly from paying patients, rather than as salaried employees of the hospitals. Consequently, when the changes were complete, "[h]ospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue."24

Voluntary hospitals changed particularly during the national economic depression of the 1890's. At this time, the cost of hospital care and the number of poor and destitute increased, and the generosity of charitable donors declined. Voluntary hospitals began implementing "means tests and other devices to assure [their affluent donors] that only the 'deserving' poor would use their services and to help suppress 'idleness and begging.' "25 For the first time, "many private hospital trustees reconsidered their hospitals' traditional role of caring only for the poor."26

After this period, public and voluntary hospitals looked very different. The public hospital, although it now attracted some paying patients who required the technology and services a public hospital had to offer, still cared primarily for the poor and unwanted. Meanwhile, voluntary hospitals openly courted paying patients whose funds, along with charitable donations, helped subsidize the increasingly expensive care provided to the poor.

As the twentieth century progressed, a new player emerged onto the scene. For-profit hospitals, created to serve the affluent patient, could not have been a major institution during the period when the need for hospital care stigmatized a patient as homeless or unwanted. However, after

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23 Id. at 159.
24 3 SECURING ACCESS, supra note 4, at 255.
25 Id. at 256.
the developments of the late nineteenth and early twentieth centuries, a market emerged for hospitals that catered to the wealthy, which offered private rooms, increased attention to their needs, and lacked the presence of poor and needy individuals.

B. The Creation of Programs to Serve the Poor

The escalating cost of hospital care led to the creation of programs designed to protect individuals faced with unexpected hospitalization. The birth of Blue Cross and Blue Shield, the ability of labor unions to bargain for employment-related insurance, and the growing importance of Health Maintenance Organizations ("HMOs") and other pre-paid health plans helped insure that most Americans would be covered in the event of hospitalization.

Beyond these private initiatives, three federal programs made the promise that no American would be without care in his or her time of need. First, the Hill-Burton Act, enacted under the Truman Administration, tied the funding of hospital construction to a commitment by the new facility to provide uncompensated care to indigent citizens. Formally known as the Hospital Survey and Construction Act of 1946, it was a partnership between the federal and state governments whereby federal funds were allocated to the states according to a formula based on relative population and per capita income. The program, designed to reduce the disadvantage rural communities experienced in the building and modernization of hospitals, attached a twenty year requirement on recipient hospitals and mandated that they provide a reasonable amount of free care.

Although the Hill-Burton Act did result in the construction of nearly

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27 For a description of these programs, see 1 SECURING ACCESS, supra note 4, at 91.
28 See generally STARR, supra note 17.
29 Health Maintenance Organizations ("HMOs") were created through the Health Maintenance Organization Act, 42 U.S.C. § 300e (1982 & Supp. 1987). HMOs have:
   four essential attributes: (1) an organized system for providing health care in a geographic area, which provides or otherwise assures the delivery of (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons (4) for which the HMO is reimbursed through a predetermined, fixed, periodic prepayment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amount of actual services provided.
Perkins, supra note 5, at 860.
30 "The vast majority of Americans have health insurance: an estimated 87-90% of the noninstitutionalized population are covered by some form of public or private insurance." 1 SECURING ACCESS, supra note 4, at 90.
31 The discussion on the Hill-Burton Act that follows draws on 1 SECURING ACCESS, supra note 4, at 122-25; 3 SECURING ACCESS, supra note 4, at 261-64; and FRIEDELB, HILL-BURTON: THE SHAPE OF THINGS TODAY AND YET TO COME (1981).
forty percent of the beds in 6000 of the nation's nonprofit and public hospitals, it failed its objectives in a number of ways. First, its matching grant provision proved to be ineffective for poor communities that were unable to raise their local share or get sufficient credit from lenders. Second, many nonprofit, inner city hospitals established satellite facilities in the suburbs which drained resources from the inner city, leaving badly deteriorated hospitals behind and resulting in the closing of many vitally important inner-city hospitals. Third, despite awakened legal advocacy to enforce Hill-Burton obligations, “compliance by hospitals remains spotty; and numerous instances have been documented of Hill-Burton hospitals denying even urgent care to indigent patients.” Fourth, when proprieters buy nonprofit hospitals, they are able to eliminate the facility’s Hill-Burton obligation by paying off the balance of the loan obtained from the government, plus interest, thus rendering unavailable a potential hospital that the indigent many turn to for care. Finally, the Hill-Burton obligation lasts only twenty years, and many hospitals are currently completing the time period required of them. Consequently, although nearly 6000 health facilities had Hill-Burton obligations in 1969, approximately 2500 were left in 1982, and this number is estimated to drop to 1000 by 1990.

The other two federal programs of major significance are Medicare and Medicaid. Medicare, a health insurance program for persons over sixty-five years old and for certain disabled Americans, has a uniform eligibility and benefit structure throughout the country, and has resulted in coverage for many previously uninsured elderly citizens. Although the federal government spent $33.6 billion on Medicare expenditures for the program’s 28.5 million recipients in 1980, Medicare requires copayments and deductibles. The costliness of Medicare led to the controversial shift by the federal government to diagnostic related groups (“DRGs”), which established reimbursement limits to hospitals based on the treatment provided and the age of the enrollee.

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33 These beds were the result of four billion dollars in federal grants and loans and 10.4 billion dollars in state and local matching funds from 1947 to 1974. See 3 SECURING ACCESS, supra note 4, at 261-62.
34 Id. at 262-63.
35 1 SECURING ACCESS, supra note 4, at 128. In no case was the interest rate higher than ten percent, which is considerably lower than most private loans. Id. at n.30. On the other hand, for-profits can choose to retain the Hill-Burton obligation and instead waive the repayment of the loan. See Dallek & Lowe, supra note 9, at 80.
38 1 SECURING ACCESS, supra note 4, at 147. At the inception of Medicare in 1965, the projected cost to the government in the year 1990 was $8.8 billion. This figure was surpassed in 1973. Perkins, supra note 5, at 831.
39 See id. at 849. “Diagnostic related groups: [o]ne of 468 categories of illness into which
Medicaid, however, was the program truly designed to meet the needs of the poor. A partnership between the states and the federal government, Medicaid "has enabled many poor people to get care for the first time or more care; enrollees now see a physician more often than privately insured persons do." Nevertheless, Medicaid has not been a panacea, and it has failed to uphold the promise it offered for several reasons. Initially, states enjoy wide latitude in designing the specific eligibility requirements that will apply within their boundaries; being poor in and of itself is not enough. For example:

The Commission also learned of an Atlanta couple, with one child, who were unable to afford needed care. The husband, an automobile mechanic by trade, had been unable to find work after being laid off. They had virtually no income but were ineligible for Medicaid because they were married; Medicaid in Georgia does not cover families in which both parents are in the home.

