### WIDENER UNIVERSITY LAW CENTER

Health Law Institute: news, insights, and discussion

Fall 2008

## Health Law Program Retains Top Ten Ranking

nce again, our health law program has been honored by U.S. News & World Report and our colleagues everywhere by being ranked among the top ten health law programs nationally.

Thank you!

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## The Return of "Charity Care"

The Evolving Debate over Nonprofit Hos-Tax-Exempt pitals' Status

By Nicholas A. Mirkay, Associate Professor of Law

ith nonprofit hospitals1 receiving an estimated \$12.6 to \$20 billion a year in federal, state and local benefits on account of their tax-exempt status,2 the commensurate public benefit from that status is once again the focus of federal and state tax authorities

and lawmakers. Although nonprofit hospitals must provide "community benefit" in order to maintain their federal income tax exemption,3 ample disagreement exists on what constitutes, and how to measure, community benefit. A recent Congressional Budget Office (CBO) report compared the community benefit conferred by nonprofit and for-profit hospitals, evaluating primarily "uncompensated care," health care services to Medicaid/Medicare patients, and unprofitable specialized services (e.g., burn victims' intensive care, emergency

room care).4 The report defines uncompensated care as "the sum of charity care (services for which a hospital does not expect payment) and bad debt (services for which a hospital expects but does not collect payment)."5 The comparison, based on a five-state survey, produced mixed results. The CBO determined that nonprofit hospitals provide, on average, more uncompensated care than their for-profit counterparts. However, that provision of uncompensated care varied extensively among individual hospi-

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### Letter from the Director

ever-impressive faculty.

The biggest news is the addition of *Thaddeus Pope* to our tenure-track faculty, beginning with the 2008-2009 academic year. Thad was a visitor during the last academic year from the University of Memphis, where he was an assistant professor of

nce again, it's my pleas- and Ph.D. (in Philosophy) from Thad's scholarship has been ant job to report on some of the Georgetown University. Fol- published in the Tennessee Law exciting developments here at lowing graduation from law Review, Ohio State Journal on the Health Law Institute. I'll school, Thad clerked for the Dispute Resolution, Health start with a report on some of U.S. Court of Appeals for the Matrix, University of Pittsburgh the activities and news from our Seventh Circuit and worked as Law Review, Georgia State

> areas of Health Law and Bio- www.thaddeuspope.com and ship focuses on medical futility end-of-life health law at medilaw, and on the definition and calfutility.blogspot.com. Thad justifiability of hard paternalism

> law. Thad holds both the J.D. in public health contexts. an attorney with Arnold & Por- University Law Review, UMKC LLP in Los Angeles. Law Review, Marquette Elder's Advisor, and ABA Health Thad teaches and writes in the eSource. He posts his articles at ethics. His most recent scholar- tracks recent developments in

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### Letter from the Director

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recently delivered a series of who also serves as the Execupresentations on inappropriate tive Director of Institutes, treatment conflicts to medical somehow found time to comstudents, residents and faculty of plete his latest article, entitled the University of New Mexico "The Law of Doctoring," soon Health Sciences Center. We are to be published in Health Malucky to have him.

Michele Forzley, our Distinguished Visiting Professor, continues to develop her International Public Health Law Information Project and will begin teaching a course in Global Public Health Law this Fall. In addition, Michele is involved in a number of important policy initiatives. She serves as a consultant to the Global Fund Against AIDS, Malaria and TB, where she is collaborating on the development of a policy on product and service donations. She has recently completed a study of problems in medical products procurement across the World Bank, and has also finished writing a book chapter on the use of the criminal law to combat counterfeit drugs. This work, for the Max Planck Institute, is part of a global comparative legal analysis, for which Michele was the country reporter for the United States. Michele appreciated the research assistance she received from two Widener law students.

Professor *James Wu* of Taiwan is concluding a year's residence as a Visiting Scholar. James holds degrees in both law and dentistry, and he and I are collaborating on an article that traces and compares the law of informed consent in the United States and Taiwan.

Professor Andrew Fichter, trix. In this piece Andy undertakes to examine the concept of professionalism as it appears in health law, using definitions developed in classical social science literature. Andy also wrote several pieces on healthcare reform, including one for the Delaware Lawyer, entitled "What If We Do Nothing to Reform Health Care," and one for the Temple Political & Civil Rights Law Review, entitled "State Healthcare Coverage Reform: Where is Federalism Leading Us?" See also his piece on ERISA on page 6, below.

Andy will be the presenter at a Widener Town Hall meeting this fall in which he will compare the health care reform proposals of Presidential candidates Obama and McCain. Along with Professor Pope and me, Andy spoke at the Annual Conference of Health Law Teachers, sponsored by the American Society of Law, Medicine, and Ethics.

Professor *Jean Eggen's* latest of many articles on toxic torts is entitled "The Synergy of Toxic Torts and Public Health: Lessons from a Century of Cigarettes," upcoming in the Connecticut Law Review. Her Toxic Torts in a Nutshell is now in its third edition.

