

## **Religious Hospitals and the Federal Community Benefit Standard—Counting Religious Purpose as a Tax-Exemption Factor for Hospitals**

*Michael J. DeBoer\**

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\* Associate Professor of Law, Faulkner University, Thomas Goode Jones School of Law. The author wishes to thank H. Beau Baez, Jeffrey B. Hammond, and Erin Hoskins for their assistance, insights, and input. The author also appreciates the research grant awarded by Faulkner University that supported my work on this Article.

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## I. INTRODUCTION

These remain challenging days for tax-exempt hospitals. Like most other enterprises struggling during difficult economic times, tax-exempt hospitals are laboring to maintain their bottom lines in the complex and competitive hospital marketplace,<sup>1</sup> which is

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<sup>1</sup> See Carolyn Davis, *Not-for-Profit Hospitals: Top-Line Revenue and Liquidity Are Critical Indicators*, FIERCE HEALTH FIN., June 30, 2010, available at <http://www.fiercehealthfinance.com/story/not-profit-hospitals-top-line-revenue-and-liquidity-are-critical-indicators/2010-06-30> (stating that “Moody’s Investor Service of New York downgraded the not-for-profit hospital sector to negative from stable in November 2008” and noting the following challenges faced by nonprofit hospitals: (1) state and federal government deficits; (2) the end of federal stimulus funds; (3) threats to the tax-exempt status of nonprofit hospitals at the national and local levels; and (4) hospital expenses such as pension expense, bad-debt expense, interest costs and bank fees, and physician-related investments); Lisa Lambert & Caryn Trokie, *Economy, Budget Woes Threaten Non-Profit Hospitals: Moody’s*, REUTERS, July 23, 2012, available at <http://www.reuters.com/article/2012/07/23/us-municipals-hospitals->

2012]

## COUNTING RELIGIOUS PURPOSE

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populated by public hospitals, for-profit hospitals, and nonprofit hospitals.<sup>2</sup> Additionally, tax-exempt hospitals have been at the center

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ratings-idUSBRE86M0UH20120723 (reporting that the “number of rating downgrades for non-profit hospitals outpaced upgrades in the first quarter of 2012” and that Moody’s Investors Service “is maintaining its long-standing negative outlook on the sector” and “remains cautious about the effects of a slow economic recovery, federal deficit cutting measures and state budget pressures on the sector”); *Nonprofit US Hospitals to Do More with Less-Moodys* [sic], REUTERS, May 9, 2012, available at <http://www.reuters.com/article/2012/05/09/usa-healthcare-nonprofits-idUSL1E8G8DDM20120509> (reporting that “[n]onprofit hospitals in the United States face a future of rising costs and dwindling funds as the healthcare reform is implemented and the Congress battles over the budget, according to Moody’s Investors Service”); *US Hospital M&A Generally Positive for Bondholders*, FITCH WIRE, FITCH RATINGS, July 6, 2012, available at [http://www.fitchratings.com/web/en/dynamic/articles/US-Hospital-MA-Generally-Positive-for-Bondholders.jsp?cm\\_sp=homepage\\_-FitchWire\\_-US%20Hospital%20MA%20Generally%20Positive%20for%20Bondholders](http://www.fitchratings.com/web/en/dynamic/articles/US-Hospital-MA-Generally-Positive-for-Bondholders.jsp?cm_sp=homepage_-FitchWire_-US%20Hospital%20MA%20Generally%20Positive%20for%20Bondholders) (identifying the following factors as driving consolidation in the nonprofit health care sector: (1) “[r]eimbursement under the Medicare and Medicaid programs is expected to be constrained due to the weak economy and difficult fiscal conditions at both the state and federal levels”; (2) “[c]ertain supplemental funding programs such as disproportionate share are facing reductions as part of the Patient Protection and Affordable Care Act”; (3) “pressure on commercial and managed care rates, which have historically offset losses on governmental reimbursement”; and (4) benefits from size and scale that result from consolidation including “diversification of revenue sources, elimination of duplication costs, and allocation of resources to better withstand likely future reductions in funding”). Tax-exempt hospitals are not alone in facing serious financial challenges—many nonprofit organizations are experiencing similar challenges. See Mark J. Cowan, *Nonprofits and the Sales and Use Tax*, 9 FLA. TAX REV. 1077, 1085 (2010) (“Due to the confluence of reduced donations and increased needs by their charitable classes, many nonprofit organizations, like state governments, are in a precarious financial position at present and could ill afford an abrupt loss of sales/use tax exemptions.”).