In fact, of the thirty-five million Americans who are uninsured for all or part of the year, forty to sixty percent are ineligible for Medicaid. A second problem is that twenty percent of all physicians have no Medicaid patients at all, and just six percent of all doctors care for one-third of all Medicaid patients. Therefore, many low-income citizens and the indigent have difficulty securing private physicians and are forced to rely on hospital emergency rooms and clinics for their basic care. This ultimately serves to increase the health system's costs, while denying the indigent a source of regular care. Another problem is that, because of "the dramatic increase in governmental expenditures for health care for the poor, private donors, under the impression that the government has assumed responsibility for the indigent, have apparently turned their support to other causes and institutions." Consequently, philanthropic donations to nonprofit hospitals have declined dramatically: donations covered less than four percent of the total health care costs by 1975. Finally, the

patients with clinical conditions are placed for which flat payment rates are preestablished. Medicare and some other insurers now pay for hospital services according to DRG classification." Id.

99 Dallek, supra note 5, at 11.
100 1 Securing Access, supra note 4, at 96.
12 Brown, supra note 5, at 930.
13 3 Securing Access, supra note 4, at 266.
15 Id. at 394. Nevertheless, charitable contributions amounted to $3.68 billion in 1972. Bromberg, Financing Health Care, supra note 18, at 158. These contributions support research and education within hospitals, in addition to offsetting operating expenses. Id. at 159.
sheer expense to the government of the Medicaid program has made it an attractive target for budget-cutting.46

C. The Charitable Tax Exemption and the Role of the Internal Revenue Service in Reducing the Volume of Free Care

1. The Charitable Tax Exemption

Internal Revenue Code section 501(c)(3) exempts from federal income tax organizations that are “operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes.”47 Once an organization qualifies under section 501(c)(3), other important tax benefits beyond the exemption from federal income tax follow as well. Donations and bequests to the organization are deductible by individual contributors,48 the United States Post Office offers its preferred second and third class mailing rates,49 and many states follow the federal lead and exempt hospitals from property, sales, and use taxes.50 This package of waived governmental taxes is a “form of subsidy, similar to a cash grant in the amount of taxes the organization would otherwise have paid.”51

Nonprofit hospitals, including those which were religiously-affiliated, traditionally received tax-exempt status from the IRS, largely because they cared for the poor and unwanted members of society.52 Within the last twenty years, however, this prerequisite to achieving tax-exempt status has changed dramatically.

46 Medicaid expenditures grew from a combined federal and state spending level of $6.3 billion in 1972 to a level of $23 billion in 1980. As these costs have risen, so has the government’s willingness to create stricter eligibility guidelines as a cost containment measure. Perkins, supra note 5, at 831 (citing HEALTH CARE FINANCING ADMINISTRATION, THE MEDICARE AND MEDICAID DATA BOOK (1983)).
47 I.R.C. § 501(c)(3).
48 See id. §§ 170, 545(b)(2), 556(b)(2), 642(c), 2055, 2106(a)(2), and 2522 (deductibility of charitable contributions); see also Bromberg, Financing Health Care, supra note 18, at 157.
50 See Bromberg, Financing Health Care, supra note 18, at 159. For a general discussion of the state ad valorem tax exemption, and for an analysis of the relationship between state and federal tax exemption provisions, see infra notes 87-92 and accompanying text.
51 Developments, supra note 36, at 473; see also Regan v. Taxation with Representation of Wash., 461 U.S. 540, 544 (1983) (deductible contributions similar to cash grants of a portion of individual’s contributions).
52 “The term ‘charitable’ has traditionally been tied to the provision of free care to the poor uninsured persons who are unable to pay for necessary medical care.” Developments, supra note 36, at 472; see also Rose, The Implication of the Charitable Deduction and Exemption Provisions of the Internal Revenue Code Upon the Service Required of a Voluntary Hospital to Treat the Poor, 4 CLEARINGHOUSE REV. 183 (1970).
2. Changing Interpretations of “Charitable” Under Section 501(c)(3)

In 1956, the IRS promulgated a revenue ruling to clarify the meaning of the word “charitable” for purposes of exempting hospitals under section 501(c)(3). Consistent with traditional concepts of charity, the ruling required that a nonprofit hospital “be 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.”

For thirteen years this revenue ruling reflected the IRS’s position on the tax-exempt status of nonprofit hospitals. In 1969, however, the IRS abruptly (and without administrative hearings) announced a new stance, modifying the requirement of uncompensated care that a nonprofit hospital must provide to remain tax-exempt. In Revenue Ruling 69-545, a hypothetical, tax-exempt hospital, Hospital A, is described as follows:

The hospital operates a full time emergency room and no one requiring emergency care is denied treatment. The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.

In other words, a hospital can deny admission to all indigent patients other than those in emergency situations and still receive the huge government subsidy tax exemption provides. Moreover, the practice of “dumping” poor, uninsured patients on public hospitals is essentially suggested by this revenue ruling. The rationale the IRS offers for Revenue Ruling 69-545 is that the term “charitable” within the meaning of section 501(c)(3) “encompasses a broad concept of community benefit,” and is not limited to relief of poverty, and that “care for this limited class of patients promotes health and, thus, generates tax exemption.” The IRS posits that because the surplus revenue over expenses of operating a tax-

56 Id. This Revenue Ruling also stated that the exempt hospital:

must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.”

Id. at 203.
57 Rev. Rul. 69-545, 1969-2 C.B. 117. “Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost.” Id. at 119.
58 Id.
59 Bromberg, Financing Health Care, supra note 18, at 165.
60 Developments, supra note 36, at 473.
exempt hospital does not inure to the benefit of a private shareholder, excess funds are applied to the replacement of existing facilities, expansion, improvement in medical care and medical education, and research. As a result, the community as a whole is benefited and health in general is promoted.68

The most recent modification relating to tax-exempt hospitals came from the IRS in 1983.69 Revenue Ruling 83-157, like Revenue Ruling 69-545, attempts to instruct hundreds of nonprofit hospitals through a single example. In Revenue Ruling 83-157, Hospital A does not even operate an emergency room because a "state health planning agency has determined that the operation of an emergency room by the hospital is unnecessary because it would duplicate emergency services and facilities that are adequately provided by another medical institution in the community."70 An emergency room in Hospital A would not promote health because of its duplication of existing facilities; therefore, the hospital may be considered "charitable" for purposes of section 501(c)(3) only on the basis of other factors.71

The combination of Revenue Ruling 69-545 and Revenue Ruling 83-157 strikes a major blow against the provision of indigent care by nonprofit hospitals and the continued fiscal vitality of public hospitals. Revenue Ruling 69-545 rejects as a prerequisite to tax-exempt status the provision of indigent or below-cost care, while allowing nonprofits to transfer such patients to "another hospital in the community that does serve indigent patients,"72 a thinly veiled euphemism for a public hospital. Revenue Ruling 83-157 further closes the door on poor patients by eliminating emergency room access to nonprofit hospitals (the only access left intact by Revenue Ruling 69-545) when a state health planning agency determines that "it would duplicate emergency services and facilities that are adequately provided by another medical institution in the community."73 Therefore, Revenue Ruling 83-157 places sole responsibility for indigent

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The promotion of health . . . is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community."