Professor *Nicholas Mirkay* continues his important work on taxation of non-profit entities, most recently with his Losing Our Religion: Reevaluating the § 501 (c) (3) Exemption of Religious Organizations that Discriminate, forthcoming in the William and Mary Bill of Rights Journal. In March, Nick gave a presentation to the St. Louis Area Health Lawyers Association entitled "Recent Developments Affecting Tax-Exempt Health Care Organizations."

Professor Tom Reed, meanwhile, continues at the helm of the Veterans Law Clinic. The importance of the Clinic, which handles the appeals from denials of benefits for veterans, has been confirmed by its receipt of private and public grant funding (from both Delaware and Pennsylvania). This funding has allowed the clinic to expand to both Harrisburg and Chester, where its day-to-day operations are under the direction of supervising attorneys.

In addition to the work of our faculty, other important initiatives and programs continue to keep us excited. On November 17, we will host the 4<sup>th</sup> Annual Raynes McCarty Distinguished Lecture in Health Law, funded by a generous grant from the Raynes McCarty law firm. This year, we are honored to have Professor Timothy S. Jost, Robert L. Willett Family Professor of Law and Ethan Allen Faculty

Upcoming events include a Town Hall Meeting this Fall to compare the Obama and McCain health care proposals and a two-day symposium, March 20-21. 2009, on Medical-Legal Partnerships. Stay tuned for updates on our own entry into the medicallegal partnership arena.

### Letter from the Director (continued)

Fellow at the Washington and Lee School of Law as our speaker. Professor Jost will speak about his recent book, Health Care at Risk: A Critique of the Consumer-Driven Movement, which describes the consumer-driven movement and incisively critiques its potential as a vehicle for health care reform.

Upcoming events include a two-day symposium in the Spring of 2009 on Medical-Legal Partnerships. This event will bring together professionals and academics across a wide, interdisciplinary range, including health care professionals, social workers, and lawyers and legal academics. Stay tuned for details as we put this conference together, and for updates on our own entry into the medical-legal partnership arena - scheduled for Fall 2009.

We are also excited about our new Health Law Institute Research Fellowship, to be inaugurated this Fall. The Fellows will be chosen from among our very best and most motivated students with a strong interest in health law, and will conduct research for faculty and on broader institutional issues. They may also be working under faculty supervision to provide the Delaware legislature with important "white papers" on matters on which the legislators are considering action.

Speaking of collaborations, we have also reached out to area health care institutions —

Christiana Care and the Nemours Foundation — to explore possible joint projects. These informal partnerships will be a continual work-inprogress, but for now will include law student externships at Christiana and visits by Nemours health care providers to our campus to discuss the medical malpractice suits from their perspective.

Because my own principal interest is in public health law, I can't resist closing with a few updates on the subject. In addition to our ongoing work on the Public Health Law Information Project ("PHLIP"), in collaboration with the National Library of Medicine, this Fall will see the first fruits of our joint programs with Thomas Jefferson University's Master of Public Health Program. The first class from the J.D. and M.J. programs will be beginning the second year at Jefferson, and we will be eager to hear back from them, and then to see them at this time next year, when they will complete their course and degree work here. (See sidebar article profiling Shannon Mace, now at Jefferson for her MPH course work after one year here at the law school). In other public health news, several co-authors and I have in the works a book on using a population-based, public health perspective to address important political and social issues. Further developments will be disclosed in the next newsletter.

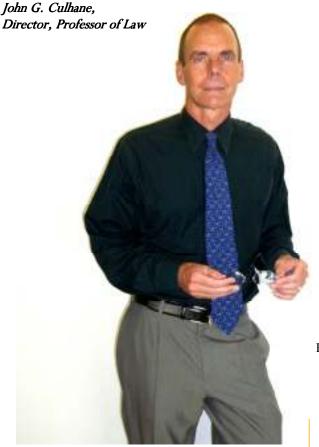
Finally, the just-released

documentary entitled America Betrayed deals in part with the institutional failings of the Army Corps of Engineers that enabled the Katrina disaster; I mention this only to brag that the film features some comments from me about the different ways we compensate victims of tragedy (think about September 11 as compared to Katrina), and how these differences raise some serious questions about justice and equity. The film is narrated by Richard Dreyfuss and is set to hit the "festival circuit" soon.

Let me end by wishing all of you a happy and productive New Academic Year.

Sincerely,

Professor John
Culhane appears in
the just-released
documentary,
America Betrayed,
commenting on
discrepancies in the
ways we compensate
victims of tragedies
such as 9/11 and
Katrina.