<sup>2</sup> In 2007, nongovernmental, nonprofit hospitals accounted for 2,913 of the 4,897 community hospitals in the United States, thus constituting nearly sixty percent of all community hospitals. AM. HOSP. ASS’N, AHA HOSPITAL STATISTICS: THE COMPREHENSIVE REFERENCE SOURCE FOR ANALYSIS AND COMPARISON OF HOSPITAL TRENDS 8 (2008) [hereinafter AHA, HOSPITAL STATISTICS]. In 2010, nongovernmental, nonprofit hospitals accounted for 2,904 of the 4,985 community hospitals. AM. HOSP. ASS’N, FAST FACTS ON U.S. HOSPITALS (Jan. 3, 2012), available at <http://www.aha.org/aha/resource-center/Statistics-and-Studies/101207fastfacts.pdf> [hereinafter AHA, FAST FACTS]. For 2010, the total number of registered hospitals was 5,754, and this number included 4,985 community hospitals, 213 federal governmental hospitals, 435 nonfederal psychiatric hospitals, 111 nonfederal long term care hospitals, and 10 hospital units of institutions. *Id.* In 2010, the total number of community hospitals included 2,904 nongovernment, nonprofit community hospitals, 1,013 for-profit, investor-owned community hospitals, and 1,068 state and local government community hospitals. *Id.*

The terms “nonprofit” and “tax-exempt” are not synonymous. John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 433, 435 (2007) [hereinafter Colombo, *Tax Exemption Policy*]. Nonprofit status is a matter of state organizational law and involves the formation of an organization, association, or trust under state law. *Id.* A nonprofit organization

of a public relations whirlwind surrounding the pricing, billing, and aggressive debt collection practices of some tax-exempt hospitals.<sup>3</sup>

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may not distribute net revenues to owners. *Id.* Tax-exempt status is a matter of state and federal tax law and involves qualifying for exemption from a state or federal tax, such as state income, sales/use, or property tax, or federal income tax. *Id.* To be exempt from tax, an organization must be a nonprofit organization and meet additional requirements imposed by state and federal tax law. *Id.* Consequently, a tax-exempt organization must be nonprofit, but a nonprofit organization is not necessarily tax exempt. *Id.*

Additionally, commentators vary in their use of the terms “nonprofit” and “not-for-profit,” and some use these terms interchangeably. Some have argued that the term “not-for-profit” “more accurately depicts the reality that such institutions may seek and earn profits as long as they are used in fulfilling the organization’s missions.” BARRY R. FURROW ET AL., HEALTH LAW § 5-11, at 202 n.1 (2d ed. 2000) (citing Robert S. Pasley, *Organization and Operation of Non-Profit Corporations—Some General Considerations*, 19 CLEV. ST. L. REV. 239, 241 (1970)). Another commentator has suggested that the term “not-for-profit,” in addition to being more cumbersome than the term “nonprofit,” “suffers from some ambiguities of its own,” but that the term “nonprofit” seems to “misleadingly suggest[] that [nonprofit] organizations . . . are distinguished by the fact that they make no profits.” Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L. J. 835, 838 n.17 (1980). Hansmann has noted that nonprofit organizations are not “barred from earning a profit,” which might also be called an annual accounting surplus or an excess of revenues over expenses; what they are barred from doing is distributing the profit. *Id.* at 838. This Article will use the term “nonprofit.”

