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The existence of a health crisis in this country is universally acknowledged. While the costs of medical and hospital care have far out-distanced the inflationary spiral in the consumer price index over the past decade,[1] the health status of the American population vis-a-vis the rest of the industrialized world has seriously deteriorated.[2] At the same time the public hospitals have become progressively more overcrowded, underfinanced and understaffed. In the past two years these hospitals have also faced threatened loss of accreditations, have been forced to shut down facilities and services, and have been sued by both

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1. Since 1950, health expenditures have risen more than 400 percent. If we compare the rise in the per diem cost of hospital care against the overall consumer price index since 1959 (the last base period), we find that by 1969 hospital costs soared over 250 percent of the 1959 rate while the overall CPI reflected a 125 percent rise. *See* COMMITTEE FOR NATIONAL HEALTH INSURANCE, WHY HEALTH SECURITY 15-16 (1971). The most dramatic upturn occurred after 1965, for two reasons: (1) the advent of Medicare and Medicaid, 42 U.S.C. §§ 1395-1396 (Supp. V, 1970), gave the aged (those over 65) and the poor (chiefly categorical assistance recipients) government-paid hospital coverage, thus putting more demand into an economic system in which cost fluctuates with demand; (2) the Fair Labor Standards Amendments of 1966 extended that Act to cover hospital workers, 29 U.S.C. § 203 (Supp. V, 1970), thus partially eliminating the subsidization of the health care system by the working poor employed by the hospital system.

2. *E.g.*, in 1951-53 the United States ranked lowest among 15 industrialized countries in maternal mortality; by 1966 it dropped to seventh among these same countries; 22 WORLD HEALTH STATISTICS REPORT NO. 6 (1970).

In none of the areas of major health status measurements does the United States rank high. In 1968 the United States ranked 13th among a selected group of developed countries in infant mortality; UNITED NATIONS, POPULATION, AND VITAL STATISTICS REPORT, Series A, XXII, No. 1 (1970). In the same year the United States also ranked 18th in male and 11th in female life expectancy among other industrial countries. *See generally* COMMITTEE FOR NATIONAL HEALTH INSURANCE, WHY HEALTH SECURITY 1-8 (1971). See P. DEVISE, SLUM MEDICINE: CHICAGO'S APARTHEID HEALTH SYSTEM, ch. 1 (1969), for a description of the interrelationship between poverty and health status in a major American city.

poor people and young doctors charging that the hospitals are not complying with minimum standards of medical care in violation of statutory, regulatory, and constitutional obligations.[3] During the same period private hospitals have begun to abandon their historic charitable mission and have closed their doors to persons unable to pay for medical services.[4] The nearly 40 million persons without hospital and medical insurance have been trapped between insufficient services in the public hospital sector and denial of admission into the private sector. Groups ranging from the American Medical Association to the United Automobile Workers have proposed legislative solutions, and the twin issues

3. Underfinancing, shutdown services, accreditation problems, and quality-of-care standards are all related. With respect to accreditation, Cook County Hospital in Chicago was on the verge of complete shutdown as a result of political interference in the running of the hospital and deplorable patient care conditions. *See* Chicago Daily News, May 20, 1970, at 1, col. 1. It was given a one-year provisional accreditation in 1970 by the Joint Commission on Hospital Accreditation. Similarly, D.C. General Hospital in Washington, D.C., was given a one-year provisional accreditation in 1970 (*See* HOSPITAL WEEK, Sept. 4, 1970), and was sued in 1971 for failing to provide minimum standards of medical care. Greater Washington D.C. Area Council of Senior Citizens v. D.C. General, Civil No. 275-71 (D.D.C. 1971). Boston City Hospital lost its accreditation in January 1970, but thereafter was given a one-year provisional accreditation; St. Louis City Hospital was disaccredited in September 1969. 27 MED. CARE REV. 584-85 (1970). In Los Angeles some 75 interns and residents in internal medicine brought suit against the Los Angeles General Hospital, challenging the quality of care which conditions there forced them to render to patients. Fisher v. Los Angeles County, Civ. No. 968621 (Super. Ct. L.A. County 1969). A subsequent review by the Board of Supervisors (*Final Report on Investigation of Charges Made by Young Doctors*, April 13, 1971) and independent charges brought by "establishment" surgeons (Los Angeles Times, June 3, 1971, at 1, col. 1), confirmed many of the allegations. In New Orleans, lack of funds caused Charity Hospital to temporarily close down 500 of its 2100 beds in May 1970, at a time when it was daily turning away 25 to 50 patients who ordinarily would have been admitted as inpatients at private hospitals; it was subsequently named as a defendant along with ten private and district hospitals in the New Orleans metropolitan area in an action charging, *inter alia*, discrimination against the poor. Cook v. Ochsner Foundation Hosp. 319 F. Supp. 603 (E.D. La. 1970). Charity has been operating on a temporary license from the state for the past two years. In Philadelphia and New Jersey, the shutting down of services at public hospitals because of lack of funds has also resulted in litigation by the poor. Boone v. Tate, Civil No. 713 (C.P. Phila. County). *See* HOSPITALS, May 16, 1971, at 24.

4. *E.g.*, in New Orleans two private hospitals, Sara Mayo and Flint-Goodridge Hospital of Dillard University, closed their "free or below cost" clinics in 1970. *See* Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603 (E.D. La., 1970) (*Answers to Interrogatories*): the same thing is happening all over the nation. *See, Public Hospitals Live With Recession, Some May Die of It*, MODERN HOSPITAL, April, 1971, at 40-41, reporting that private hospitals in New York and Houston are also curtailing or eliminating charity service.

This dual problem of the deterioration of the public hospital and closed doors of the private hospital has been recognized by persons within the inner sanctum of the hospital field. Thus, in the July 1970 issue of HOSPITALS, (which is the official publication of the American Hospital Association), devoted to the plight of the public hospital, its feature editor states:

> Whereas the 'mainstream' of health care during the 1950s and early 1960s was progressive and represented by research-oriented medical centers, public hospitals became the 'dumping grounds' for the medically indigent and had come to be identified

of financing and delivery of health care have been, and continue to be, the subject of intensive investigation by the two congressional committees (House Ways and Means and Senate Finance) in which these subjects are merged for consideration.[5]

Apparently disregarding the severity of these health problems, the Internal Revenue Service (IRS) thrust itself into the crisis by fashioning a tax policy with deleterious implications for the health of the indigent. In October 1969, IRS reversed its longstanding position that private hospitals, if they wish to retain tax-exempt status under the Internal Revenue Code, must not deny services to persons unable to pay.[6] This reversal of a longstanding definition of "charitable," which had been reflected over the years in decisions of the tax court and the federal courts, was issued while Congress was considering and rejecting the feasibility of so amending the Internal Revenue Code.[7] The reversal of policy with regard to the obligation to serve the indigent as a condition of tax exemption was in the form of a Revenue Ruling, a way least likely to give opponents an opportunity to challenge the policy, on either a legal or a policy basis. IRS thereby foreclosed consideration of the implications of its ruling in the context of national health policy which the Senate Finance Committee considered necessary for appropriate consideration of the subject.[8]

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with a dual standard of health care delivery. The passage of Medicare and Medicaid legislation in the mid-1960s was expected to unify the dual system. Unfortunately, the private sector has not absorbed its proportionate share of the sick poor.

HOSPITALS, July 1, 1970, at 54.

This problem of the private hospitals "dumping" patients onto the public hospitals has been cited as one of the factors contributing to the crisis in public hospitals throughout the country. As stated by the interns and residents suing Los Angeles County Hospital, "The root of the problem . . . is the private hospitals in the county which transfer to County-USC all the patients who are unwanted for one reason or another." Los Angeles Times, Jan. 13, 1970, at 3, col. 2. Across the country, in the District of Columbia, a survey of patients by Georgetown University students uncovered 30 cases of patients harmed by transfer from private hospitals to D.C. General. The Washington Post, March 30, 1970, at 1, col. 2.

5. These Committees not only consider tax policy and tax reform legislation, they also are considering the operation of the Medicare and Medicaid system and the various proposals and substitutes. *See, e.g.*, STAFF OF THE SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID, PROBLEMS, ISSUES, AND ALTERNATIVES (Comm. Print 1970); *Hearings on Medicare and Medicaid Before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance*, 91st Cong., 2d Sess., pt. 2 (1970).

6. Rev. Rul. 69-545, 1969-2 CUM. BULL. 117.

7. *See* H.R. CONF. REP. 782, 91st Cong., 1st Sess. 289-90 (1969).