Timothy S. Jost, Robert L. Willett Family Professor of Law at the Washington and Lee University School of Law, will lecture on consumer-driven health care reform theories

## Jost to Give Annual Raynes McCarty Lecture

deliver the 2008 Raynes McCarty American Enterprise Institute, insur-Distinguished Lecture in Health Law ance companies and various other on November 17 at locations in industry groups. Professor Josts's Philadelphia and Wilmington. He recent book represents a penetrating will address the subject of his recent analysis and evaluation of the theobook, Health Care at Risk: A Cri- ries and assumptions underlying this tique of the Consumer-Driven movement and of its implications for Movement, which was published in healthcare. 2007 by Duke University Press.

tion for controlling rising healthcare annually through the sponsorship of costs involves making patients per- Raynes McCarty, the Philadelphiasonally feel more of the economic based trial and appellate law firm. consequences of their treatment Lectures will be delivered twice on choices. Its advocates are generally November 17, once at the Union conservative and libertarian theo- League in Center City Philadelphia rists, including the Heritage Founda- and once at Widener's Wilmington tion, the National Center for Policy campus.

Professor Timothy Jost will Analysis, the Cato Institute, the

The Health Law Institute pre-The consumer-driven prescrip- sents the Raynes McCarty Lecture

## Forzley Assesses Barriers to Access to **Essential Drugs in Developing Countries**

Tariffs and non-tariff barriers (NTBs) limit access to finished drugs and developing countries to reduce such and pharmaceutical ingredients in many barriers are generally encouraged and developing countries. (NTBs include facilitated by the General Agreement on preferences given to domestic bidders Tariffs and Trade (GATT) and subsein government procurement programs quent World Trade Organization acand complex packaging requirements.) cords; but negotiations tend to stall Adjunct Professor Michele Forzley calls where developed countries are asked to attention to the problem in a recent relinquish subsidies they provide for policy brief written with Global Health their own agricultural products, and Council staff (available at http://www. developing countries are asked to reglobalhealth.org/images/pdf/ duce their general import tariffs. publications/tarrifs\_09\_2007.pdf).

Negotiations between developed

Adjunct Professor Michele Forzley will offer a special onecredit, two-day course on Hot Topics in Global Health Law this fall. By popular demand the course will be repeated at the beginning of the spring term.

### Charity Care

(Continued from page 1)

largely overlapping.6

In July 2007, the Internal Revenue Service (IRS) released an Interim Report with respect to its Hospital Compliance Project, enumerating the results of surveys sent to more than 500 nonprofit hospitals concerning their community benefit programs practices. Uncompensated care comprised the largest reported expenditure and most frequently reported type of community benefit.8 The report stated that approximately 22 percent of the responding nonprofit hospitals spend less than one percent of their total revenue on uncompensated care; 23 percent spend between one and three percent.9 Although 97 percent of responding nonprofit hospitals have a written charity care policy, no uniform definition of what constitutes uncompensated care emerged from the responses. Specifically, divergence existed in the survey results as to tions?

A late October 2007 roundtable

on tax-exempt hospitals spon- policy. 15 This test reflects the tals, with distributions by non- Committee addressed this char- prior to the 1969 conversion to profit and for-profit hospitals ity care question. In advance of the community benefit stanleased a discussion draft. In patient hospital services promany . . . are sitting in the a pre-billing designation of paexecutive compensation proposed "alternatives to be cally necessary hospital services federal tax-exemption."<sup>12</sup> One medical clinics.<sup>18</sup> meeting the section 501(c)(3) est rate paid by Medicare/ charity requirements, and (2) Medicaid, or (2) actual unreim-(c)(3) will be eligible to receive upon nonpayment, recharactertax-deductible exempt bonds.

whether bad debt expenses and Among other prerequisites,14 Medicare shortfalls are included one of the proposed requirein a hospital's uncompensated ments to maintain exemption community needs assessment care calculation. 10 Accordingly, under section 501(c)(3) is a every three years with an ema fundamental question remains quantitative charity care stan- phasis on vulnerable populaunresolved - how much uncom- dard. Under that standard, a tions, 21 a nonprofit hospital expensated care or "charity care" hospital must dedicate a mini- empt under section 501(c)(3) should nonprofit hospitals pro- mum of five percent of its an- would also be subject to addivide to justify their tax exemp- nual patient revenues or operat- tional rules and restrictions on dance with a written and widely-disseminated charity care

sored by the Senate Finance common IRS audit practice that roundtable, the Commit-dard. 16 Charity care is defined tee's Minority Staff (Staff) re- as "medically necessary in/out acknowledging the varying de- vided without expectation of grees of charity care being pro- payment from or on behalf of vided, the Staff concluded that the individual receiving the hossome hospitals are "helping to pital services." It also includes pull the wagon . . . but far too revenue write-offs as a result of wagon."11 Accordingly, the Staff tients unable to pay for mediconsidered in drafting legislation and medical care provided to reform nonprofit hospital through free and community proposed reform would bifur- Staff's proposal, medical care cate nonprofit hospitals into two would be valued at a rate that tax-exempt classes: (1) those equals the lower of the (1) lowthose meeting the section 501(c) bursed cost to the hospital for (4) social welfare require- the service provided. Bad debt ments.<sup>13</sup> While hospitals will be would not be included in any exempt from federal income tax charity care calculation because under either classification, only it would be "inappropriate" to those exempt under section 501 bill for services and only later, contributions ize it as charity care. 19 The Staff under section 170 and issue tax- acknowledged the necessity of a transition period to satisfy this quantitative standard.20

In addition to conducting a ing expenses to charity care, its joint ventures with for-profit whichever is greater, in accor- health care providers. The Staff

(Continued on page 8)

"[A] fundamental question remains unresolved - how much uncompensated care or 'charity care'should nonprofit hospitals provide to justify their tax exemptions?"