Id. at 118 (emphasis added).


70 Id.

71 Among the factors found to be important to the IRS are a board of directors drawn from the community, an open medical staff policy, treating Medicaid and Medicare patients, and the fact that surplus funds are applied to improving facilities, equipment, education, and research. See id.


patients on public hospitals in both emergency and non-emergency situations. The local nonprofits are tax-exempt on the basis of requirements that offer them prestige (adding new facilities, upgrading the medical education they provide, and improving existing equipment) and which benefit the nonpoor community members who can afford to pay for the services that are rendered.

3. Standing is Not Available to Challenge the IRS's Interpretation of the Meaning of "Charitable"

The promulgation of Revenue Ruling 69-545 in 1969 shocked the poverty law community, and several cases were brought by poverty law attorneys challenging its unexpected interpretation of the term "charitable" as stated in Internal Revenue Code section 501(c)(3). Most important among these challenges was a case that eventually reached the Supreme Court in 1975, *Simon v. Eastern Kentucky Welfare Rights Organization.*

In *Eastern Kentucky*, several low-income plaintiffs, who were denied access to nonprofit hospitals, and organizations composed of indigent members brought suit against the Secretary of the Treasury and the Commissioner of Internal Revenue. They alleged that Revenue Ruling 69-545 violated the Code and the Administrative Procedure Act. The Supreme Court, in a unanimous decision, held that the plaintiffs lacked standing to bring the suit.

The test applied by the Court, which the plaintiffs failed to meet, was whether the injury to the plaintiffs was “likely to be redressed” by a favorable court decision. The Court held that, although it was clear that the plaintiffs were denied access to the health care facilities involved, it did not follow that “a court-ordered return by petitioners [the IRS] to their previous policy would result in these respondents' [the low-income plaintiffs] receiving the hospital services they desire.” The Court stated that, even if the remedial measure sought (a return to the pre-1969 standard) was granted, it is entirely plausible that the particular hospitals involved would elect to forgo the preferrable tax treatment of section

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47 Id. at 28.
48 Id. at 46.
49 Id. at 38.

[T]he relevant inquiry is whether, assuming justiciability of the claim, the plaintiff has shown an injury to himself that is likely to be redressed by a favorable decision. Absent such a showing, exercise of its power by a federal court would be gratuitous and thus inconsistent with the Art. III limitation."

*Id.* (footnote omitted).
50 *Id.* at 42.
501(c)(3) in order to avoid the financial drain of uncompensated care, and that these particular plaintiffs might not be admitted even if the hospitals did choose to remain tax-exempt. Therefore, the plaintiffs failed to meet the "likely to be redressed" test.\(^7\)

Justice Brennan's concurrence chastised the plaintiffs' counsel for failing to name the particular hospitals involved as defendants and for failing to demonstrate the importance of the tax exemption to these hospitals.\(^7\) If the plaintiffs had demonstrated that the hospitals involved needed the preferrable tax treatment that tax-exempt status provides, Justice Brennan would have been willing to decide, on the merits, the role of Revenue Ruling 69-545 in affecting indigent care.\(^7\)

Following Justice Brennan's lead in Eastern Kentucky, poverty law attorneys in Lugo v. Miller\(^7\) named the specific hospitals involved as defendants, and:

The complaint also alleged that each of the hospitals was so financially dependent upon the favorable tax treatment it received by virtue of its "charitable" status, that it would not relinquish such status if required to provide free or reduced cost services to the poor to the extent of its financial ability as a condition to retaining this tax exempt status.\(^7\)

Despite this improvement in the pleadings, the Sixth Circuit in Lugo adhered to the majority opinion in Eastern Kentucky and denied the plaintiffs standing because the plaintiffs failed to show any connection between the issuance of Revenue Ruling 69-545 and a change in the hospitals' policies toward indigent patients, and because the plaintiffs failed to demonstrate that they specifically would be admitted if the hospitals were forced to provide uncompensated care.\(^7\) Therefore, the plaintiffs in Lugo, like the plaintiffs in Eastern Kentucky, failed to meet the "likely to be redressed" test.\(^7\)

The final nail in the federal standing coffin came in Allen v. Wright,\(^7\) a private school segregation case. In Wright, parents of black
public school children alleged, in a nationwide class action, that their children had a diminished ability to receive an education in racially integrated schools because the IRS continued to provide tax-exempt status to discriminatory private schools. The parents sought a declaratory judgment that the IRS's practices were unlawful, and they sought to remove the tax-exempt status of the private schools.

The Supreme Court dismissed the suit by denying the plaintiffs standing through 'the application of the old test under a new name. Justice O'Connor, writing for the Court, held that, even if the tax exemption were removed from discriminatory private schools, it would be entirely speculative as to whether any particular private school would change its racial composition; whether the parents of children attending the affected private school would transfer their children to public schools; and whether enough children would transfer to affect the racial balance of the public schools. The Court determined that all of the above are necessary to integrate the public schools. Upon finding that there are many possible causes of the problem of segregated schools, Justice O'Connor stated that the “alleged injury is not fairly traceable to the assertedly unlawful conduct of the IRS.” Therefore, the plaintiffs lacked standing, according to Justice O'Connor, because there was no Article III "case or controversy." Under this reasoning, the Court was proscribed from hearing the case under “the idea of separation of powers on which the Federal Government is founded.”

Dissenting Justices Blackmun and Stevens rejected the majority's separation of powers analysis, arguing that it was “undefined, but clearly more rigorous” than earlier standing tests. Justice Brennan, also in dissent, had particularly harsh words for the majority, stating that “[o]nce again, the Court 'uses standing to slam the courthouse door against plain-
tiffs who are entitled to full consideration of their claims on the merits."

The truly troubling aspect of Wright is the unwillingness of the the Court to review executive branch decisions in the area of tax law. Eastern Kentucky and Wright apparently require a plaintiff to prove the merits of his complaint against the IRS in order to cross the standing threshold and earn Article III jurisdiction. The "[Wright] opinion appears to give the IRS sole discretion to interpret the Internal Revenue Code."