8. S. REP. NO. 552, 91st Cong., 1st Sess. 61 (1969). The Senate Committee deleted the amendment appearing in the House version of the bill which would have adopted the position of Revenue Ruling 69-545, stating that "it decided to reexamine this matter in connection with pending legislation on Medicare and Medicaid." *Id. See also* STAFF OF THE SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID, PROBLEMS, ISSUES, AND ALTERNATIVES 55-58 (Comm. Print 1970).

The Revenue Ruling

The ruling issued by IRS in October 1969, provides in part:

> In order for a hospital to establish that it is exempt as a public charitable organization under § 501(c)(3) it must . . . be operated for the care of all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, . . .[9]

This ruling expressly reversed a 1956 ruling, which interpreted the Internal Revenue Code as requiring that hospitals must provide free patient care to qualify for tax-exempt status. The earlier ruling specifically required that a qualifying hospital:

> Must 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. It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It 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 who it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.[10]

In sharp contrast with the 1969 ruling, the 1956 ruling did not reflect the view that a hospital might totally exclude those unable to pay for services yet confer a public, charitable benefit within the meaning of the Internal Revenue Code. The "policy" described in the 1956 ruling did not originate at that time with IRS; it had long been accepted by the Tax Court and federal courts which considered the issue.[11] Indeed, even its critics concede it was a longstanding policy and the 1969 ruling constituted a "major revision."[12] Thus, in 1969 IRS abandoned a well-recognized principle of federal tax law in a most informal way, without congressional sanction, and in the face of congressional action

9. Rev. Rul. 69-545, 1969-2 CUM. BULL. 117.
10. 1956-1 CUM. BULL. 202.
11. *See* notes 57-70 and accompanying text *infra*.
12. Bromberg, *The Charitable Hospital*, 20 CATHOLIC U.L. REV. 237 (1970).

which expressed, at the very least, disagreement with the timing, if not the substance, of the change.

The Role of the American Hospital Association

To understand the full implications of the IRS's actions, it is necessary to review the events immediately preceding the Revenue Ruling, including the role of the American Hospital Association (AHA) and the response of Congress to its pleas.

In 1969 the American Hospital Association attempted to obtain tax-exempt status and tax deduction eligibility for hospitals under Sections 501(c)(3) and 170 of the Internal Revenue Code, without regard to the amount of services rendered to persons unable to pay. It sought to obtain such benefits by means of amendments to the Internal Revenue Code. Witnesses appeared in support of such propositions before the House Ways and Means Committee in February 1969.[13] AHA representatives advanced the proposition that the mere existence of a nonprofit hospital facility whose purpose is the advancement of health is charitable.[14] To support this, AHA argued that the amount of free care required was uncertain, that universities, symphony orchestras, and jazz festivals obtained tax-exempt status without regard to the relief of the poor, that the 1956 ruling and the Treasury regulations were inconsistent on the definition of "charitable" issued under the 1954 Code, and that Scott on the law of charities in trusts[15] supported the AHA proposed definition of "charitable" for tax purposes.

Congressman Gibbons of Florida questioned the AHA spokesman about the effect of removing the tax-exempt status requirement of service to the poor. Despite their protestations that voluntary hospitals carried "a public trust," he voiced skepticism about future hospital beneficence if the coercive pressure to serve the poor was removed.[16]

No one testified on behalf of the poor, and no reference was made to the inadequacies of the present dual system[17] in dealing with their hospital needs.

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13. *Hearings on the Tax Reform Act of 1969 (H.R. 13270) Before the House Comm. on Ways and Means*, 91st Cong., 1st Sess., pt. 4, at 1425 (1969).

14. *Id.* at 1428, 1433.

15. *Id.* *See* notes 31-37 and accompanying text *infra* for a refutation of AHA's position.

16. *Id.* at 1440-41.

17. The dual system of health care is that which places the indigent and medically indigent into the public hospital system. It has been widely attacked for creating the quality-of-care crisis for the poor. *E.g.*, "A dual system of health care—one for the indigent, another for paying patients—is indefensible as a concept and unacceptable as a practice. That view represented

The House bill, as reported in August 1969, provided that "hospitals" be added to the list of Section 501(c)(3) organizations and to the list of organizations to which Section 170 contributions could be made, thus "freeing" hospitals from the requirement of giving "charitable" services. The rationale for the amendment in the House report was basically one proffered by the AHA—that the present enforcement of the law "has resulted in significant uncertainty as to the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status."[18]

However, the House amendment was rejected by the Senate Finance Committee and omitted from the bill passed by the Senate. Congress acceded to the Senate on this question, and the final act (of December 1969) followed the Senate version.[19] The Report of the Staff of the Senate Committee on Finance, issued in early 1970, exhibits a detailed history of the Senate deletion of the House amendment.[20] The Staff Report notes that the Committee on Finance instructed it to summarize the major arguments for and against the amendments in the House bill, and insofar as the hospital amendment was concerned, it stated the following:

> Arguments For.—B(1) These provisions are necessary to eliminate challenges to the tax-exempt status of hospitals on the ground that the hospitals are accepting insufficient numbers of patients at no charge or at rates that are substantially below cost.
>
> (2) By establishing hospitals as a separate exempt category and removing the indefinite test of to what extent a hospital must serve those who cannot pay, this bill removes the uncertainty surrounding the hospital's continued ability to draw necessary support from the public or from private foundations to accomplish its function.
>
> (3) Hospitals perform a useful function of the sort that deserves treatment in Section 501(c)(3) on the same basis as the other organizations specifically named in that provision.
>
> (4) The present environment of governmental assistance to permit medical care to be made available to those otherwise unable to pay, appears to make obsolete the need for hospitals themselves to

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virtually the unanimous consensus of those who testified at hearings held by an Illinois State Senate subcommittee created recently to investigate the plight of Cook County Hospital, Chicago." HOSPITALS, May 1, 1970, at 107.

18. H.R. REP. NO. 413, 91st Cong., 1st Sess. 43 (1968).

19. H.R. CONF. REP. 782, 91st Cong., 1st Sess. 289-90 (1969).

20. STAFF OF THE SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID, PROBLEMS, ISSUES, AND ALTERNATIVES 55-58 (Comm. Print 1970).

subsidize the providing of medical care to poor people. This is as true regarding hospitals as it is regarding schools and churches.

Arguments Against.—(1) In order to be tax exempt hospitals historically have been required to render service to the poor whether or not there was an ability to pay for the services rendered. These provisions would do away with that requirement and many marginal income families that are now ineligible for payment of hospital care under Medicaid, and who do not have sufficient resources to pay for hospital treatment might be denied care now available to them. This is especially true in States that do not pay for hospital care of people who are eligible for general assistance under the welfare programs of the State. The bill will pose particular hardships on poor families priced out of hospital care by continually rising health costs and this will put greater pressure on Congress to expand the Medicaid program at the very time Congress is seeking to contract and moderate it.

(2) To the extent hospitals contend Medicare and Medicaid does not pay their full costs they would also contend that they are providing *charitable* services for those patients. If the bill were not changed these hospitals could refuse Medicare and Medicaid patients with impunity or could limit their services to such patients unless the Government met the hospitals' unilateral cost demands. Without the balancing effect of the present Internal Revenue Service position, government might be faced with the choice of either complying with such payment ultimatums or seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals.

(3) There is no substantial evidence that contributors to hospitals will decrease or stop their donations because the Internal Revenue Service is questioning the tax-exempt status of a hospital (or hospitals) on the ground that sufficient charitable services are not being rendered to the poor.

(4) The extent of free and "below cost" hospital care has diminished greatly with the advent of public programs such as Medicare and Medicaid. The pressure to provide free care has lessened to the extent that these multi-billion dollar programs and private hospital insurance are now paying for many of those whose bills previously went unpaid.

(5) The bill discards the charitable basis—the "community service to all" concept—on which tax exemption of hospitals is founded.