# ERISA: The Law of Unintended Consequences By Andrew Fichter, Executive Director, Institutes

One objective frequently attributed to the federal Employee Retirement Income Security Act of 1974 ("ERISA") is to promote the growth of private benefit plans by preempting the patchwork of state laws that would otherwise burden plan administration. Given this objective, it may seem ironic that ERISA now serves increasingly to limit rather than expand employee benefits, as employers invoke its preemption feature to challenge state and local laws intended to mandate minimum health care benefit packages. ERISA seeks to encourage multijurisdictional employers to offer benefits by removing regulatory obstacles, without exception for those existing in the form of state and local laws that ostensibly share ERISA's purpose of expanding the reach of employer-sponsored plans.

The preemption tool proved its effectiveness against state benefit mandates in 2006 when Maryland sought to force Wal-Mart to pay what state legislators deemed to be its "fair share" of its employees' health care costs. Taking note of employment practices that resulted in total compensation sufficiently low to permit Wal-Mart employees and their families to qualify for Medicaid and State Children's Health Insurance Program programs, Maryland enacted the Fair Share Health Care Fund Act. It was drafted in such a way as to apply only to Wal-Mart and no other employer then conducting business in the state. The Fair Share Act required for-profit employers of a certain size that did not spend at least 8% of payroll on health insurance costs (read Wal-Mart) to pay the difference into a Medicaid support fund. Wal-Mart took the state to federal district court in Retail Industry Leaders' Association v. Fielder, 435 F.Supp.2d 481 (D. Md. 2006), aff'd 475 F.3d 180 (4th Cir. 2007), claiming that the Fair Share Act was preempted by ERISA, specifically by Section 514 thereof, which provided for preemption of any state laws that relate to any employee benefit plan, with certain enumerated exceptions.

Wal-Mart prevailed in district court, and thereafter on appeal to the Fourth Circuit, on the grounds that the Act would have effectively required Wal-Mart to establish a benefit plan with a minimum benefit level set by the state, namely, 8% of payroll. The Act thus *related to* a benefit plan sufficiently to trigger preemption. Maryland countered that the Act allowed Wal-Mart the alternative of paying into a public fund, but the district court dismissed this as a Hobson's choice, observing that no reasonable employer would pay into a fund rather than spend the same amount on employee benefits and reap the goodwill.

In 2007, Suffolk County, New York, lost a preemption challenge to a "fair share" law similar to Maryland's. Retail Industry Leaders' Association v. Suffolk County, 497 F.Supp.2d 403 (E.D.N.Y. 2007). Suffolk County's law was notably different from Maryland's in that Suffolk County linked the charge to employers directly to the cost the County would have incurred for uninsured employees, whereas Maryland specified a percentage of payroll. Under the Suffolk County program, the County would annually estimate the public cost per uninsured employee per hour and require employers to pay that amount into either a public fund or an employee health benefit package. Certain other options were available to employers under the law, but like the Fielder courts, the Eastern District of New York determined them to be illusory, with the result that Suffolk County's "fair share" law also related to employee benefits sufficiently to trigger ERISA preemption.

Can an employer mandate be structured so that it will not relate to employee benefit plans within the meaning of ER-ISA? The phrase "relate to" has been interpreted broadly to take in any state law having a "reference to" or a "connection with" an employer plan. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983). A state law references a plan within the meaning of ERISA where the law immediately and exclusively acts upon the plan, as in Mackey v. Lanier Collection Agency & Services, Inc., 486 U.S. 825 (1988), where a state law prohibited garnishment of plan funds. The effect of the state law on employee benefit plans there was immediate (because not indirect – the law acted directly upon ERISA plans), and exclusive (because it affected only employee benefit plans). Courts have also found sufficient reference to plans where they were essential to the operation of the state law, even without immediacy and exclusivity. An example is California Div. of Labor Standards Enforcement v. Dillingham Constr., Inc., 519 U.S. 316, 325 (1997), where a state law created a wrongful discharge cause of action for an employer intending to avoid its obligations under an employee benefit plan.