<sup>3</sup> In a recent case, the president and chief executive officer of Fairview Health Services, a nonprofit academic health system with a history that extends back a century and includes the Lutheran church, resigned after Minnesota’s Attorney General released a report detailing aggressive debt collection practices by a firm Fairview had hired and after the system’s board decided not to renew his contract. Maura Lerner & Tony Kennedy, *Damaged Fairview Ousts Exec: Mark Eustis was Linked to Firm Behind High-Pressure Debt Collection Tactics*, STAR TRIBUNE (Minneapolis, Minn.), May 25, 2012, at 1A, available at 2012 WLNR 11114550. In another well-publicized case, an uninsured Virginia man complaining of chest pains was taken to Inova Fairfax Hospital, a tax-exempt hospital in Northern Virginia. He was charged \$29,500 for a twenty-one hour, overnight hospital stay. The hospital’s charge was reported to be considerably higher than would be charged to private and public insurance plans for the same care. Lucette Lagnado, *Anatomy of a Hospital Bill—Uninsured Patients Often Face Big Markups on Small Items: “Rules Are Completely Crazy,”* WALL ST. J., Sept. 21, 2004, available at <http://online.wsj.com/article/0,,SB109571706550822844,00.html>. Another widely publicized case involved the Yale-New Haven Hospital, a nonprofit hospital, and Quinton White, a seventy-seven-year-old widower who was still paying his wife’s hospital bill twenty years after she died. Over the years, he had paid the hospital almost \$16,000 on a \$19,000 bill, but with compounded interest charges and fees, he still owed nearly \$40,000. Lucette Lagnado, *Jeanette White Is Long Dead But Her Hospital Bill Lives On*, WALL ST. J., Mar. 13, 2003, available at <http://online.wsj.com/article/SB104750835516087900.html>. After a Yale Law School legal clinic announced its intention to bring a class action lawsuit against the hospital, other Yale-New Haven Hospital patients came forward with complaints of overly aggressive collection efforts. Lucette Lagnado, *Call It Yale v. Yale—Law-School Clinic Is Taking Affiliated Hospital to Court over Debt-Collection Tactics*, WALL ST. J., Nov. 14, 2003, available at

Negative publicity has also surrounded executive compensation at some tax-exempt hospitals.<sup>4</sup> Furthermore, reports have suggested that tax-exempt hospitals do not provide much more uncompensated care for uninsured Americans than for-profit hospitals, which are not exempt from taxes, and that the amount of charity care provided by tax-exempt hospitals does not equal the value of the tax exemptions they receive.<sup>5</sup>

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<http://online.wsj.com/article/0,,SB106876490084695900,00.html>. Between 1995 and 2003, a nonprofit hospital in Illinois, Carle Foundation Hospital, the primary teaching hospital of the University of Illinois, sought more than 164 arrest warrants for debtors who missed court hearings, including a warrant that resulted in the arrest of a man who missed a court hearing involving a \$579 hospital bill. Lucette Lagnado, *Hospitals Try Extreme Measures to Collect Their Overdue Debts—Patients Who Skip Hearings on Bills Are Arrested; It's a 'Body Attachment'*, WALL ST. J., Oct. 30, 2003, available at <http://online.wsj.com/article/0,,SB106745941349180300,00.html>. A county agency in Illinois proceeded against Carle Foundation Hospital and another tax-exempt hospital, Provena Covenant Medical Center, seeking to revoke their tax-exempt status based upon these and other collection tactics. *Id.* The Illinois Department of Revenue later revoked the tax-exempt status of Provena Covenant Medical Center after it found that the Catholic hospital was not operating with a charitable purpose. Lucette Lagnado, *Hospital Found 'Not Charitable' Loses Its Status as Tax Exempt*, WALL ST. J., Feb. 19, 2004, available at [http://www.rasmusen.org/g406/readings-old/readings-refg406/hospital\\_loses\\_tax\\_exempt.WSJ.2004.htm](http://www.rasmusen.org/g406/readings-old/readings-refg406/hospital_loses_tax_exempt.WSJ.2004.htm).