> (6) If there is a legitimate complaint that Internal Revenue rulings are too vague on this point, a clarifying amendment establishing statutory standards is the appropriate remedy rather than the blanket approach of the House provision.
>
> (7) Since the need for new legislative language has arisen because of uncertainties in administration, then the resolution of such uncertainties could be handled on an administrative basis.[21]

The Staff Report noted AHA's representation in its testimony of October 28, 1969 at the Senate Finance Committee hearings on Medicare, that hospitals recognize "the right to receive service regardless of the ability to pay is extended to the entire community."[22] In view of AHA's action in seeking the amendment in the first place the report found this inexplicable[23] and concluded that services offered by hospitals that turned away the poor were *not* extended to the entire community.[24] It was recommended that the ruling be revoked,

> until such time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action . . . would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients.[25]

To date this ruling has not been revoked, and IRS apparently has continued to grant tax-exempt status to hospitals without regard to policies of excluding the poor. This action obviously has had the impact Congressman Gibbons

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21. *Id.* at 55-56.
22. *Id.* at 57.
23. *Id.*
24. *Id.* at 58.
25. *Id.* In his article, Mr. Bromberg notes that this recommendation leaves the issue still in dispute. Bromberg, *The Charitable Hospital*, 20 CATHOLIC U.L. REV. 237 (1970). The AHA apparently is aware of the questionable status of the ruling, since it continues to seek congressional approval. Testimony in support of its proposition of "tax-exemption-without-regard-to-free-service" was offered in the Senate hearings. *Hearings on Medicare and Medicaid before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance*, 91st Cong., 2d Sess. 374-77 (1970). Senator Ribicoff strongly rejected the proposition, stating,

> I think there is something abhorent in the thought that there is a community hospital that holds itself out to take care of the health needs of the people, and yet would feel free to turn away a sick person who needs care on the basis that they cannot pay for it. Now, I tell you, as far as I am concerned, I would not accept what you are saying under any circumstances. Maybe others in the Senate would, but I would not.
>
> . . . .
>
> I think that there is a public responsibility on your part to take care of the needs of the indigents.

Id. at 375.

feared. In New Orleans two hospitals which prior to 1970 claimed they had "free or below cost" clinics closed those operations in early 1970. Reportedly the same is occurring throughout the country.[26]

The Legal and Social Infirmities of the New Revenue Ruling

In light of the legislative history of the tax-exempt provisions, including recent events and the longstanding interpretation of those provisions by the Tax Court and the federal courts, the 1969 ruling is clearly an *ultra vires* action on the part of the Commissioner of Internal Revenue. The ruling "legislated" a critical change in tax policy without appropriate authority. Even if one assumes *arguendo* that the Commissioner has the power to "reinterpret" the tax law in this way, doing so by means of an interpretive bulletin illegally circumvents the requirements of the Administrative Procedures Act.[27] Most importantly, this tax policy operates as unwise health policy by perpetuating and enlarging the gulf between the health care available to the rich and that available to the poor when government and private organizations are working toward the elimination of this dual system.[28]

An Erroneous Application of Legal Principles

An institution may be deemed "charitable" for at least three purposes, each

26. *See* note 4 *supra*.

27. 5 U.S.C. § 500 (1964).

28. Written into both the Medicare and Medicaid systems is the philosophy that the poor should be able to obtain health care from the same providers as do the rich. 42 U.S.C. §§ 1395a, 1396a (a)(23) (Supp. V, 1970). Ironically, even the opponents of major health programs have opposed them for the stated reason of fear of treating the needy "differently." During the hearings on Medicare and Medicaid in 1965, the California Medical Association stated, "It is important that the patient stay in the mainstream of medical care in his community. He should be subject to no discrimination or segregation from other citizens who are able to provide for their own care. He should be able to use the same facilities." *See Hearings on H.R. 6675 Before Senate Comm. on Finance*, 89th Cong., 1st Sess. 656 (1965). The necessary effect of the IRS ruling is to cast the poor back upon the public hospital system. The "dumping" of indigent patients by private charitable hospitals onto the municipal or county hospitals is a common and widely acknowledged practice. *See* note 4 *supra*.

That "dumping" is a problem has been acknowledged by the Joint Commission on Accreditation of Hospitals, a prestigious voluntary organization composed of representatives of the AMA, AHA, American College of Physicians, and American College of Surgeons. In its recently adopted Standards for Hospital Accreditation, the Joint Commission requires that each person who presents himself at a hospital emergency room must be at least appraised and diagnosed. Moreover transfers of patients cannot be made until such time as medical records are complete and only *with the consent* of the transferee institution. This latter provision was added to the Standards at the request of groups representing poor persons who were concerned about the "dumping" syndrome.

involving unique legal principles and rationales. Regarding the law of trusts one evaluates whether property may be dedicated to a specific use in perpetuity (a "charitable" use). In the law of torts one evaluates where certain institutions may be immunized from individual suits based on injuries committed by the institutions ("charitable" immunity).[29] In the law of taxation one evaluates the consequences of releasing an institution from its normal share of the costs of government (exemption from tax, as a "charitable" institution).

When the Commissioner reconsidered the requirements for a hospital's eligibility for tax exemption he cited *Scott on Trusts* and the *Restatement of Trusts* (of which Professor Scott is the principal reporter) as sole authority for the proposition that,

> [t]he promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit 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.[30]

Scott's characterization, of course, applied to the law of trusts.[31] It does not automatically apply to the policies underlying the grant of a tax exemption.

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29. Based on a theory that tort liability could obliterate the assets of the institution, historically certain charitable institutions were given immunity from suit. In recent days, however, insurance has been looked upon as a more viable and just substitute, and this immunity from suits has almost disappeared from the law as it pertains to charitable hospitals. It is not relevant to our discussion herein, and will not be further discussed.

30. Rev. Rul. 69-545, 1969-2 CUM. BULL. 117.

31. Even for the law of trusts, however, the law is not settled in that a hospital, is "charitable" without regard to free services to the poor. As stated in Trust Co. of Georgia v. Williams, 184 Ga. 460, 462, 192 S.E. 913, 914 (1937): "A hospital, however, is not any more than a drugstore, a charitable institution per se; and, in order for a devise or other gift establishing a hospital to come within the classification of a charitable institution, the terms of the gift must themselves require that it be operated in whole or at least in substantial part for the gratuitous relief of its inmates."

It is not altogether clear how Scott came to his conclusion; many of the cases he cites in his long footnote actually spell out the requirement that the poor as well as the rich be treated in charitable hospitals. *E.g.*, Hart v. Taylor, 301 Ill. 344, 133 N.E. 857, 858 (1922); O'Brien v. Physicians' Hosp. Ass'n, 96 Ohio St. 1, 116 N.E. 975, 977 (1917). They rather support the proposition that health is a purpose which may be charitable, provided that actual charity is bestowed. This is fully in keeping with the pre-1969 position of the IRS. As stated in Sonora Community Hosp., 46 T.C. 519, 525-26 (1966), "The mere fact that petitioner maintained a hospital does not in and of itself justify the conclusion that it was operated exclusively for charitable purposes. While the diagnosis and cure of diseases are indeed purposes that may furnish the foundation for characterizing an activity as 'charitable,' something more is required." *See* Rev. Rul. 56-185, 1956-1 CUM. BULL. 202.

In discussing the reasons for classifying trusts as "charitable" thus nondestructible under the rule against perpetuities, Scott states:

> In classifying the purposes which are held to be charitable, it is possible to enumerate some of them, as has been done in the preceding sections. But no matter how many types of purposes are thus enumerated, there will always be another class to include the miscellaneous purposes which cannot be classified under a single heading. *The common element is that the purposes are of a character sufficiently beneficial to justify permitting property to be devoted for an indefinite time to their accomplishment.*[32]

The determination that a purpose is "sufficiently beneficial" tips the scale in favor of control by the "dead hand of the past" to the detriment of the deceased ancestor's disinherited heirs.

Granting tax-exempt status to a charity, however, does not involve the same considerations as evaluating the claims of private persons to the property of their ancestor. Rather it results from legislative balancing of two competing public interests—that everyone pays his share of the costs of government,[33] and

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The concept of charitable trusts emerges from the Statutes of Elizabeth I, and the relief of "aged impotent and poor people" set forth therein. This provision was part of the Elizabethan poor laws, and implicit throughout was the concept of assistance to the poor. As set forth in TenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status*, 16 STAN. L. REV. 257, 267 (1964):

> Under the Tudors charitable foundations and the law of charitable trusts were developed in connection with the poor law. As the state assumed public responsibility for the poor, it built upon private charity and sought to encourage it. At best, such charity was an alternative to public expenditure; at least, it served as a method of reducing the cost. As the poor law system evolved, the Tudors sought to assure that charitable foundations devoted their resources without diversion or misapplication, that private and public charitable works were interrelated administratively, and the establishment of private charitable foundations occurred, especially in the area covered by the public responsibility. While we cannot ignore pressures arising from the political changes of the times and the developing *parens patriae* and police functions of the state, it is probably not too much to say that the modern law of charitable trusts evolved as an integral part of the poor law system and did so primarily because of the assumption of public responsibility by that system, with the resulting necessity of finding means of keeping down public expenditures.