On the other hand, the scope of the phrase "relate to" has limits, as the Supreme Court determined in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995). There a state legislature had sought to impose a surcharge on hospital bills for patients covered by commercial insurers other than Blue Cross or Blue Shield, thereby creating an economic incentive for anyone, including ERISA plan administrators, to enroll with the Blues. The

law did not relate exclusively to ERISA plans, but the effect of the law was certainly felt by those enrolled in ERISA plans, then, we can hope for a reconciliation of the divergent posiamong others. The Court held that this connection between the law and employee benefit plans was not sufficient to trigger ERISA, since otherwise all that would be needed for preemption would be for a plaintiff to show an economic effect, however tenuous, on a plan. The Court specifically asserted that cost uniformity was almost certainly not an object of Congress in establishing ERISA preemption. Uniformity of plan administration, structure and benefits from state to state, on the other hand, certainly is an object of ERISA; but if a state law of general applicability regulating health has an incidental effect on an ERISA plan, and does not bind plan administrators to a particular choice, preemption is not justified. At 659.

limitation can rescue an employer mandate from ERISA preemption. In 2006 San Francisco implemented its Health Access Program (known as Healthy San Francisco), which contains an "Employer Spending Requirement." Under Healthy San Francisco, employers must spend amounts varying between \$1.17 and \$1.76 per employee per hour on health care, either through a benefit plan or into a public fund. An employer association's ERISA challenge succeeded in district court, but in January of 2008 the Ninth Circuit granted a temporary stay of the district court's order to permit the city to implement the mandate. 512 F.3d 1112 (C.A.9 2008). Unlike the Fielder and Suffolk County courts, the Ninth Circuit did not deem the choice of contributing the same amount to either an ERISA plan or a public fund (thereby forgoing employee goodwill) to be a Hobson's choice. Rather, the Ninth Circuit took the choice to be justified under Traveler's rationale that laws having the incidental and indirect effect of motivating employers to offer ERISA benefits do not effectively require employers to establish ERISA plans or dictate their terms. The Ninth Circuit accordingly held that San Francisco was sufficiently likely to prevail on the merits to justify the stay.

For better or worse, this nation long ago adopted an employer-based system of providing health care benefits. This has engendered not only the kind of inequitable burden sharing among employers that drove Maryland and Suffolk County to pursue Wal-Mart to pay its "fair share", but also a huge national insurance coverage gap. There are just too many population subgroups not included among insured employees, Medicare/ Medicaid/ SCHIP eligibles, and those sufficiently affluent to be privately insured. The universe of solutions to this problem would include exchanging the employer-based coverage system for one at either the state or federal level based on general revenues. Such a solution has proved to be beyond the reach of our political will, however, which leaves us in the space ERISA inhabits.

Confining ourselves to solutions to the ERISA problem, tions of the Fourth and Ninth Circuits as to employer "pay or play" mandates. Is the choice between providing minimum health care benefits and paying into a public fund a Hobson's choice or a real one? If it can be a real one, "pay or play" legislation may be structured so as to survive preemption.

The ERISA problem could also be resolved by legislative or administrative action. Congress could finally respond to calls to make ERISA work within the health care environment. A less intrusive way of proceeding, however, may be for Congress to authorize the Department of Labor to issue ERISA waivers for states and localities wishing to establish employer coverage minimums. A waiver program would be consistent The Ninth Circuit seems convinced that the Travelers with ERISA's presumption against preemption of state or local laws regulating matters that fall within traditional state police powers. Dillingham, at 325; ERISA §514(a). Waivers could be granted for reasonably delimited programs. Based on findings of state legislatures to the effect that the current system enables certain employers effectively to shift the cost of employee health care to public programs (475 F. 3d 180, 184), it is reasonable to expect that the Department of Labor would look favorably on waiver applications from jurisdictions establishing and quantifying such costs, as Suffolk County attempted to do.

> True, a waiver program would compromise ERISA's objective of establishing uniform regulatory conditions for plan administration across all jurisdictional lines, but compromise seems reasonable where employers could otherwise shift a burden onto a state or locality. It is one thing for an employer to be discouraged from offering a benefit by multijurisdictional requirements, and another for an employer to be able to pass costs on to the jurisdiction in question. It would be hard to argue that this was ever ERISA's intent.



Andrew Fichter, Executive Director, Institutes

### Charity Care

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Prof. Mirkay teaches tax, nonprofit and business law at Widener's Delaware campus. Before Widener he was a partner in the tax department at Lewis, Rice & Fingersh in St. Louis, after serving in the IRS Office of Chief Counsel and as an Attorney-Advisor to the U.S. Tax Court.

recommended that any joint venture conferring patient care must have its own charity care policy. As to wholehospital joint ventures (the nonprofit hospital transfers all or substantially all of its assets into the venture), the venture is subject to the same charity care standard as hospitals and the tax-exempt hospital must "control" the venture's board.22 With respect to ancillary joint ventures (the nonprofit hospital places a portion of its assets into the venture), the nonprofit hospital must control the venture's charity care policy and each nonprofit hospital participant in the venture must have one voting seat on the venture's board.<sup>23</sup> The nonprofit hospital's proportionate share of the venture's charity care, based on its investment percentage in the venture, may be credited towards fulfilling its own charity care standard.