<sup>4</sup> See, e.g., Julie Appleby, *Non-Profit Hospitals' Top Salaries May Be Due for a Check-Up*, USA TODAY, Sept. 30, 2004, available at [http://www.usatoday.com/money/industries/health/2004-09-29-nonprofit-salaries\\_x.htm](http://www.usatoday.com/money/industries/health/2004-09-29-nonprofit-salaries_x.htm) (reporting that “[e]xecutives at the six largest non-profit, tax-exempt hospital systems all make more than \$1.2 million a year” noting that “[o]ne large system has given \$5.1 million in forgivable loans to eight top executives since 1998,” and summarizing the compensation paid and perks given to executives at several large nonprofit hospitals); Jamie Smith Hopkins, *Paychecks Raise Eyebrows*, BALT. SUN, May 15, 2005, available at <http://www.baltimoresun.com/business/bal-bz.ex.nonprofits15may15,0,3189688.story> (noting that Bon Secours Health System, Inc., a nonprofit organization, paid its chief executive officer more than \$1.5 million in salary, bonus, and benefits in fiscal year 2003, and that the University of Maryland Medical System Corporation, the Johns Hopkins Health System Corporation, MedStar Health, Inc., and LifeBridge Health, all located in Maryland, each paid their top executive at least \$1.2 million during that year).

<sup>5</sup> See, e.g., John D. Colombo, *The Role of Tax Exemption in a Competitive Health Care Market*, 31 J. HEALTH POL. POL'Y & L. 621, 632 (2006) [hereinafter Colombo, *The Role of Tax Exemption*] (citations omitted) (stating that researchers have found that “what charity care is provided [by nonprofit hospitals] often does not measure up to the value of taxes forgone by exemption”); 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 (2003) (citations omitted) (stating that “[r]egardless of its merits as a measure of charity, research on the gap between for-profit and not-for-profit provision of uncompensated care cannot support arguments in favor of the not-for-profit sector”). Both proponents and opponents of the nonprofit form and tax exemption are able to cite empirical literature in support of their respective positions. Professor Colombo has noted that the empirical evidence and arguments supporting the nonprofit form “are decidedly mixed” and that the “conflict in the empirical work

State and federal legislatures and regulators have responded with an array of reforms. These reform efforts have focused on undesirable pricing, billing, and collection practices, disclosure practices regarding indigent care policies, and executive compensation practices. They have also focused on various economic and policy considerations, including: (1) whether tax-exempt hospitals provide sufficient charity care to offset the subsidies they receive through state and federal tax exemptions; (2) whether the qualifications for tax exemption are an effective prod to spur nonprofit hospitals to provide more charity care and address the larger social problem of the uninsured and underinsured; and (3) whether bad debt and Medicaid and Medicare under-reimbursement should be included or excluded in calculating the amount of charity care.<sup>6</sup> In these reforms, policy makers and regulators have scrutinized and enhanced the community benefit standard, the primary standard used for over four decades to determine whether a nonprofit hospital qualifies for the federal income tax exemption, and they have imposed additional requirements on nonprofit hospitals to qualify for tax exemption under state law. New laws and regulations have also increased governmental oversight of exempt hospitals, restricted charging, billing, and collection practices, and

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and arguments” means “that policy makers should neither uncritically accept the argument of nonprofit superiority nor dismiss it out of hand.” Colombo, *The Role of Tax Exemption*, *supra*, at 634.

<sup>6</sup> For instance, a study for the Congressional Budget Office, which was requested by the Chairman of the House Committee on Ways and Means, observed that “[t]he various tax exemptions provided to nonprofit hospitals have come under scrutiny by policymakers, with the central concern being whether those hospitals provide community benefits that justify forgone government tax revenues.” CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 1 (2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>; see also initiatives discussed *infra* Section III.A. Scholars and commentators have advocated using tax exemption policy to address the problem of the uninsured and underinsured by requiring nonprofit hospitals to satisfy certain charity care standards. See, e.g., Colombo, *Tax Exemption Policy*, *supra* note 2, at 434, 449–53 (confessing a shift in his perspective from favoring using tax exemption policy and strict charity care standards to change hospital behavior and promote provision of health care to uninsured individuals to opposing such use of charity care standards because of certain policy weaknesses); Colombo, *The Role of Tax Exemption*, *supra* note 5, at 624–25. Scholars have questioned whether it is advisable to require tax-exempt hospitals to shoulder such a large portion of the uninsured and underinsured problem in America. See Colombo, *Tax Exemption Policy*, *supra* note 2, at 449–50 (citations omitted) (“Perhaps the biggest policy weakness [of a strict charity care standard] is that there simply is not enough money in the tax exemption system to make a significant dent in the problem of medical care for the uninsured . . . . Put bluntly, we have an enormous problem in financing medical care for the uninsured and under-insured, and tax exemptions simply cannot pay for it.”).