Justice Stevens suggests in Wright that lawsuits brought against the IRS in the area of tax-exempt hospitals should fail on standing grounds because, unlike the private schools in Wright, the economic incentives in Eastern Kentucky flowed in two opposite directions and it is not clear that Revenue Ruling 69-545 affected the hospitals' economic decision-making. As a result, lawsuits against nonprofit hospitals and against the IRS, challenging Revenue Ruling 69-545 and Revenue Ruling 83-157, are not currently viable, and the hardship these rulings create for indigent Americans seeking uncompensated care from nonprofit hospitals is a clear part of the health care landscape.

4. The Relationship Between Federal Tax Exemption and State Ad Valorem Tax Exemption

Once it became apparent that both the IRS and the federal courts were ignoring the needs of the uninsured poor, poverty law attorneys turned to the state tax codes, hoping to find leverage against nonprofit hospitals that did not provide uncompensated care to indigents.

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"Id. at 766 (Brennan, J., dissenting) (quoting Valley Forge Christian College v. Americans United for Separation of Church & State, Inc., 397 U.S. 159, 178 (1970) (Brennan, J., dissenting)).

"With all due respect, the Court has either misread the complaint or is improperly requiring the respondents to prove their case on the merits in order to defeat a motion to dismiss." Id. at 775 (footnote omitted) (Brennan, J., dissenting).

"Developments, supra note 36, at 476. One tax commentator suggests that Congress should, at the least, permit lawsuits brought by third parties against the IRS where constitutional injuries are alleged. See Simon, Supreme Court Limits Ability of Third Parties to Sue Agencies Such as the I.R.S., 61 J. Tax'n 400 (1984).

"[I]n Simon [Eastern Kentucky] the plaintiffs were seeking free care, which hospitals could decide not to provide for any number of reasons unrelated to their tax status. . . . Moreover, in Simon, the hospitals had to spend money in order to obtain charitable status. Therefore, they had an economic incentive to forgo preferential treatment." Allen v. Wright, 468 U.S. 737, 788-89 n.6 (1984) (Stevens, J., dissenting).

States require ad valorem taxes against the assessed value of property located in the state. Lately, "[b]ecause of high property tax rates in some states and the changes in hospital staff activities, organization, and equipment in recent years, a hospital exemption from local property tax has become, perhaps, more important than ever before." Manual, supra note 20, at 1.
though states occasionally follow the federal lead and offer a tax exemption to hospitals that are exempt from federal taxes, this is by no means automatic. Very often state courts explicitly reject the import of a federal tax exemption.

State ad valorem tax exemption standards offer indigent Americans three advantages over the federal tax exemption granted in Internal Revenue Code section 501(c)(3). First, state standing rules are often less onerous than those set forth in Eastern Kentucky, Lugo, and Wright, thus enabling poor plaintiffs to challenge particular hospitals in court. Second, "[a] number of states already have clear requirements that charitable, tax-exempt institutions provide free care to the poor." Finally, and most importantly, the state ad valorem tax exemption statutes pit local governments, which must often bear both the fiscal burden of the uncollected tax and the burden of supporting a public hospital, against the nonprofit hospitals in their communities. This factor more than any other offers hope that the uninsured poor will have as advocates local governments, who want to collect property taxes, representing their interests.

III. Toward an Understanding of the Current Problems Faced by Indigent Citizens in Achieving Access to Hospital Care

It would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that person could not at that moment assure payment for the service.

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91 Bromberg, Financing Health Care, supra note 18, at 159.
92 See, e.g., State ex rel. Cook v. Rose, 299 S.E.2d 3 (W. Va. 1982) (standing accorded to third parties to challenge state tax commissioner where cause of action based on general statute affecting public at large, namely state tax code). In Cook, the tax commissioner, under a writ of mandamus, was required to establish standards by which a hospital becomes tax exempt. See id. at 8. The court stated clearly that the fact that the hospital involved had a federal tax exemption only had limited probative value in determining property tax exemptions. See id. at 6.
93 See, e.g., id.
94 Developments, supra note 36, at 477. In Burgess v. Four States Memorial Hospital, 250 Ark. 485, 465 S.W.2d 693 (1971), for example, the phrase "exclusive public charity" in the Arkansas Constitution was held to mean that hospitals must provide care to all patients regardless of ability to pay, and that care for Medicaid and Medicare patients is not the sole prerequisite for an institution to be classified as "charitable." See Burgess, 250 Ark. at 491-92, 465 S.W.2d at 697; see also Iowa Methodist Hosp. v. Board of Review, 252 N.W.2d 390, 392 (Iowa 1977) (hospital operating nursing home denied exemption on nursing home property as no patients accepted if unable to pay).
95 See infra notes 159-171 and accompanying text.
96 Mercy Medical Center v. Winnebago County, 58 Wis. 2d 260, 268, 206 N.W.2d 198, 201 (1973).
A. For-Profit Hospitals Provide Little Indigent Care

The growth of for-profit hospital chains, such as the Hospital Corporation of America (“HCA”) and Humana, Inc. (“Humana”), have dramatically affected upon the amount of uncompensated care that is provided to the uninsured poor. For-profit hospital chains\(^7\) often buy struggling public hospitals, pay off the existing Hill-Burton obligations owed to the government by these hospitals,\(^8\) “change policies in a way that will discourage or prevent noninsured or low-income patients from using the facilities,”\(^9\) implement tougher debt collection policies,\(^10\) skim the most profitable patients and procedures from other facilities,\(^11\) and achieve economies-of-scale through horizontal and vertical consolidations; thus placing nonprofit and public hospitals under intensive competitive pressure.\(^12\)

However, for-profit hospitals are financially successful not because they are intelligently managed, but rather because they systematically exclude the uninsured poor,\(^13\) and charge patients far more than public and

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\(^7\) In 1979, the distribution of hospitals in the United States was as follows:

Brown, supra note 5, at 928.

\(^8\) See supra notes 29-34 and accompanying text.

\(^9\) SECURING ACCESS, supra note 4, at 89.

\(^10\) See id. at 143.

The evidence to date, however, suggests that when these companies [the for-profit chains] do improve the financial positions of public hospitals it is usually by collecting revenue more aggressively from patients and third-party payors (citation omitted), an approach that can raise financial barriers to health care for the poor.”

Id.

\(^11\) 3 id. at 275.

\(^12\) Dallek & Lowe, supra note 9, at 83.