With respect to IRS enforcement of these proposed standards, the new Schedule H of the revised IRS Form 990, Annual Information Return, would provide the majority of information on charity care and joint venture participation necessary for such enforcement. In addition, under the Staff's proposal, the IRS would be provided an arsenal of sanctions to impose on any nonprofit hospital that fails to meet the requirements for tax-exempt status under either section 501(c) (3) or section 501(c)(4). These sanctions include (1) a new excise tax (amount equal to at least twice the hospital's charity care shortfall based on a three-year average), (2) expansion of the section 4958 excise tax on excess benefit transactions with respect to joint ventures with for-profit health care providers, and (3) possible revocation of the nonprofit hospital's tax exemption.24

Not all legal experts on the nonprofit sector support a charity care test as the fundamental standard for section 501(c)(3) exemption. Professor John Colombo, a participant in the roundtable discussion, suggested an alternative "enhancing access" test, which would grant exemption only to nonprofit hospitals that establish that they "either provide substantial services to the general population that are otherwise unavailable from for-profit competitors or . . . provide services to populations underserved by for-profit competitors."25 In support of his proposal, empirical research indicates that qualitative differences exist between forprofit and nonprofit hospitals as to the services provided.26 For instance, nonprofit hospitals are more likely to offer

valuable, but unprofitable, services such as psychiatric emergency care, AIDS treatment, burn units, trauma services and obstetric care.<sup>27</sup> In addition, for-profit hospitals tend to respond more readily to changes in financial incentives, such as home health care when it was profitable, and exit more quickly when the profitability decreases. Therefore, the conclusion drawn from the research is that these distinctive features, rather than charity care alone, justify the continued tax exemption of nonprofit hospitals.28

Although this recent focus on nonprofit hospitals' tax exemption is not novel, it is also not likely to evaporate quickly. A House bill has already been introduced that would institute a minimum charity care requirement and similar Senate-initiated legislation has been threatened.29 The detail and tone of the Staff's discussion draft, as well as the IRS's compliance initiatives, arguably reveal a concerted objective to institute some bright-line standard for nonprofit hospitals' tax exemption. The primary question that remains is whether this reform will continue to be governmentally driven or whether it will emerge from the nonprofit hospital sector itself.

### Charity Care

- <sup>1</sup>Unless otherwise indicated, the term "nonprofit hospitals" refers to hospitals exempt from federal income tax under section 501(c) (3) of the Internal Revenue Code of 1986, as amended.
- <sup>2</sup> MINORITY STAFF OF S. COMM. ON FINANCE, TAX-EXEMPT HOS-PITALS: DISCUSSION DRAFT 2 (July 19, 2007) (hereinafter, DISCUSSION DRAFT), available at http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf.
- 3 See Rev. Rul. 69-545, 1969-2 C.B. 117. Factors that demonstrate a "community benefit" include: (i) An emergency room that is "open to all persons" (i.e., no one requiring emergency care is denied treatment); (ii) hospital care provided to all persons in the community able to pay the cost thereof either directly or through third party reimbursement (including both private health insurance or public programs such as Medicare); (iii) an open medical staff, with members of its active staff having the privilege of leasing available space in its medical building; (iv) control of the hospital rests with a community board of trustees comprised of independent civic leaders; and (v) any surplus in operations used to improve the quality of patient care, expand its facilities, and advance medical training, education, and research. See also Rev. Rul. 83-157, 1983-2 C.B. 94.
- <sup>4</sup>CONG. BUDGET OFFICE, NON-PROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 1 (Dec. 2006), (hereinafter CBO REPORT), available at http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf). The survey focused on California, Florida, Georgia, Indiana, and Texas utilizing 2003 data.
- <sup>5</sup> *Id.* at 1-2. Limitations on available data prevented the CBO from separately quantifying charity care and bad debt.
- 6 *Id*
- <sup>7</sup> Fred Stokeld, EO Guidance, Compliance Dominate Panel Discussions, TAX NOTES 217 (Oct. 15, 2007).