The Statute was a product of the realization that laws against vagrancy and begging would not work if men were hungry, and the enlightenment when "the eminent statesmen of Elizabeth's reign courageously determined to act upon the principle that the relief of destitution must be undertaken as a public duty, and be provided for at the public charge, in order to ensure the due ascendancy of the law; and this principle was finally established by the passing of the 43rd Elizabeth." G. NICHOLS, A HISTORY OF THE ENGLISH POOR LAW 194 (rev. ed. 1967).

32. 4 A. SCOTT, THE LAW OF TRUSTS § 372.1 (3d ed. 1967) (emphasis supplied).

33. "Based on the theory that all property should bear its proportionate share of the costs of government and property be absolved from such obligation only for good cause, taxation is

that since the government must perform certain functions if private parties do not, the use of tax incentives to subsidize such work by private parties lessens the burdens of government.[34] Not all purposes which are "sufficiently beneficial" for trust purposes, commensurately lessen the burdens of government for tax purposes. Neither the absence of a profit motive[35] nor the accumulation of income for future charitable uses is enough.[36] In *Erie Endowment v. United States* the Third Circuit held that the unreasonable accumulation of income deprived a charitable foundation of tax-exempt status. The court states:

> It has no natural right to tax exemption, but rather a Congressional balm granted because losses in tax revenue were deemed compensated for by the value of charitable work. Absent a sufficient amount of charitable work commensurate with the total amount of Erie's available funds, exempt status must cease, or in fact, never come into existence.[37]

The Intention of Congress: the Legislative History of Charitable Tax Status of Hospitals

The Internal Revenue Code does not presently contain, nor has it ever contained, specific exemptions for hospitals as a class. To be eligible for tax-exempt status under federal law, hospitals always have had to qualify under the classification "charitable." The legislative history of the charitable tax exemption and deduction provisions establishes that Congress never intended those provisions to apply to hospitals solely because of their nonprofit dedication to health if only persons able to pay were to be served and persons unable to pay could be turned away.

The present provision bestowing tax-exempt status provides in part:

> An organization described in subsection (c) . . . shall be exempt

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the rule and exemption the exception." Cleveland Osteopathic Hosp. v. Zangerle, 153 Ohio 222, 223, 91 N.E.2d 261, 263 (1950). "The fundamental approach of our statutes is that ordinarily all property shall bear its just and equal share of the public burden of taxation. As the existence of government is a necessity, taxes are demanded and received in order for government to function." Presbyterian Homes v. Division of Tax Appeals, 55 N.J. 275, 279, 261 A.2d 143, 147 (1970).

34. This "lessening the burdens of government" theory underlies the charitable exemption history. *See* H.R. REP. No. 1860, 75th Cong., 3d Sess. 19-20 (1939). It appears in the current IRS regulations defining "charitable." Treas. Reg. § 1.501(c)-1(d)(2) (1970).

35. "[P]rofit is a factor for consideration, but is not necessarily controlling since nonprofit status 'cannot be equated with charitableness, ...'" Catholic Charities v. City of Pleasantville, 109 N.J. Super. 475, 263 A.2d 803 (1970).

36. Erie Endowment v. United States, 316 F.2d 151 (3d Cir. 1963).

37. *Id.* at 153.

> from taxation . . . (c) The following organizations are referred to in subsection (a) . . . (3) Corporation, and community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual . . . .[38]

Absent such qualification hospitals must pay taxes just like any other "business."[39] Further, they cannot be tax-deductible beneficiaries of the largess of other individual or corporate taxpayers seeking to channel otherwise taxable income to private institutions.[40] In this latter respect the Code provides:

> There shall be allowed as a deduction any charitable contribution (as defined in subsection (c)) . . . (c) For purposes of this section, the term "charitable contribution" means a contribution or gift to or for the use of— . . . (2) a corporation, trust, or community chest, fund, or foundation— . . . (B) organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes or for the prevention of cruelty to children or animals; (c) no part of the net earnings of which inures to the benefit of any private shareholder or individual; . . . .[41]

Moreover, if the hospital qualifies as a "charitable" entity under Section 170 it becomes a member of a special category of institutions to which a taxpayer may contribute amounts totaling up to 50 percent of his income;

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38. INT. REV. CODE of 1954 §§ 501(a) and 501(c)(3) (Supp. V, 1970). [Hereinafter cited as IPC].

39. In addition to federal income taxes, hospitals which are not tax exempt are subject to state income taxes, county and municipal property taxes, business taxes, payroll taxes (including SSA, unemployment), sales taxes, and state franchise taxes. The amount of these taxes can be considerable. In a report by an association of proprietary hospitals to the California State Agency for Health Planning, there is stated that eight such hospitals, ranging in size from 53 to 180 beds, paid some $2,356,432 in taxes in fiscal 1969. Extrapolating these figures to cover the nearly 14,000 proprietary beds in California would amount to some $41,276,000 paid in taxes. *See* Weissburg, *Factors for Consideration in Determining Bed Need of Hospitals,* UNITED HOSPS. ASS'N, July 30, 1970.

40. Such donations can be considerable. For example, in fiscal year 1969, some $22.5 billion was spent for hospital care in the United States, and an additional $2.5 billion was spent for construction and modernization of health care facilities. Approximately 51 percent of the $25 billion total came from the private sector, with philanthropy providing $2.3 billion of that 51 percent. Of particular significance is the fact that of the $2.3 billion from charity, $1.5 billion was for construction or modernization of facilities (or 60 percent of the $2.5 billion spent for construction). *See Hearings on Medicare and Medicaid before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance*, 91st Cong., 2d Sess. 422 (1969). It is also obvious that tax-deductible status encouraged donors to give to institutions which quality. *See Hearings Before the House Comm. on Ways and Means*, 91st Cong., 1st Sess. 1475 (1969) (Statement of Ass'n of Independent Colleges). *Cf.* Green v. Kennedy, 309 F. Supp. 1127, 1134-5 (D.D.C. 1970).

41. IRC §§ 170(a), (c) (1964).

whereas gifts to charitable institutions not so favored may be deducted only to the extent that they do not exceed 20 percent of the taxpayer's income.[42]

These provisions originated in the first federal income tax statute in 1894 which was declared unconstitutional before any of its provisions were interpreted. Section 32 of the Act of August 27, 1894, exempted from taxation,

> Corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes, including fraternal beneficiary societies, orders, or associations operating upon the lodge system and providing for the payment of life, sick, accident, and other benefits to the members of such societies, orders, or associations and dependents of such members . . . .[43]

Legislative history explaining inclusions or exclusions is scanty. However, the existence of hospitals as a separate exempt classification (apart from "charitable") would not have been unprecedented; and such classification could have appeared if the spokesmen for the legislation so desired.

William Jennings Bryan of Nebraska, one of the spokesmen for the bill, introduced into the record information on the income tax in other countries. He found that in England, "there are exemptions extending to charities, universities, friendly, industrial, and provident societies, hospitals, etc . . . ."[44] A separate exemption for hospitals could also have been found under the laws of certain states. In New York, for example, hospitals were an "exempt" classification, provided they rendered medical care "to poor persons in need of such treatment without charge."[45]

The same exemptions with respect to corporations or associations organized for "religious, charitable, or educational purposes" were carried into the corporation excise tax law of 1909, and the income tax of 1913.[46] To the latter, the "line" progenitor of the present law, the classification "scientific" was added. The restrictive interpretation given to exemption eligibility can be seen in some remarks supporting this addition and a provision for "benevolent" organizations which was not adopted:

> Mr. Rogers . . . The words which I have caused to be added will make an exemption in favor not only of religious, charitable,

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42. *Id.*

43. Law of August 27, 1894, § 32, 28 Stat. 509.

44. 26 CONG. REC. 584, 586 (1894).

45. Section 4 of the Laws of 1889, Chapter 95 so provided. Subsequently, Section 4, subdivision 6, of the Tax Law of 1896, chapter 908, exempted a list of organizations, including hospitals and infirmaries, without mention of service to persons unable to pay. In 1907, the 1896 law was interpreted as superceding the earlier law, and in 1944 it was said to have deleted the service to the poor requirement. *See* People v. Sexton, 267 App. Div. 736, 48 N.Y.S.2d 201 (1944).