\(^14\) Dallek & Lowe, supra note 9, at 80. “When asked why he would not post notices explaining how to apply for charity care, one HCA administrator in Georgia replied, ‘You wouldn’t
voluntary hospitals charge.\textsuperscript{108} For-profit hospitals are no more efficient or well-managed than nonprofit public hospitals. On the contrary, there is evidence that for-profit hospitals may be less efficient, creating more beds than they need. In Georgia, Humana proposed to build a 100-bed hospital near an existing 330-bed public hospital that itself was seeking approval for an 82-bed expansion. The public hospital, Clayton General, projected eighty-two percent occupancy in its addition, which was necessary to pay for its twenty percent uncompensated care load, while Humana projected forty-five percent occupancy in its proposed hospital. At Clayton General, the paying patients subsidized free care; at Humana, they subsidized excess capacity.\textsuperscript{108}

\textbf{B. Nonprofit Hospitals No Longer Provide a Significant Volume of Uncompensated Care to Indigents}

The diluted IRS standards with respect to the required provision of free care, the accelerating competition within the health care market, and the increasing antipathy patients and third-party payors have for subsidizing uncompensated care have caused profound changes in nonprofit hospitals, including Catholic hospitals.\textsuperscript{107} Voluntary nonprofit hospitals no longer care for the vast number of indigent patients who were admitted when nonprofits first came into existence. Instead, they earn a tax-exempt profit\textsuperscript{108} which can be used, within revenue ruling guidelines, to acquire equipment, add facilities (which are often denied to the poor), improve patient care for the paying patients, and amortize institutional debts.\textsuperscript{108}

Although nonprofits have cut back on uncompensated care for reasons of fiscal survival,\textsuperscript{110} they have made other decisions which have resulted in a diminished level of indigent care. First, many nonprofits have relocated to suburban communities, either directly or by shifting resources to satellite clinics, thus removing vital health care facilities from

\textsuperscript{108} According to one study of 280 California for-profit and nonprofit urban and suburban hospitals, the for-profit hospitals charged twenty-four percent more than nonprofit hospitals and forty-seven percent more than public hospitals per admission, and thirty-eight percent more than nonprofit hospitals and seventy-six percent more than public hospitals in ancillary charges per admission. \textit{Id.} at 82 (citing a study conducted by the New England Journal of Medicine in 1983).

\textsuperscript{109} Rev. Rul. 69-545, 1969-2 C.B. 117; see also supra notes 50-61 and accompanying text.

\textsuperscript{110} Dallek & Lowe, supra note 9, at 79-80.
the inner cities where they are most needed.\footnote{111} Second, nonprofits have increased access barriers, either by requiring cash deposits from potential patients, by requiring that these patients demonstrate an existing relationship with a practicing hospital physician, or by requiring these patients to have insurance other than welfare.\footnote{112} Finally, "[i]n 1981 and 1982, about 15 percent of hospitals [including nonprofits] adopted charity care limits. . . ."\footnote{113}

It appears that nonprofit hospitals are less socially responsible than they have ever been. Despite federal budget reductions in health programs serving the poor, nonprofit hospitals did not increase the level of uncompensated care they provided, as President Reagan maintained they would do in the spirit of voluntaryism. Instead, the amount of uncompensated care decreased.\footnote{114} After Revenue Ruling 83-157,\footnote{115} in many ways little difference remains between nonprofit and proprietary hospitals.\footnote{116}

In addition, nonprofit hospitals have transferred record numbers of indigent patients to public hospitals,\footnote{117} a practice known as "dumping." In a recent study of 467 consecutive adult transfers to Cook County Hospital in Chicago, Illinois, researchers concluded that eighty-seven percent were transferred because of lack of insurance.\footnote{118} At Cook County Hospital, the number of transfers has increased from 1295 in 1980, to 2906 in 1981, and from 4368 in 1982, to 6769 in 1983.\footnote{119} Clearly, then, President Reagan's notion that voluntaryism will compensate for federal funding cutbacks is mistaken in the area of indigent health care. The cost of the 467 studied transfers amounted to $3.35 million, of which $2.81 million was nonreimbursable (uninsured patients). If this is extrapolated to all of 1983, the total cost that was shifted to Cook County Hospital alone through these transfers was $24.1 million, or twelve percent of the hospital's operating budget.\footnote{120}

\footnote{111} 3 SECURING ACCESS, supra note 4, at 272.
\footnote{112} Id. at 400-01.
\footnote{113} Perkins, supra note 5, at 832.
\footnote{114} Dallek, supra note 5, at 12.
\footnote{116} "Although charitable facilities [nonprofits that are exempt under I.R.C. § 501(c)(3) as charitable institutions] must continue to choose their boards from the community and maintain open medical staffs, proprietary hospitals often boast these characteristics." Developments, supra note 36, at 474.
\footnote{117} "[M]any private [nonprofit] hospitals have for years been transferring poor or uninsured patients to public hospitals, admitting only those persons who are well insured or are affluent enough to pay the high cost of hospital care." 3 SECURING ACCESS, supra note 4, at 254.
\footnote{118} Schiff, Ansell, Schlosser, Idris, Morrison & Whitman, Transfers to a Public Hospital: A Prospective Study of 467 Patients, 314 New Eng. J. Med. 552, 555 (Feb. 27, 1986) [hereinafter Transfers]. This study was conducted from November 1983 to January 1984. Id.
\footnote{119} Id. at 552.
\footnote{120} Id. at 556. There are significant human costs as well. The risks to a patient's health rise
C. Public Hospitals Continue to Provide Indigent Care, But Under Enormous Financial Stress

The failure of proprietary and nonprofit hospitals to care for indigent individuals, coupled with the rise in the number of poor people, threatens the financial fabric of many public hospitals and the local communities responsible for supporting them. Public hospitals find themselves trapped by the current make-up of the health care market. On the one hand, public hospitals, like Cook County Hospital in Chicago, receive thousands of indigent patients as other hospitals shrug off responsibility for these individuals, and this costs them millions of dollars. On the other hand, public hospitals must pay market prices in the hiring of staff, the acquisition of equipment and basic goods, and the retention of other services. Consequently, the current health care market places enormous financial stress on public hospitals, by permitting leading proprietaries and nonprofits to dump record numbers of patients on public facilities, and simultaneously forcing public hospitals to pay escalating prices for goods and services with decreasing surplus revenue.

As a result, public hospitals are under financial siege, and the cost of as the patient is subjected to the destabilizing effects of a transfer. The proportion of transferred patients who died was more than twice that of nontransferred patients. Id. at 555. As a resident at Cook County Hospital wrote, "Everyday hospitals send us patients who are at risk of dying in the ambulance on the way over." Bernard, Patient Dumping: A Resident's Firsthand View, 34 New Physician 23, 23 (1985).