- <sup>8</sup> I.R.S. HOSPITAL COMPLIANCE PROJECT INTERIM REPORT 1 (July 19, 2007) (hereinafter INTERIM REPORT), available at http://www.irs.gov/pub/irs-tege/eo\_interim\_hospital\_report\_072 007.pdf. After uncompensated care, the next largest components of community benefit expenditures were medical education and training (23% of aggregate expenditures), medical research (15%), and community programs (6%). *Id.* at 48.
- <sup>9</sup> *Id.* at 24.
- <sup>10</sup> *Id.* at 26-28. Forty-four percent of responding hospitals included bad debt expense and 20 percent included Medicare shortfalls in their calculations of uncompensated care. Although uncompensated care comprised the largest reported expenditure, other community benefit costs included medical education and training, research, and community outreach and education. *Id.*
- DISCUSSION DRAFT, *supra* note 2, at 2.
- <sup>12</sup> *Id.* at 3.
- <sup>13</sup> *Id*.
- <sup>14</sup> Other standards required for section 501(c)(3) exemption are: (i) written and widely-disseminated charity care policy; (ii) special rules for joint ventures with for-profit entities; (iii) board composition and governance reforms; (iv) limitations on charges billed to uninsured; (v) restrictions on unfair billing and collection practices; (vi) transparency requirements; and (vii) sanctions for noncompliance Id. at 3. Similar requirements are imposed on section 501(c)(4) exemption. *Id.* at 3.
- <sup>15</sup> *Id.* at 7. In formulating this standard, the Staff reviewed charity care requirements or proposals of Illinois, Texas, Rhode Island, and Pennsylvania, as well as other federal laws. *Id.* at 9-10.
- <sup>16</sup> *Id.*; *see* Rev. Rul. 56-185, 1956-1 C.B. 202, which required hospitals to demonstrate charity care for eligibility under section 501(c)(3). Specifically, "hospitals were required to operate to the extent of their financial ability for those unable to pay for services rendered." *Id.* at 4.
- <sup>17</sup> DISCUSSION DRAFT, *supra* note 2, at 7.
  - 8 Id. at 8. Charity care would

- also include grants to other taxexempt health care providers that administer free health care services to "vulnerable populations" through clinics. *Id*.
- <sup>19</sup> *Id*.
- <sup>20</sup> *Id.* At 7.
- <sup>21</sup> *Id.* at 12. "Vulnerable populations" are defined as ones "with barriers to care: financial, transportation, disability, language, etc." *Id.*
- <sup>22</sup> *Id.* at 11. The Staff following the meaning of "control" set forth in Rev. Rul. 98-15, 1998-1 C.B. 718 and Rev. Rul. 2004-51, 2004-22 I.R.B. 974.
- DISCUSSION DRAFT, *supra* note 2, at 11.
- <sup>24</sup> *Id.* at 15-16.
- <sup>25</sup> JOHN D. COLOMBO, STATEMENT TO SENATE FINANCE COMMITTEE MINORITY STAFF ROUNDTABLE ON TAX EXEMPTION STANDARDS FOR NONPROFIT HOSPITALS 1 (Oct. 30, 2007), available at http://finance.senate.gov/press/Gpress/2007/prg102607c.pdf; see also John D. Colombo, Federal and State Tax Exemption Policies and Healthcare for the Poor, 51 ST. LOUIS U. L.J. (2007).
- <sup>26</sup> Jill R. Horwitz, Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals, 50 UCLA L. REV. 1345, 1354-55 (2003).
- <sup>27</sup> *Id*.
- <sup>28</sup> *Id. generally.*
- <sup>29</sup> Diane Freda, *Thomas Introduces Hospital Bill to Require Minimum Charity Care*, DAILY TAX REP. (Dec. 12, 2006) at G-7; Diane Freda, *At Roundtable, Hospitals, Patient Advocates, Split on Mandatory Charity Care, Standards*, DAILY TAX REP. (Nov. 1, 2007) at G-4 (Senate Finance Committee ranking Republican Charles Grassley "told the roundtable that those who are trying to water down the standard for community benefit . . . could actually tip him over to reform legislation. . . .").

Prof. Mirkay's recent publications include "Losing Our Religion: Re-evaluating the  $\S 501(c)(3)$ Exemption of Religious Organizations that Discriminate" (forthcoming, 2008); "Is It 'Charitable' to Discriminate?". 2007 Wisc. L.Rev. 47 (2007); and "Relinquish Control! Why the IRS Should Change Its Stance on Exempt Organizations in Ancillary Joint Ventures," 6 Nev. L.J. 21 (Fall 2005).

## Spotlight on Shannon Mace: Dual Degree Candidate

Shannon Mace, 24, is among the first students to embark on the JD/MPH program. Shannon has just finished her first year at Widener, and has a September start to her MPH course of study at Thomas Jefferson University in Philadelphia. She will return to Widener for her final two years after that.

Hailing from "the middle of coal country," in Mt. Carmel, PA, Shannon graduated from Temple University in Philadelphia in 2006 with a degree in Biological Anthropology. She then worked for a year as a social worker for the Philadelphia Corporation for Aging before beginning her legal studies in 2007.

Shannon's interests are ideally suited to the joint program. As her undergraduate degree indicates, she is interested in biology and social and medical issues, but didn't think a medical school education and a subsequent career as a physician suited her. "I wanted to see things on a grander scale, looking at policy," she stated. "I'm attracted to the field of population genetics, and the public health degree ties together many of my interests. The JD degree gives me more options, too." Among those options might be working inhouse as counsel for a non-profit, or possibly a hospital, she added.

And while she's still unsure of her career goals, Shannon is confident that the multiple yet related perspectives of the law and public health will serve her well. "I can see myself doing lots of different things," she said, "possibly including teaching, likely at the undergraduate level."