required a minimum amount of charity care.<sup>7</sup>

However, an important reality has been largely overlooked in these efforts (and in prior efforts) to reform the tax-exemption standards governing nonprofit hospitals. In the United States, a substantial percentage of nongovernmental, nonprofit community hospitals are religious institutions.<sup>8</sup> Furthermore, an array of religious traditions and denominations (both Christian and non-Christian) have sponsored hospitals, including the Baptist, Catholic, Episcopal, Jewish, Latter-day Saints (Mormon), Lutheran, Methodist,

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<sup>7</sup> See *infra* Sections II.D & III.A.

<sup>8</sup> In its classification of hospitals, the American Hospital Association (AHA) distinguishes nongovernmental, nonprofit hospitals that are church-operated from other nongovernmental, nonprofit hospitals. See AMERICAN HOSPITAL ASSOCIATION, AHA GUIDE: AMERICA'S DIRECTORY OF HOSPITALS AND HEALTH CARE SYSTEMS (2006). The AHA classifies hospitals according to the following four types based upon organization control: government, nonfederal; non-government, not-for-profit; investor-owned, for-profit; and government, federal. The government, nonfederal type is further divided into the following categories: state; county; city; city-county; and hospital district or authority. The non-government, not-for-profit type is comprised of two categories: church-operated; and other not-for-profit. Investor-owned, for-profit is divided into three categories: individual; partnership; and corporation. Finally, the government, federal has the following categories: Air Force; Army; Navy; Public Health Service (PHS); Veteran's Affairs; PHS Indian Service; Department of Justice; and other federal. Each of these has a separate classification code. For instance, the AHA has assigned church-operated hospitals control code 21 and other not-for-profit hospitals control code 23. This Article uses the term "religious hospital" generically to refer to Catholic and other church-owned hospitals. The AHA defines community hospitals as follows:

[A]ll nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers and other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

AHA, FAST FACTS, *supra* note 2. Several legal scholars have thoughtfully studied legal and policy issues related to religious hospitals, but additional study is warranted. See, e.g., William W. Bassett, *Private Religious Hospitals: Limitations upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455 (2001); Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429 (1995); Donald H.J. Hermann, *Religious Identity and the Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers*, 34 CREIGHTON L. REV. 927 (2001); Lawrence E. Singer, *Does Mission Matter?*, 6 HOUS. J. HEALTH L. & POL'Y 347 (2006); Lawrence E. Singer & Elizabeth Johnson Lantz, *The Coming Millennium: Enduring Issues Confronting Catholic Health Care*, 8 ANNALS HEALTH L. 299 (1999); Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159 (1997).

Presbyterian, and Seventh-day Adventist traditions.<sup>9</sup>

Among religious hospitals, Catholic hospitals have predominated. In 2009, there were 624 Catholic hospitals in the United States,<sup>10</sup> which represented almost 12.4% of all community hospitals.<sup>11</sup> In other words, one of every eight community hospitals is a Catholic hospital.<sup>12</sup> Catholic hospitals constitute slightly more than twenty-one percent of all nonprofit hospitals.<sup>13</sup> Of all patients admitted to a hospital in the United States in 2009, sixteen percent were admitted to a hospital affiliated with the Catholic Church.<sup>14</sup> Medicare discharges of Catholic hospitals totaled 2,485,715, and Medicaid discharges totaled 916,020.<sup>15</sup> Furthermore, eleven of the