"Certain hospitals, particularly the municipal, county, and state institutions . . . traditionally bear the greater part of this [financial] burden." Bromberg, Charitable Hospital, supra note 19, at 249.

Texas and South Carolina have anti-dumping legislation, which penalizes nonprofit and proprietary hospitals that risk patient health in transfers to public hospitals. See Dallek & Waxman, supra note 14, at 1414. Congress enacted similar legislation as part of the Consolidated Omnibus Budget Reconciliation Act. This federal anti-dumping measure became law on April 7, 1986. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164-67 (1986) (codified at 42 U.S.C. § 1395dd (1982 & Supp. 1987)). It penalizes hospitals that turn away emergency room patients, including women in labor, without first stabilizing their condition and ascertaining that another facility will provide access. See id. Hospitals still may transfer patients; basically, a safer trip to the public hospital is provided.

The problem of transfers is by no means unique to Cook County Hospital. Transfers to D.C. General in Washington, D.C. have increased 374% since 1980 and to Parkland Memorial in Dallas also increased 400% over that same period. Dallek, supra note 5, at 12. In addition, in 1979, Los Angeles County hospitals received 21,000 patients from other hospitals. See id. Hospitals still may transfer patients; basically, a safer trip to the public hospital is provided.

Brown, supra note 5, at 932.
operating these hospitals is forcing many local governments to rethink their roles in this distribution of responsibilities. Since financially stressed public hospitals receive less per-patient revenue and cannot use privately insured patients to subsidize uncompensated care to the extent of nonprofit and proprietary hospitals, they cost local governments substantial sums of money. Some governments react to this problem by channeling the necessary resources to these hospitals despite the cost. Others sell their public hospitals to for-profit chains. In some cases the burden is so great that local communities even close the public hospitals. There is, however, another option available to local governments. They can sue, under the state ad valorem tax exemption statutes, the nonprofit hospitals that do not provide a reasonable volume of uncompensated care. Municipalities can bring these suits against nonprofits, alleging that the offending nonprofit hospitals do not satisfy the various charitable purpose requirements listed in most state ad valorem tax exemption statutes.

IV. CATHOLIC HOSPITALS, MUCH LIKE OTHER NONPROFITS, HAVE FAILED TO ADDRESS THE NEEDS OF THE POOR

Carefully crafted budgets, uniform contracting and auditing, joint purchases and ventures are being used at [Catholic] health care facilities which, for decades, had run their affairs in their own, occasionally idiosyncratic, ways. "Stressed hospitals" are defined as "hospitals with deficits on their operating and total accounts." Feder, Hadley & Mullner, supra note 5, at 250 n.6.

"Their relatively low proportion of care to privately-insured patients meant that providers heavily involved in serving the poor were less able than others to generate a financial surplus from patient care." Id. at 241.

That government funds are insufficient to cover care to the poor was not the result of inadequate government effort. Health care spending per 1000 poor people by these hospitals' local governments was almost three times that of the local governments in the communities of hospitals with low proportions of care to the poor, in spite of the fact that the latter were in better fiscal condition . . . and had relatively fewer people below 125 percent of the poverty line . . .

Id. See supra notes 94-103 and accompanying text.

1 See supra note 4, at 144. Public hospitals also close when local physicians and private hospital trustees have enough political leverage that they "successfully apply pressure on local authorities, already anxious to reduce their net health costs, to close the public hospital so that a private hospital can improve its occupancy rate, or retain or increase its allotment of beds." Brown, supra note 5, at 937.

12 For a discussion of this option, see infra notes 159-171 and accompanying text.

Against this background of dwindling access for the indigent, Catholic hospitals, historically intertwined with the notion of free care for the poor, have in recent years vastly neglected indigent care. This has occurred in part because Catholic hospitals only recently realized the importance of professional management, in part because of the fierce competition within the hospital industry, and in part because Catholic hospitals generally treat a larger volume of Medicaid and Medicare patients than other nonprofit hospitals. Thus, there has been a financial inability in most Catholic hospitals to generate a working surplus for the provision of uncompensated care.

Additionally, the failure of Catholic facilities to provide indigent care is caused by certain cultural aspects of Catholicism itself. First, Church thinking places a high value on the administrative autonomy of individual Orders, allowing Catholic health facilities to become largely unaccountable, even to the Church. Second, the internal workings of Catholic hospitals, like other Catholic institutions, are deliberately hidden from public view. Consequently, the Catholic Health Association ("CHA") does not release the information it has gathered on the provision of indigent care at Catholic facilities.

Information that is available, however, discloses that Catholic hospitals, like nonprofit hospitals generally, fail to provide free care to the poor. In 1985, the CHA commissioned the Urban Institute at Georgetown University to study the availability of uncompensated care in Catholic hospitals, fully expecting the results of this study to demonstrate that Church-run health care facilities supplied a generous volume of care. The findings of this survey were to be included in an amicus brief in Redbud Hospital District v. Heckler, but were never included in this brief or

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134 “[Forming joint ventures and paying attention to strategic fiscal matters] is a trend that has existed for a somewhat longer time among non-Catholic hospitals. It took us longer to get going but we’re going fast,” stated Dianne Moeller, Vice President of the Catholic Hospital Association. Id.
135 Telephone conversation with Ann Neale, Vice President of the Bon Secours Health System [a Catholic health Order] (Mar. 27, 1986). In addition, as at other hospitals, third party payors have pressured Catholic hospitals, seeking to reimburse those hospitals at the lower level of Medicaid and Medicare reimbursements for the same procedures. Id.
136 Neither the Catholic Health Association, nor the Catholic Hospital Association, designs or recommends a national Catholic policy toward uncompensated care. These decisions are left to individual Orders and hospitals. Telephone conversation with Mark Unger, Legal Counsel for the Catholic Health Association (Apr. 9, 1986).
137 Id.
138 Id.
139 C-84-4382-MHP (N.D. Cal. June 14, 1985). In Redbud, the issue was whether disproportionate providers of Medicaid should receive special advantages in the current reimbursement system of DRGs. The lawsuit was eventually settled when the Department of Health and Human Services issued disproportionate provider guidelines after the Supreme Court
otherwise published because, according to legal counsel for the CHA, they were “ambiguous.”\textsuperscript{140} Because the results were “ambiguous,” the CHA would not permit the Urban Institute to release the data.\textsuperscript{141} The CHA was scheduled to begin its own study of the provision of uncompensated care at Catholic hospitals in the fall of 1986.\textsuperscript{142}