46. Law of August 5, 1909, § 38, 36 Stat. 11; Law of October 3, 1913, § 11(G)(a), 38 Stat. 114.

> or education corporations, . . . but also in favor of benevolent or scientific corporations. In this connection I should like to refer to the language of the Massachusetts statute in this regard, which exempts from taxation literary, educational, benevolent, charitable, scientific, or religious corporations. Three of the six exemptions along this line which the Massachusetts law includes are already in the act as reported, namely, educational charitable, or religious corporations. I have not included in my amendment the word "literary," although I think there is much to be said for that inclusion also. But I do think that there can be no sound objection to the inclusion of the words "benevolent" and "scientific." It might be suggested by some that "benevolent" is synonymous with "charitable," and that therefore it is already sufficiently covered by the terms of the act as it has been introduced. But it has been held in Massachusetts that a corporation may be "charitable," within the meaning of the Statute, without being "benevolent," and that it may be "benevolent" without being "charitable." Therefore, in view of the undoubted fact, as I conceive it, that we ought to care not merely for charitable corporations, but also for benevolent corporations, it seems to me clear that this word should be added, so as to do no injustice to the latter class of institutions. As to the inclusion of the word "scientific," I have no especial need, I think, to dwell upon the propriety of that amendment. The great institutions in this country engaged in scientific research—with no purpose of gain or emolument to the institution as a whole or to the members who are concerned therein—certainly ought to be treated on the same basis as religious, charitable, or educational corporations.[47]

At this important juncture in the development of the tax statute, the draftsmen were carefully circumscribing the purposes and objects for exemption, and adopting narrow rather than broad classifications. Arguably, the term "charitable" could be as broad as "benevolent" and the term "educational" can include "scientific" and "literary." Nevertheless, Congress chose to restrict exemption to more narrowly defined purposes. In England the concept of "charity" had developed to include "trusts for other purposes beneficial to the community, not falling under any of the preceding heads" in addition to trusts for the relief of poverty, advancement of education, and advancement of religion.[48] However broadly or narrowly the "beneficial purposes" classification may be viewed by English trust law,[49] for purposes

47. 50 CONG. REC., 1305-06 (1913).

48. Commissioners v. Pemsel [1891] A.C. 531, 583; *See also* Brunyate, *The Legal Definition of Charity*, 61 L.Q. REV. 268, 269 (1945).

49. It is thus, in this context, not relevant whether England has come to read the words "aged,

of tax exemption under the Internal Revenue Code it would appear to include only those objects which Congress intended to be included. For example, while "prevention of cruelty to animals" appears to be included under this "beneficial purposes" heading in England,[50] it is included under the Internal Revenue Code only *because* the Code was amended in 1918 to include organizations "for the prevention of cruelty to children or animals."[51]

In 1924 Senator Willis of Ohio proposed to add parenthetical language after "charitable" so as to include "preventive and constructive service for relief, rehabilitation, health, character building, and citizenship."[52] He explained his amendment thusly:

> The present Commissioner of Internal Revenue has decided that under the existing law an allowance can not be made for gifts to a community chest unless those gifts shall be for the relief of the poor. That is a rather recent decision to which the attention of Senators may not have been drawn. It was made on the 8th of October, 1923, and is found in volume 2 of the Decisions of the Commissioner of Internal Revenue. Under that decision he holds that gifts to financial federations doing welfare work and social service other than relief to the poor would not be among the allowable deductions. It is to be noted that the decision is exactly contary to a decision made by his predecessor, who held that deductions could be made for such gifts . . . .
>
> It seems to me, Mr. President, the law ought not require that gifts shall be used only to alleviate poverty. It ought to be permissible to use them so, if possible, as to prevent poverty.[53]

Other Senators disagreed with the suggestions of Senator Willis, indicating that the terms he suggested were too elastic, and that Congress had gone as far as it should go in tinkering with the revenues of government.[54] The amendment was withdrawn after it became clear that the sentiment of the Senate was against the broad sweep of the parenthetical language. No modification or change was made in the tax exemption and deduction provisions to indicate any departure from the Commissioner's "relief of the poor" concept of

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impotent and poor" as those terms appear from the ancient Statute of Charitable Uses in the disjunctive rather than conjunctive, as suggested by Bromberg, *The Charitable Hospital*, 20 CATHOLIC U.L. REV. at 240-41 (1970).

50. Brunyate, *The Legal Definition of Charity*, 61 L.Q. REV., at 276-77 (1945).

51. Int. Rev. Act of 1921, § 231, 42 Stat. 227 (now INT. REV. CODE OF 1954, § 501(c)(3)) which also added "literary" to the classifications covered by the present tax exemption.

52. 65 CONG. REC. 8171 (1924).

53. *Id.*

54. *Id.* at 8172-73.

"charitable."[55] Thus failed the only attempt, prior to 1969, to specify health per se as a tax exempt purpose.

While other subsections have been added to the overall provisions dealing with tax exemptions for very specifically described organizations, since 1924 the only addition to Subsection 501(c) and its predecessors has been the inclusion of organizations operated for the purpose of "testing for public safety."[56]

The Judicial Interpretation of the Application of "Charitable" to Hospitals Under the Internal Revenue Code.

Judicial construction of the requirements essential for hospitals to attain charitable status under the Code appears to begin with *Commissioner v. Battle Creek Sanitarium*,[47] the leading case on the subject. The sanitarium had maintained a regular schedule of rates, which were charged to patients able to pay; those unable to pay full rates paid nothing or a fraction of the regular charge. From 1930 to 1935, 926 day patients paid the full charges, 145 paid fractional charges, and 705 paid nothing; 515 home patients paid full charges, 533 paid part, and ten paid nothing. The court set forth the premise for finding such an institution qualified for charitable exempt status:

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55. In that ruling the Commissioner, after noting that "in dealing with charitable trusts or uses the courts have tended to give a very broad meaning to the term 'charitable,' on the ground that it was expedient to uphold such trusts or uses," stated that charitable for internal revenue purposes was more restrictive, *i.e.*, used "in its popular and ordinary sense [which] pertains to the relief of the poor." INT. REV. BULL. II-1-2 (1923), Ruling II-2-1128 I.T. 1800, 152, 153.

56. This provision was added to the new INT. REV. CODE OF 1954, § 501(c)(3). *See* U.S. CODE CONG. & AD. NEWS, 83rd Cong., 2d Sess., 4950 (1965). No comparable provision was added to the tax deduction definition of "charitable" in § 170(c).

57. 126 F.2d 405 (5th Cir. 1942). The issue does not appear to have arisen earlier. This is probably due to a number of factors, including the fact that prior to World War II the hospital was not the center of the medical universe which it has thereafter become. After the War the combination of the increased use of hospitals because of multiple breakthroughs in sophisticated medical techniques and the inflationary pressure of the economy have increased the cost of charity care. In 1946, when Congress passed the Hospital Survey and Construction Act, known popularly as Hill-Burton, the traditional notion of charity care, meaning free and below-cost services to the indigent and medically indigent, was therein reflected. 42 U.S.C. § 291 c(e) (1964). No hospital has ever received a Hill-Burton grant without making the commitment to afford a reasonable volume of services to persons unable to pay. *See* Rose, *Hospital Admission of the Poor and the Hill-Burton Act*, 3 CLEARINGHOUSE REV. 185 (1969); Rose, *The Duty of Publicly-Funded Hospitals to Provide Services to the Medically Indigent*, 3 CLEARINGHOUSE REV. 254 (1969). Nonprofit facilities, most especially hospitals, are eligible to receive such moneys, and it appears that IRS's determination under IRC § 501(c)(3) (1964) is used as proof of "nonprofit status." As of June 30, 1968, some 5,128 nonprofit projects had received such moneys. These projects furnish some 261,760 beds or 59.1 percent of the beds so funded and have received some 58.1 percent of federal Hill-Burton funds. PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, FACTS ABOUT THE HILL-BURTON PROGRAM, JULY 1, 1947-JUNE 30, 1968 (1968).

> It is also usual for hospitals and sanitariums to charge those able to pay for services rendered, in order to pay the expenses of the institution, while not denying treatment to others unable to pay anything. Such institutions are classed as charitable.[58]

For the following 27 years this remained the basic rule for all federal tax exemption provisions relating to hospitals, until the 1969 ruling eliminated the requirement that in order to qualify institutions must not deny treatment to persons unable to pay.

In *Intercity Hospital Association v. Squire*,[59] the IRS denied charitable tax status, resting its conclusion upon the dual findings that, "in practically every case a charge is made for the services rendered" and "neither your articles of incorporation nor by-laws provide for the treatment of charitable patients, and it is apparent from the evidence presented that you have no purpose and made no pretense of bestowing charity."[60] The district court held that these findings were unsubstantiated, and found rather that the evidence established "no questions whatever were asked and no statement required of financial standing nor ability to pay immediately or prospectively . . . an amount ranging from six to eight percent of such gross income was donated to charity patients."[61]

The Tax Court issued similar opinions during that same period. Thus, in *Davis Hospital*,[62] it deemphasized the stress the Commissioner had placed upon the fact that the hospital charged those able to pay for the services rendered, citing *Battle Creek* for the proposition that, "This is the usual practice of hospitals. So long as admission and treatment are not denied to those unable to pay, an institution is classed as charitable."[63] In *Goldsby King Memorial*,[64] the Tax Court quoted *Battle Creek* for the same proposition. This was the state of the law which the Revenue Service codified in 1956 when it issued Revenue Ruling 56-185 requiring that tax-exempt hospitals in order to retain their tax-exempt status must accept persons in need of hospital services but unable to pay.