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<sup>9</sup> See generally JOHN R. AMOS ET AL., *THE SEARCH FOR IDENTITY: CANONICAL SPONSORSHIP OF CATHOLIC HEALTHCARE* (1993); STANLEY S. HARAKAS, *HEALTH AND MEDICINE IN THE EASTERN ORTHODOX TRADITION: FAITH, LITURGY, AND WHOLENESS* (1990); CATHOLIC HEALTH ASSOCIATION, *THE SEARCH FOR IDENTITY: CANONICAL SPONSORSHIP OF CATHOLIC HEALTHCARE* (1988); DAVID M. FELDMAN, *HEALTH AND MEDICINE IN JEWISH TRADITION: L'HAYIM TO LIFE* (1986); E. BROOKE HOLIFIELD, *HEALTH AND MEDICINE IN THE METHODIST TRADITION: JOURNEY TOWARDS HOLINESS* (1986); DAVID H. SMITH, *HEALTH AND MEDICINE IN THE ANGLICAN TRADITION: CONSCIENCE, COMMUNITY, AND COMPROMISE* (1986); KENNETH L. VAUX, *HEALTH AND MEDICINE IN THE REFORMED TRADITION: PROMISE, PROVIDENCE, AND CARE* (1984); MARTIN E. MARTY, *HEALTH AND MEDICINE IN THE LUTHERAN TRADITION* (1983); MARTIN E. MARTY & KENNETH L. VAUX, *HEALTH, MEDICINE, AND THE FAITH TRADITIONS: AN INQUIRY INTO RELIGION AND MEDICINE* (1982).

<sup>10</sup> *Health Care Reform, Facts and Statistics*, U.S. CONF. OF CATHOLIC BISHOPS, <http://old.usccb.org/healthcare/facts.shtml> (last visited Oct. 4, 2012) [hereinafter USCCB, *Health Care Reform*].

<sup>11</sup> *Fast Facts—Care Provided by Catholic Hospitals*, CATHOLIC HEALTH ASS'N OF THE U.S., [http://www.chausa.org/Pages/Newsroom/Fast\\_Facts/](http://www.chausa.org/Pages/Newsroom/Fast_Facts/) (last visited Oct. 4, 2012) [hereinafter CHAUS, *Fast Facts*]. This number represents almost 11% of all registered hospitals. The expenses of Catholic hospitals totaled \$91.76 billion. CHAUS, *Fast Facts, supra*. The expenses of community hospitals totaled \$583.3 billion, and the expenses of nonprofit hospitals totaled \$436.3 billion. AHA, *HOSPITAL STATISTICS, supra* note 2, at 9.

<sup>12</sup> Stephanie Simon, *Health-Care Overhaul Creates Dilemma for Some Catholics*, WALL ST. J., Aug. 5, 2009, [online.wsj.com/article/SB124942609292506021.html](http://online.wsj.com/article/SB124942609292506021.html).

<sup>13</sup> This number is calculated based upon the total number of nongovernmental, nonprofit hospitals in 2007 (2,913) and in 2010 (2,904). See AHA, *HOSPITAL STATISTICS, supra* note 2, at 8; AHA, *FAST FACTS, supra* note 2.

<sup>14</sup> Simon, *supra* note 12. Catholic hospitals also employ 750,000 people. *Id.* Catholic hospitals make up 12.7% of the nation's hospitals. CHAUS, *Fast Facts, supra* note 11. The total number of staffed beds in Catholic hospitals was 122,475. *Id.* The total number of staffed beds in community hospitals was 800,892, and the total number of staffed beds in nonprofit hospitals was 553,748. AHA, *HOSPITAL STATISTICS, supra* note 2, at 8. The total number of admissions at Catholic hospitals was 5,647,565. CHAUS, *Fast Facts, supra* note 11. The total number of admissions in community hospitals was 35,345,986, and the total number of admissions in nonprofit hospitals was 25,752,285. AHA, *HOSPITAL STATISTICS, supra* note 2, at 8.

<sup>15</sup> CHAUS, *Fast Facts, supra* note 11. Medicare discharges of community hospitals totaled 14,912,904, and Medicaid discharges totaled 6,870,817. AHA, *HOSPITAL*



forty largest hospital systems in the United States are Catholic.<sup>16</sup> Consequently, “Catholic hospitals and health-care facilities make up the largest private nonprofit health-care system in the nation.”<sup>17</sup>

This inattention to the religious identities and missions of many nonprofit hospitals is reflected in federal tax-exemption law, and no aspect of the community benefit standard explicitly factors into consideration the religious identities and missions of religious hospitals.<sup>18</sup> Likewise, legislators, administrative bodies, courts, and scholars have seemingly overlooked (or at least under-appreciated) the religious identities and missions of religious hospitals.<sup>19</sup>

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STATISTICS, *supra* note 2, at 9.

<sup>16</sup> USCCB, *Health Care Reform*, *supra* note 10.