According to an unnamed source at the U.S. Catholic Conference, the results of the Urban Institute’s research were never published because they demonstrated that Catholic hospitals did not provide an adequate level of uncompensated care, and that they were no better than secular nonprofit hospitals in providing access to the poor.\textsuperscript{143} Moreover, in the study of transfers to Cook County Hospital,\textsuperscript{144} forty-two hospitals transferred poor, uninsured patients to Cook County; Catholic hospitals were among the biggest offenders.\textsuperscript{145} Finally, in Texas, where all hospitals must make their financial data available to the state, it was found that “large disparities [exist] in the amount of indigent care provided by for-profit hospitals and voluntary (not-for-profit, often church-run) hospitals and public hospitals. Typically, public hospitals provide the lion’s share of uncompensated care [86.9\% of the charity care] . . . .”\textsuperscript{146} Clearly, Catholic health administrators are sensitive about this issue. Currently, in addition to the CHA study, a number of measures are under way to address the problem of indigent access to hospital care.\textsuperscript{147}

V. TOWARD THE PROVISION OF UNCOMPENSATED CARE: INVOLVING CATHOLIC HOSPITAL SYSTEMS AND LOCAL GOVERNMENTS

First, last and always, [Catholic] health facilities have to maintain a balance between mission and business . . . . Increased attention is needed to make

\begin{itemize}
\item refused to stay an order for the issuance of such guidelines. See Heckler v. Redbud Hosp. Dist., 473 U.S. 1308 (1985).
\item Telephone conversation with Mark Unger, \textit{supra} note 136.
\item \textit{Id.}; telephone conversation with Jack Hadley and Judith Feder of the Urban Institute (Feb. 12, 1986).
\item Telephone conversation with Mark Unger, \textit{supra} note 136.
\item Telephone conversation with health policy analyst at the U.S. Catholic Conference, \textit{supra} note 10.
\item Telephone conversation with health policy analyst at the U.S. Catholic Conference, \textit{supra} notes 114-16 and accompanying text.
\item Telephone conversation with health policy analyst at the U.S. Catholic Conference, \textit{supra} note 10.
\item Dallek & Lowe, \textit{supra} note 9, at 79.
\item In Boston, Dr. Pamela Pettinati is gathering nationwide information on the provision of uncompensated care in the ninety Sisters of Mercy Corporation hospitals. Telephone conversation with Dr. Pettinati (Mar. 12, 1986). In Chicago, Cardinal Bernardin is forming a consortium of Catholic hospitals, in part to address the provision of uncompensated care for the indigent in Catholic hospitals in the Chicago Archdiocese. Cardinal Law is doing the same in Boston. Telephone conversation with health policy analyst, U.S. Catholic Conference, \textit{supra} note 10.
\end{itemize}
sure that in a market-driven environment with shrinking resources, the mission is not lost.148

Catholic hospitals are moving in the direction of more uncompensated care to the poor. First, by demonstrating a willingness to join the corporate age in the health care market,149 they are becoming better able to achieve multi-institutional efficiencies. This enhances the capacity of these hospitals to generate working surpluses, enabling them to increase the volume of free care they provide to indigent members of the community. Second, the recent acknowledgment of Catholic hospital failings, from within the Church,150 from concerned Catholics outside the religious Orders,151 and from outside the Church, has made Catholic health administrators extremely self-conscious, and has resulted in the studies mentioned above.153

One particular Order has developed a comprehensive plan for facilitating indigent access that should serve as an example to other Catholic health administrators. The Sisters of Bon Secours, a religious Order in Baltimore, Maryland, owns and operates four hospitals, one drug and rehabilitation center, four nursing homes, and several satellite centers.153 In addition, the Bon Secours manage one other hospital and are loosely affiliated with a sixth.

The Sisters of Bon Secours formed a Task Force in December, 1984 which evaluated the hospitals they manage in order to determine whether they were meeting the needs of the poor. The Task Force issued its report in August, 1985,154 which called for several changes in the administration

148 See Bronner, supra note 133, at 19 (quoting Michael Doody, President of Consolidated Catholic Health Care, a Chicago-based association of Catholic hospitals).
149 Fifty-five Catholic multi-institutional systems, many recently formed, represent sixty-two percent of all Catholic hospitals. Id. Moreover, these chains have been active in both horizontal and vertical consolidations. Id.
150 "The full range of human rights has been systematically outlined by Pope John XXIII in his encyclical 'Peace on Earth'. . . . In the first place stand the rights to life, food, clothing, shelter, rest, and medical care." BISHOPS' LETTER, supra note 1, at ¶ 4. Also, Cardinals Bernardin and Law formed their consortiums in part because of the dissatisfaction they felt with the Catholic hospitals in their Archdioceses. Telephone conversation with health policy analyst, U.S. Catholic Conference, supra note 10.
152 See supra note 147 and accompanying text.
153 Telephone conversation with Ann Neale, supra note 135.
and priorities of hospitals that are affiliated with the Bon Secours. Initially, the salary determination procedure of Bon Secours administrators was modified, resulting in remuneration based on the successful adherence to “mission goals” dealing with, among other items, the provision of care to Medicaid and Medicare patients, and uncompensated care to indigents. Mission goals, like “sales targets” in certain jobs, serve as a form of job evaluation in the Bon Secours scheme.

Other structures were put in place as a result of the report. Care for the poor is explicitly included in hospital budgets, rather than handled through residual funds. The poor may submit applications for uncompensated care. Advocates for indigent patients receive one position on the Board of Directors in each Bon Secours facility. Each hospital’s newsletter includes a column on the provision of care to the poor. Seminars and slide shows are regularly conducted for Bon Secours administrators, focusing on the theological and political responsibility incumbent upon administrators to care for the indigent. Collaborative efforts with governmental bodies, other health care facilities, community organizers, health care advocates, and other interested persons “should be pursued to respond to the health care needs of the poor.”

A. Local Governments Must Bring Ad Valorem Lawsuits Against Hospitals, Including Catholic Facilities, That Fail to Provide Uncompensated Care to Indigents

In Utah County v. Intermountain Health Care, Inc., a county government sought review of a Utah Tax Commission decision exempting nonprofit hospitals from ad valorem property taxes, and prevailed on the merits. The hospitals, Utah Valley Hospital and American Fork Hospital, were among 21 nonprofit hospitals in the Intermountain Health Care (“IHC”) chain. While the Tax Commission found that in hospitals in the IHC chain “no person in need of medical attention is denied care solely on the basis of lack of funds,” the chairman of the Board of Directors

160 For purposes of the Report, the poor are defined as “those persons who are unable through private resources, employer support, or public aid to provide payment for health care services, or those unable to gain access to health care because of limited resources, inadequate education, or discrimination.” Id. at 2.
161 Id. at 6.
162 Id. at 8.
163 Id.
164 Id. at 9.
165 Id. at 10.
166 709 P.2d 265 (Utah 1985).
167 Id. at 267.
168 Id. at 274.
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of IHC admitted that: "[W]e provide as a policy in Intermountain Health Care charity care to a certain level, and when I say certain level I should say we provide health. We try not to publish that because everybody wants charity care, and they all consider them as good for charity cases." Between 1978 and 1980, when this lawsuit commenced, this "level" of charity care amounted to less than one percent of the hospitals' gross revenues. Moreover, every effort was made to collect from all patients, free care was not advertised, and Utah Valley Hospital offered to help arrange bank loans for individuals who claimed inability to pay.