The same approach was followed by the Tax Court subsequent to the ruling. In 1958 it denied tax-exempt status in *Lorain Avenue Clinic*,[65] but granted it in *Robert C. Olney*.[66] In *Olney* the two cases were compared. The court stated

58. *Id.* at 406.
59. 56 F. Supp. 472 (W.D. Wash. 1944).
60. *Id.* at 474.
61. *Id.*
62. 4 CCH Tax Ct. Mem. 312 (1945).
63. *Id.* at 315.
64. 3 CCH Tax Ct. Mem 693 (1944).
65. 31 T.C. 141 (1958).
66. 17 CCH Tax Ct. Mem. 982 (1958).

that in *Lorain Avenue Clinic*, "charitable services as were rendered . . . were occasional and of too minor volume to qualify petitioner for exemption [where] in the instant case . . . the hospital has numerous charity patients and was operated on a charitable basis to the extent of its financial ability."[67] Again in *John J. Cranley, Jr.*,[68] the Tax Court rejected a claim of charitable exemption due to the absence of any evidence as to "how many patients, if any, paid reduced or nominal charges or no charge at all" during the five year period in question. In *Sonora Community Hospital*[69] in 1966 the Tax Court continued to reiterate this same theme: "The amount of free care as rendered by petitioner was on a *de minimus* level, being less than 1 percent of paid care . . . a 'charitable' hospital may impose charges or fees for services rendered, and indeed, its charity record may be comparatively low . . . *but a serious question is raised where its charitable operation is virtually inconsequential.*"[70]

The Commissioner Lacks the Legal Authority to Promulgate this Ruling.

Although the Secretary of the Treasury, and through him the Commissioner, has authority to promulgate regulations for the enforcement of the Internal Revenue Laws[71] he does not have the authority to amend the Code by either regulation or interpretive bulletin. In *Fribourg Navigation Co. v. Commissioner*,[72] the Supreme Court admonished the Commissioner thusly:

> Over the same extended period of years during which the foregoing administrative and judicial precedent was accumulating, Congress repeatedly re-enacted the depreciation provision without significant change. Thus, beyond the generally understood scope of the depreciation provision itself, the Commissioner's long-standing and consistent administrative practice must be deemed to have received congressional approval.

In light of the legislative history, the longstanding judicial and administrative construction of the Code (in which Congress over the years acquiesced), and

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67. *Id.* at 993.
68. 20 CCH Tax Ct. Mem. 20 (1961).
69. 46 T.C. 519 (1966).
70. *Id.* at 526 (emphasis supplied).
71. *See* IRC § 7805 (Supp. V, 1970).
72. 383 U.S. 272, 283 (1965). *Accord* United States v. Leslie Salt Co., 350 U.S. 383, 396-97 (1955):

> Against the Treasury's prior longstanding and consistent administrative interpretation its more recent *ad hoc* contention as to how the statute should be construed cannot stand. Moreover, the original interpretation has had both express and implied congressional acquiescence, through the 1918 amendment to the statute . . . which has ever since continued in effect, and through Congress having let the administrative interpretation remain undisturbed for so many years. [Citations omitted].

the recent action of Congress in rejecting amendment to the Code and holding legislative resolution of the issue in abeyance until it could be considered in the context of health policy, the Commissioner without appropriate authority, in effect "legislated" an amendment to Section 501(c)(3) to include hospitals as a separate classification.[73]

Further, assuming that the Commissioner had the power to reinterpret the tax law as he did, his method of doing so by means of an interpretive bulletin illegally circumvented the Administrative Procedures Act (APA). The APA sets forth specific requirements to be followed by an agency in promulgating substantive rules. Among them is a mandate that general notice of proposed rule making must be announced in the Federal Register and an opportunity must be presented for interested persons to participate through the submission of written data, views and arguments.[74] That statutory provision does exclude from its requirements so-called "interpretive rules." In *Gibson Wine Co. v. Snyder*,[75] the Court of Appeals for the District of Columbia distinguished between rules which must proceed under the requirements of Section 553 and interpretive rules: "Generally speaking, it seems to be established that 'regulations,' 'substantive rules' or 'legislative rules' are those which create law, usually implementary to an existing law; whereas interpretative rules are statements as to what the administrative officer thinks the statute or reglation means."[76] The court in *Gibson* split in applying these principles to the facts; the majority finding the action of IRS "interpretative." However, in the instant case, where even proponents of the ruling admit that the opposite position has been longstanding, and that the change is a "major revision,"[77] the ruling can hardly qualify as merely interpretive. Moreover the major policy implications of the revision necessitate precisely the kind of forum and opportunity for exchange of views contemplated by the APA in its requirements for agency rule-making procedures. It would be anomalous, indeed, to label such an important policy change merely interpretive, thereby depriving interested persons of the opportunity to express their views.

The Policy Considerations for Requiring Private Hospitals to Give Services to Persons Unable to Pay.

Although the critics of the "relief of the poor" requirement acknowledge that

73. The Commissioner acted while the matter was pending in Congress, after the House had approved the AHA proposal and before the Senate rejected it. Although the issue might have been "moot" had the proposal been adopted, the final action would appear to require IRS to revoke the Ruling, which it has not done.

74. *See* 5 U.S.C. § 553 (Supp. V, 1970).

75. 194 F.2d 329 (D.C. Cir. 1952).

76. *Id.* at 331.

77. Bromberg, *The Charitable Hospital*, 20 CATHOLIC U.L. REV. 237 (1970).

hospitals have always been required to serve persons unable to pay in order to qualify for federal tax exemption and deduction status, they claim that the perpetuation of this policy is "archaic" and that nonprofit hospitals confer a "community benefit" regardless of policies of nonadmission of persons unable to pay.[78]

In *The Charitable Hospital*, Mr. Bromberg characterizes his position as an "existential community benefit" approach, in which the public and the large teaching hospitals bear the brunt of service of the poor while "other hospitals are responsive to the needs of the middle and more affluent classes."[79] This characterization merely begs the question—whether a hospital which denies service to those members of the community who are unable to pay is conferring a community benefit within the meaning of the Internal Revenue Code.

This "community-benefit-sans-service-to-the-poor" approach ignores the underlying rationale for the granting of tax-exempt status to charities as well as the tax deductible status accorded to donations made to them.

> The exemption from taxation of money or property devoted to charitable and other purposes is based upon the theory that the Government is compensated for the loss of revenue by its relief from financial burden which would otherwise have to be met by appropriations from public funds, and by the benefits resulting from the promotion of the general welfare.[80]

If private hospitals treat only paying patients, the burden to be borne by the federal government increases. This is not a theoretical statement, but the reality of a crisis which even the AHA acknowledged by devoting its July 1, 1970 issue to the subject.[81] At the very time when government is most pressed by a financial squeeze on health services, when municipal hospitals are closing services and operating at deficits, when poor people are being turned away from the inadequate services at the public hospital and are denied access into the private sector because of lack of money and health insurance,[82] when state

78. *Id. See also Hearings Before the House Comm. on Ways and Means*, 91st Cong., 1st Sess., pt. 4, at 1425 (1969) (testimony of AHA).

79. It should be noted with reference to "large teaching hospitals" that where these are not public hospitals the poor are admitted only if they offer "interesting" teaching material. The value of such institutions to the health status of the ordinary poor, sick person is questionable.