### Widener Survey Provides Insight on Senior Healthcare

n conjunction with the Pennsylvania Department of Education, Widener released preliminary findings from "The Widener Elder Pennsylvanian Survey," which included investigation into the reactions of 750 elder Pennsylvanian adults born in 1964 or earlier towards Convenient Care Clinics (CCCs). The survey found that while boomers aged 43 to 64 were most interested in using these clinics, many also expressed concerns regarding the quality of care likely to be delivered. "These clinics provide many advantages for quick, convenient, and inexpensive alternatives to doctors' offices or emergency room visits," said Dr. Eric Brucker, professor of economics and principal investigator of the survey. "While we see a fair number of people indicating that they would likely consider using a clinic, future success is somewhat hampered by current perceived disadvantages." The survey found that age plays a significant role in a person's likelihood of using a CCC. Among respondents aged 43 to 49, more than half were likely to use the clinics. However, that number dropped to a mere 25% among those over 80 years of age. In addition, respondents without health insurance were more likely to use a CCC than those with, and women in the survey indicated they worry about misdiagnosis at a CCC, yet they were more inclined to use these types of facilities than men. "We believe that as the CCC's advantages become better known and they establish a reputation for quality care, we will see an increase in usage across the state and a growing number of clinics in operation," said Dr. Brucker. Currently, 37 clinics are in operation throughout the state, with 13 in the Greater Philadelphia region.

### Form 990 – Is Your Organization Ready?

## John R. Washlick, Esq. Cozen O'Connor



John R. Washlick is a Member of Cozen O'Connor in Philadelphia, and Co-Chair of the firm's Health Law Practice Group. Among many other distinctions, he was named a Pennsylvania Super Lawver by Law & Politics in 2008; he was honored with inclusion in the 2008 edition of The Best Lawyers in America; he was elected a Director of the American Health Lawyers Association; and he is both an Adjunct Professor at Widener School of Law and a Member of the Health Law Institute's Advisory Board.

On December 20, 2007, the IRS released its final updated version of Form 990, Return of Organizations Exempt From Income Tax. Essentially, Form 990 requests detailed information about What the organization is doing to further its exempt purposes and How it is doing it. Much of the information requested on the new Form 990 is the culmination of various IRS initiatives that have focused on board transparency and accountability. In fact, many will be surprised when completing the new Form 990 to discover that some of the questions on the form are not legally required, but relate more to best practices. The new Form 990 lays out a checklist of policies and procedures that the IRS expects non-profit health organizations to have developed and implemented. In addition, the new Form 990 requests significant information that some organizations may not have traditionally captured or tracked. Many organizations will need to start now to review their information systems to make sure they can appropriately and accurately complete Form 990, and, in consequence, devote adequate financial and human resources to assure compliance.

Best governance practices, transparency, and accountability are messages that resonate throughout the new Form 990. Form 990 now essentially imposes on exempt organizations compliance with policies that the IRS perceives as best practices, and that it acknowledges are not required under the law. As a result, there are a number of new board and corporate policies that the IRS will expect charitable organizations to develop, adopt, and implement.

Many of the good governance themes in the new Form 990 were first introduced by the IRS in its draft "Good Governance Practices for 501(c)(3) Organizations," released by the IRS, first as a draft, in February 2007, and later published in final form on February 26, 2008. In that guidance, the IRS "strongly" encouraged organizations to review and consider adopting specific policies and procedures to help ensure that directors understand their roles and responsibilities and actively promote good governance practices.

The new Form 990 is yet another reminder to the boards of exempt organizations of their fiduciary duty of care with respect to income tax compliance matters. Compli-

ance with the new Form 990 and the IRS-recommended board governance best practices should be at the top of every board's agenda. new Form 990 focuses on areas of concern identified by the IRS in the past. It is relying on the redesigned Form 990 to provide transparency to those areas, in particular, fundraising, compensation, legislative activities and tax-exempt bond post issuance compliance. Another reason for exempt organization boards to pay careful attention to the new Form 990 is that information gathered by the IRS most likely will lead to future rulings, regulations, and enforcement action.

In addition to IRS scrutiny, two bond rating agencies, Moodys and Fitch, as well as a number of professional trade associations, have weighed in with their support for governance reform. These agencies now take into consideration in their bond ratings of a particular institution the organization's governance policies and board involvement with compliance matters.

WIDENER UNIVERSITY LAW CENTER



Health Law Institute: news, insights, and discussion

### **Upcoming Events**

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- Raynes McCarty Lecture: Professor Timothy S. Jost on the consumer-driven healthcare movement (see Article p. 4)
- Town Hall Meeting: McCain/ Obama Health Care Proposals
- Nemours Foundation presentations on experiencing medical malpractice litigation

### Spring

- Symposium, Delaware Campus: "Medical-Legal Partnerships" (Mar 20-21)
- Advance Directives Outreach (Student Health Law Society)
- Open House for Master of Jurisprudence in Health Law applicants
- Health Law Career Day

#### Summer

- Summer Program in Geneva
- MJ Program begins (June)

Visit our website at www.law.widener.edu for dates and locations

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