The court held for Utah County, finding that the two public policy justifications for a property tax exemption—that tax-exempt organizations provide services the government otherwise would be forced to provide, and that tax-exempt institutions provide a gift to the community that justifies a tax exemption—were both inapplicable to the IHC hospitals. The court further stated, in dicta, that a IHC hospital was no different than a for-profit hospital, and that "there is a serious question regarding the constitutional propriety of subsidies from Utah County taxpayers being used to give certain entities a substantial competitive edge in what is essentially a commercial marketplace."

Local governments have brought ad valorem lawsuits against nonprofits in their communities for many years. Still, it has been only recently that local governments have felt the fiscal bite of indigent transfers from nonprofits, combined with the escalating cost of medical care, to such a degree as to make ad valorem property tax exemption lawsuits a real threat to nonprofits. In fact, the Hospital Law Manual, a legal guide for hospital administrators, warns administrators that, "[f]inancially troubled municipalities are more and more often attempting to increase their revenues by adding to the tax rolls. Hospitals must keep on the alert for any attempt to obtain such revenues from them ... " For example, in 1984, the mayor of Austin, Texas, challenged the tax-exempt status of

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165 Id. at 274 n.13 (emphasis added).
166 Id. at 274.
167 Id.
168 Property taxes are the most important source of municipal revenue. Nationally, in 1970 and 1971, for example, property taxes comprised 64% of the general revenue raised by local governments. Id. at 268 n.5 (citations omitted).
169 Id. at 278.
170 Id. at 276. It is worth noting that two Catholic hospitals filed amicus curiae briefs in support of IHC, arguing that Utah Valley Hospital and American Fork Hospital had provided enough community benefit to warrant ad valorem property tax exemptions. Amicus curiae briefs were also filed on behalf of Utah County, by Salt Lake County, and by Pathology Associates Laboratories, a for-profit corporation. Id. at 267.
171 See Bromberg, Charitable Hospital, supra note 19, at 237.
172 MANUAL, supra note 20, at 26.
all nonprofit hospitals in Austin that transferred charity care patients to the city-owned public hospital.\textsuperscript{173} In other states, similar efforts are under way.\textsuperscript{174}

This approach toward the advocacy of the right to access for indigent Americans is promising for several reasons. Primarily, the political coalition forming between local governments, seeking to reduce the cost of running public hospitals, and poor citizens, desiring access to a greater number of facilities, offers indigents a powerful voice in litigation and, ultimately, settlements. Next, in the \textit{ad valorem} property tax lawsuits brought against nonprofit hospitals, the burden of proof is on the nonprofit hospitals to justify their tax exemption, rather than on the municipality to prove that nonprofit hospitals are not “charitable” institutions.\textsuperscript{175} Moreover, as standing is not an obstacle to the local governments and municipalities that provide the tax exemption to the nonprofits, the merits are heard regarding a particular hospital’s compliance with the state and local \textit{ad valorem} tax exemption requirements.

As a result, the role of local governments in ensuring that nonprofit hospitals, including Catholic facilities like those that dump patients into Cook County Hospital, adhere to the charity care requirements of \textit{ad valorem} tax exemption statutes will increase. This consequence is inevitable in the many communities which are forced to bear a huge financial burden in funding their public hospitals, and it is also a morally and politically sound direction to take in order to guarantee increased access for the poor to health facilities.

\section*{VI. Conclusion}

The emphasis of nonprofit hospitals over the years has changed significantly. What were once almshouses for the poor are now sophisticated facilities, vertically and horizontally connected with other facilities, filled with expensive equipment and a well-trained staff. These changes have

\textsuperscript{173} \textit{Developments, supra} note 36, at 478 (citations omitted).

\textsuperscript{174} \textit{See In re Doctor’s Hosp.,} 51 Pa. Commw. 31, 414 A.2d 134 (1980). In \textit{Doctor’s Hospital}, the court denied a property tax exemption to a nonprofit hospital because all patients were billed, even if the patients were indigent, in order to match revenues with operating costs. The hospital considered itself to be involved in a commercial undertaking. Finding that “quid pro quo” permeated the entire operation, the court rejected contentions by the hospital that it was a charitable institution. \textit{See} 51 Pa. Commw. at 36-37, 414 A.2d at 137-38. In \textit{Canyon County, Idaho Assessor v. Sunny Ridge Manor, Inc.}, 106 Idaho 98, 675 P.2d 813 (1984), the Supreme Court of Idaho removed the property tax exemption from a nursing home that charged its residents a substantial entry fee as well as an additional monthly fee to cover operating costs. In addition, the court emphasized that as only a small portion of the community was benefited, the nursing home did not qualify for special tax treatment. \textit{Id.} at 102-03, 675 P.2d at 817.

\textsuperscript{175} \textit{See Utah County v. Intermountain Health Care, Inc.}, 709 P.2d 265, 273 (Utah 1985).
brought about other changes. Nonprofit hospitals that are tax-exempt are no longer required under federal tax law to provide uncompensated care. Instead, they are permitted to funnel surplus funds into expansion and prestigious capital asset purchases. Moreover, the Supreme Court has made it clear that indigent Americans, those most effected by the changes in the IRS's interpretation of the Code, cannot achieve standing to argue their side. Even Catholic hospitals, charged with a mission to help the poor, have in many cases turned their collective backs on the needy, preferring to relegate their responsibilities to public hospitals.

However, in some subtle ways the tide is turning. State and federal dumping laws are under review. Catholic hospital administrators, stung by criticism inside and outside the Church, have begun to take some initiative into investigating the increased provision of uncompensated care. Local governments, fiscally stressed by the shifting responsibility of care for the poor, have realized that they must challenge the tax-exempt status of the hospitals that are creating their fiscal mess. At this point it is crucial for Catholic hospitals to maintain the direction they are following in studying and implementing increased indigent care, and it is also crucial that local governments keep Catholic hospitals, and other nonprofits, honest.