80. H.R. REP. No. 1860, 75th Cong., 3d Sess. (1939).

81. HOSPITALS July 1, 1970.

82. When the poor finally get into hospitals they are sicker than the middle class. Inadequate hospital facilities must treat the sicker patients, and thus the less sick are turned away until the progression of their illness "qualifies" them for treatment, often too late. In Cook v. Ochsner Foundation Hospital, 319 F. Supp. 603 (E.D. La. 1970), two would-be plaintiffs, one whose name was on the draft complaint as the first-styled plaintiff, died before the lawsuit could be brought. Both had been rejected for admission into the overcrowded public hospital several times over the

governments are cutting back on coverage and eligibility for Medicaid,[83] to cast upon the government the entire burden of caring for the poor simply cannot be a "lessening of the burdens of government." As cogently stated by the Illinois court which in denying tax-exempt status to an old people's home which reserved the right to discharge a resident who became sick, unmanageable, or depleted his assets, and then to cast him upon the state for care, went on to say: "The State would be bereft of any asset or estate from which it might seek reimbursement for its outlay after the person's demise. We can only infer that plaintiff's use of its property in this respect could tend to increase rather than lessen, the State's burden."[84]

Congressional policy in the health area has become increasingly concerned with affording hospital service to persons unable to pay. The Hill-Burton Act reflects the traditional notion that hospitals receiving such public grant-in-aid funds afford a reasonable volume of service to persons unable to pay.[85] Recently, a federal court has held that poor people are a special beneficiary

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prior few weeks before death, and also had been rejected by private, nonprofit, tax-exempt hospitals in metropolitan New Orleans because of lack of money. One died in the public hospital, an hour after being finally admitted. The other died in one of the private hospitals, to which he had been admitted after his brother borrowed $200, the price of admission, some six weeks after a physician on the staff of that hospital had noted after examining him that he should be admitted into a hospital but did not have the money for admission into that hospital. *See Cook, supra* Complaint and Answers to Interrogatories. These are the *realities* of the health problems of the poor.

83. Morris v. Williams, 63 Cal. Reptr. 689, 433 P.2d 697; C.M.A. v. Brian, Civil No. 208390-209168 (Sup. Ct., Sacramento County, 1971); Catholic Medical Center v. Rockefeller, 305 F. Supp. 1256 (E.D.N.Y. 1969), *aff'd*, 430 F.2d 1297 (2d Cir. 1970). Indeed, the National Governor's Conference opposed the House Amendment granting hospitals tax-exempt status without regard to service to the poor because of its cost implication under the Medicaid program, and the greater financial burden which would thereby be imposed on both state and federal government. *See* Letter from Charles A. Byrley, Nat'l Governors' Conf. to Senator Russell B. Long, Oct. 27, 1969, in STAFF OF THE SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., REPORT ON MEDICARE AND MEDICAID, PROBLEMS, ISSUES, AND ALTERNATIVES (Comm. Print 1970).

84. Methodist Old People Home v. Korzen, 39 Ill.2d 149, 155, 233 N.E.2d 537, 543 (1968). Other states agree. Thus, in Ruston Hosp. v. Riser, 191 So.2d 664 (La. 1966), the Louisiana court, noting that the institution did not admit charity patients and scheduled charges even for welfare patients, stated, "there is no basis for the contention that plaintiffs operation in any degree whatsoever served to relieve the State or its governmental subdivision of the burden of caring for the sick and indigent." Likewise the New Jersey courts have recognized that the failure to care for the aged poor by private homes, casts a financial burden on the state. *See* Presbyterian Homes v. Division of Tax Appeals, 55 N.J. 275, 261 A.2d 143 (1970), and Catholic Charities v. City of Pleasantville, 109 N.J. Super. 475, 263 A.2d 803 (1970). In the latter case the court stated, "Implicit in the opinion of the Division are findings that Residence performs a charitable function that benefits the public-at-large inasmuch as the burden of taxation is lessened by obviating the necessity on the part of the government to construct facilities to accommodate the poor who are unacceptable to or who cannot afford the rates charged by nursing homes operating for profit." *Id.* at 806. It is noteworthy that while New Jersey has granted hospitals a specific tax exemption as a class, where institutions must qualify as "charitable," service to the poor is required.

85. 42 U.S.C. § 291c(e) (Supp. V, 1970).

class of that legislation.[86] Indeed, the 1970 amendments establishing certain priorities for poverty areas indicate an increased concern.[87] In the Medicaid program, inpatient and outpatient hospital services are mandatory.[88] Viewing tax policy in this broader social and political context mandates that benefits of tax-exempt status be limited only to those institutions that also provide services to persons who cannot pay, including those not covered by Medicare and Medicaid, or whose coverage under those programs or private insurance has been exhausted. Consistency with congressional policies providing health care to the poor under Medicaid and Hill-Burton requires that Congress limit subsidization to those hospitals which assist it by not rejecting the poor.[89]

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86. Cook v. Ochsner, 319 F. Supp. 603 (E.D. La. 1970). The basic underlying predicate of all allegations in this case involves the refusal of all private hospitals and the two district hospitals to admit the poor, including the poor covered by the Medicaid program, casting the entire burden upon the public Charity Hospital of Louisiana at New Orleans which admittedly does not have the resources to care for all the poor. Three other lawsuits have been commenced on the same issue of hospitals, constructed under the federal Hill-Burton program, refusing to admit the poor. Organized Migrants v. James Archer Smith Hosp., 325 F. Supp. 268 (S.D. Fla. 1970); Euresti v. Stenner, Civil No. C-2462 (D. Colo. 1970); Perry v. Greater Southeast Community Hosp., Civil No. 275-70 (D.D.C. 1970). In *Organized Migrants*, the Florida court has agreed with the Louisiana court that poor people have standing to challenge the failure of Hill-Burton hospitals to treat them. In Colorado the court disagreed, and an appeal has been noted.

87. Public Health Service Act, Title VI, Pub. L. 91-296, §§ 603(a)(4), 645(a)(4)).

88. 42 U.S.C. § 1396a(a)(13)(D) (1964), *as amended*, (Supp. V, 1970). A subsidiary question to the basic issue concerns a hospital's response to the Medicaid program. Bromberg appears to take issue with a statement he attributes to former Secretary of Health, Education, and Welfare Wilbur Cohen that a charitable hospital should not follow a policy of regularly refusing admission to Medicaid patients; Bromberg states that:

> A hospital may adopt a policy of not providing care for Medicaid patients for various reasons. A principal one is that while Medicaid may be based on a cost reimbursement formula, many states rapidly use up the funds designated for health care, and then expect the hospitals to take whatever token payment is available for Medicaid patients for the balance of the year. Officials in those states rarely inquire where the hospital will obtain the funds necessary to meet the increasing costs of caring for these patients. Since they are dealing with 'charitable' institutions, they expect the difference to be made up by contributions . . . .

20 CATHOLIC U.L. REV. at 251.

Aside from its inherent "rejection-of-the-poor" thesis, this statement indicates a lack of familiarity with the requirements of the Medicaid program that a participating state must provide reasonable costs of inpatient hospital services for beneficiaries of that program, 42 U.S.C. § 1396a(a)(13)(D) (1964), *as amended*, (Supp. V, 1970). When the State of New York attempted to set a ceiling on that amount, that attempt was voided. Catholic Medical Center v. Rockefeller, 305 F. Supp. 1256 (E.D.N.Y. 1969), *aff'd*, 430 F.2d 1297 (2d Cir.1970). The Second Circuit said in this regard:

> As long as the state participates in a plan for medical assistance to the medically indigent under the provisions of Title XIX of the Social Security Act, it must provide for payments to hospitals of the full actual and current costs of inpatient hospital services furnished to eligible individuals, including retroactive payments or an allowance in lieu of retroactive payments.

430 F.2d at 1299.

89. It would appear more in keeping with the policies and philosophies of Congress which

The argument for bestowing tax-exempt status on hospitals which do not afford service for persons unable to pay are set forth in the testimony of the American Hospital Association before the House Ways and Means Committee in February 1969. As already described, AHA contended that Sections 501(c)(3) and 170 should be amended: (1) because of the uncertainty in the amount of free care required, (2) because universities, symphony orchestras, and jazz festivals were tax exempt without regard to relief of the poor, (3) because of an alleged inconsistency between the 1956 ruling and the Treasury Regulations on the subject, and (4) because of Scott's position that health per se was a charitable object for trusts. These contentions do not meet the policy considerations discussed above, nor do they withstand analysis.

With respect to uncertainty in the amount of free care required, the argument that free care should be deleted as a requirement because there are no guidelines could be dispatched simply by establishing guidelines. The exempt status of universities, as well as symphony orchestras and jazz festivals exist under the category of "education," which historically has always been separate from "charitable" under both the law of trusts and the federal tax statutes.[90] Although Congress could also create a separate category for hospitals, as AHA unsuccessfully sought in 1969, Congress has not so acted; the Commissioner's ruling must be interpreted within the Code as it exists. As for policy considerations, the argument that the Code should be amended to include hospitals which charge all patients because universities, or symphony orchestras, or jazz festivals charge all their "customers" avoids the special policy considerations applicable to hospitals in the context of congressional concern for health-delivery programs. Each class of claimants for special tax benefits should stand or fall, independent of every other class, and dependent only on the impact upon society of acquiescence to its claim.

It is notable that while universities are seeking ways to expand opportunities for the admission of the poor through scholarships and loan programs, hospitals are seeking to erect a financial barrier through pre-admission deposits. The issue of tax exemption without provision for free services is hardly likely to arise when, in fact, the institution does afford such services. It arises in the

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passed the Medicaid statute to deny tax exemption to hospitals which refuse to participate in that program and fail to admit even those poor for whom the government pays. Further, granting tax exemption to hospitals which deny admission to poor persons arguably may be a denial of equal protection. *See* Loredo v. Sierra View Dist. Hosp., Civil No. 67414 (Sup. Ct., Tulare County, Feb. 5, 1969) CCH MEDICARE & MEDICAID REP. ¶ 26,198. *Cf.* Green v. Kennedy, 309 F. Supp. 1127 (D.D.C. 1970). Tax exemption and deduction advantages may subject an otherwise private organization to constitutional obligations, and the grant of tax-exempt status may be considered as an indirect subsidization not too unlike a Hill-Burton grant.

90. *See* Rev. Rul. 64-175, 1964-1 CUM. BULL. 185 for history dating back to 1919 that cultural activities are educational under Section 501 (c) (3).

hospital area precisely because a financial barrier has been erected even as protestations of "public trust" have been voiced by AHA spokesmen about their colleagues in the hospital business.

With respect to AHA's argument that the "relief of the poor" obligation is inconsistent with the Treasury Regulation implementing Section 501(c) (3), it should be noted that Section 1.501(c) (3) 1(d) (2) of the tax regulations provides:

> Charitable defined. The term 'charitable' is used in section 501(c)(3) in its generally accepted legal sense and is, therefore, not to be construed as limited by the separate enumeration in section 501(c)(3) of other tax exempt purposes which may fall within the broad outlines of 'charity' as developed by judicial decision. Such a term includes: Relief of the poor and distressed or of the underprivileged; advancement of religion; advancement of public buildings, monuments, or works; lessening the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes, or (i) to lessen neighborhood tensions; (ii) to eliminate prejudice and discrimination; (iii) to defend human and civil rights secured by law; or (iv) to combat commuity deterioration and juvenile delinquency . . . .[91]

To be sure the list includes purposes other than "relief of the poor." However, none of the purposes therein specifically listed is fulfilled by institutions that require remuneration for their services. Recently, IRS made it clear that public interest law firms, in order to qualify for charitable status under Section 501(c)(3), must restrict their representation to cases involving public interest causes which are not "fee-generating," except in an amicus capacity.[92] On the other hand, it appears inconsistent for IRS to afford charitable status to a hospital which charges *all* its customers (and is in competition with proprietary hospitals).

With respect to defining "charitable" in its "generally accepted legal sense," to the extent there is any doubt, its historic meaning, both in the legal and popular senses, is *relief of the poor* and not *assistance to nonprofit fee-charging institutions which may be benevolent.* Indeed, "benevolent" was a purpose not accepted by the draftsmen in 1913 and never incorporated into the statute. The Commissioner cannot by regulation amend the Code; regulations must be construed within the meaning of the statutory provisions they implement or are themselves void.[93]

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91. Treas. Reg. § 1.501(c)(3)1(d)(2) (1970).

92. *See* Guidelines for Tax-exempt Organizations, New York Times, Nov. 12, 1970, at 23, col. 1.

93. *Cf.* Fribourg Navigation Co. v. Commissioner, 383 U.S. 372 (1966). The reliance of AHA concerning the position of Scott on health as a charitable purpose has already been refuted above.

The basic contention of the American Hospital Association, and indeed the underlying contention of Robert Bromberg's community benefit approach,[94] is that hospital services are per se entitled to charitable status, as long as they do not confer private benefits on stockholders. This basic contention underscores why the revenue ruling is legally incorrect. The requirement of no private benefit is separately stated in Sections 501(c)(3) and 170, to the effect that "no part of net earnings of which inures to the benefit of any private shareholder or individual," and has been part of the federal tax laws since the 1909 corporation excise tax.[95] It applies to all categories, *i.e.*, educational, scientific, religious, testing for public safety, literary, and the prevention of cruelty to children or animals, as well as charitable. Arguably proprietary hospitals are also performing a community health function, and are doing so while paying substantial federal, state, and local taxes.[96] If the obligation to provide free services to persons unable to pay is removed from nonprofit hospitals, the only true legal difference between the two categories is that of dividends and other similar benefits to the stockholders. But that difference is covered by the separate clause in the Code, and is not dependent upon any meaning inherent in the words "charitable," or "scientific" or "educational."

The argument that does not appear in either the AHA testimony nor Robert Bromberg's article, but which underlies the object of the AHA in seeking an amendment to the Code, relates to the enormous inflation in the cost of health care delivery. As noted in the introduction, the rise in health care costs has far out-distanced the rise in the cost of living in the past decade. Historically, paying patients absorbed the costs of charity patients, over and above that portion of charity covered by contributors. Based on the philosophy that Medicare and Medicaid would relieve hospitals from a significant portion of formerly charity patients,[97] charity and bad debts attributable to non-Medicare and non-Medicaid patients are not permitted to be absorbed into the "reasonable costs" of Medicare and Medicaid.[98]

Therefore, the question becomes who pays the costs of charitable care. Local property owners may bear the burden through a system of "double taxation" in that their tax payments operate directly to support the public hospital and indirectly subsidize the private hospital which is relieved of its tax burdens and shares in the costs of government because it qualifies as "charitable" under

94. Although Bromberg contends that his "community benefit" approach requires more than mere nonprofit dedication to health, its actual substance amounts merely to that.

95. Law of August 5, 1909, § 38, 36 Stat. 11.

96. *See* note 39 *supra*.

97. *Hearings on Medicare and Medicaid before the Subcomm. on Medicare and Medicaid of the Senate Comm. on Finance*, 91st Cong., 2d Sess. 377 (1970).

98. *See* 42 U.S.C. § 1395x(v)(1)(A) (1964), *as amended*, (Supp. V, 1970).

the IRS ruling although it does not lessen the burden on government by caring for any of the poor. The paying patient, who pays a proportionately higher cost in order to "cover" the losses which stem from charity service to the poor, may also bear the burden. A third possibility is that all patients, both rich and poor, share the burden where the hospital does not undertake certain selective "improvements" or foregoes purchasing highly expensive machines, so that a portion of its revenues or capital assets may be devoted to charity care. A fourth possibility is that the poor bear the burden at the cost of their lives and health in a dual health system which cannot "afford" to care for them. A final possibility relates to financing health and hospital care through an outside mechanism. This is the subject to which the House Ways and Means Committee and Senate Finance Committee are presently addressing themselves. The method to be chosen depends upon the valuations of society, but whichever it is, it is a matter which should be addressed to a legislative resolution and should not be disposed of through an informal interpretive bulletin by an agency without the legal power or perspective to view the impact of its action upon the country's health crisis.

Conclusion

This article began with an summarization of the health crisis in the United States, and the incongrous fact that the population of the wealthiest nation in the world has an astonishingly poor health status compared to other developed countries.[99] The bleakest part of this picture belongs to the poor. Revenue Ruling 69-545 was issued under questionable legal authority, and, most significantly, without regard to its health consequences. If the objective of Congress, from the enactment of Medicare and Medicaid through all the varied legislative proposals which it is now considering, is to eliminate the dual health system and truly to make health care accessible to all, the tax policies expressed by IRS through that ruling run counter to that objective.

Private hospitals often stand as "foreign" enclaves in poor central cities; admission to them is limited to the "magic" of being a private patient of a staff physician. Such staff physicians and their private patients reside in the affluent suburbs. In order to meet their obligations in the past, many of these hospitals operated clinics (albeit too often inadequate). Through these clinics the poor of the inner city could gain access to the mainstream medicine which

99. A lawsuit has been instituted by five organizations representing poor people in various locations in the United States (including California, Kentucky, West Virginia, the Appalachian States generally, and the country as a whole through the National Tenants' Organization) and by nine individuals from Arizona, Louisiana, and Kentucky challenging the ruling. Eastern Kentucky Welfare Rights Org. v. Connally, Civil No. 1378-71 (D.D.C., filed Feb. 5, 1971).

is lauded by its defenders. The removal of these obligations has allowed the elimination of this one access route despite the protestations of the AHA spokesmen before the House Ways and Means Committee in February 1969 and the Senate Finance Committee in May 1970. Like Senator Ribicoff, I find that result "abhorrent." Rather than the encouragement and imaginative development of more effective means to bring the poor into the health delivery system, this Ruling has shut the door. It not only should be legally overturned; it would be a most inappropriate amendment to the Tax Code.