<sup>17</sup> Thomas C. Berg, *What Same-Sex-Marriage and Religious-Liberty Claims Have in Common*, 5 NW. J. L. & SOC. POL’Y 206, 224 (2010).

<sup>18</sup> For a discussion of the community benefit standard, see *infra* Sections II.C. and III.

<sup>19</sup> The following discussion of nonprofit hospitals and tax exemption by John D. Colombo, an influential legal scholar on health law and tax exemption issues, may illustrate a similar inattention among scholars:

Several early studies of nonprofit behavior failed to differentiate among the private nonprofit hospital, the government-owned hospital, and the university-affiliated teaching/research hospital. In sorting through the use of tax exemption as a behavioral subsidy, however, it is critical to keep these groups separate. In the case of government-owned hospitals, tax exemption is not really a subsidy at all, because exemption flows from the fact that it makes no sense for the government to tax itself. Similarly, university-affiliated or free-standing teaching hospitals or medical research organizations presumably would be exempt as “educational institutions” or as “scientific” organizations under section 501(c)(3) without regard to the community benefit standard of exemption because of their education or research mission. If these organizations supply virtually all the differential behavior between nonprofits and for-profits, serious questions arise regarding the efficacy of the community benefit test in encouraging worthy behavior by nonprofit hospitals.

Colombo, *The Role of Tax Exemption*, *supra* note 5, at 629 (citing John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29 (2005)). In the context of this quotation, Professor Colombo provided a warning regarding the use of empirical literature, especially some early studies, to argue for or against the nonprofit form and continued use of tax exemption. His point that nonprofit hospitals should be differentiated is well-taken, but in his differentiation of hospitals, he did not distinguish religious hospitals as a form or consider whether they should be treated as “religious” organizations under § 501(c)(3). Over a decade earlier, Professor Colombo, in an article coauthored with Professor Mark A. Hall, wrote: “Historically, charity care and community benefit are merely the residual I.R.C. § 501(c)(3) categories to which hospitals have been relegated in their search for exemption when they have been unable to qualify under the enumerated categories of religious, educational, or scientific institutions.” John D. Colombo & Mark A. Hall, *The Future of Tax-Exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1, 22 (1992). They then added: “Under current law, many hospitals may not

Furthermore, religious hospitals themselves have minimized or downplayed their own religious identities and missions, seemingly content to operate like other nonprofit hospitals.<sup>20</sup>

This Article argues that this inattention to the religious identities and missions of religious hospitals should end, and it recommends that the religious purpose of religious hospitals should be explicitly counted for purposes of determining tax exemption under federal corporate income tax law as well as state tax law.<sup>21</sup> This argument is premised upon the special protections secured to religious institutions under federal and state constitutions, the history of tax exemptions extended to religious and charitable institutions, the separate enumeration of religious purpose as an exempt purpose in §

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need to rely on these residual categories if they serve as teaching and research institutions at private universities.” *Id.* Again, the religious purpose of religious hospitals escaped attention.

<sup>20</sup> See Alan E. Brownstein, *Evaluating School Voucher Programs Through a Liberty, Equality, and Free Speech Matrix*, 31 CONN. L. REV. 871, 938 (1999) (arguing that “religion plays a different and much less sectarian role in medical facilities today than it does in schools. The primary purpose of modern hospitals is to treat ill and injured individuals in an institutional environment that is driven as much by economics as any other factor. To the extent that these institutions are involved with the inculcation or promotion of beliefs, they are client-centered and respectful of religious differences. Spiritual values may still motivate the provision of care, but in the great majority of cases they do not determine its content.”) (citing Gloria Shur Bilchik, *When the Saints Go Marching Out: Is American Health Care Losing Its Religion?*, HOSPS. & HEALTH NETWORKS, May 20, 1998, at 38 (noting that “the picture has changed [so] dramatically” from the first part of the century when “hospitals stayed close to their religious roots” that some commentators “compare the intentional diminution of church control to a parallel phenomenon in higher education early in the century”)); H. Tristram Engelhardt, Jr., *The DeChristianization of Christian Health Care Institutions, or, How the Pursuit of Social Justice and Excellence Can Obscure the Pursuit of Holiness*, in 7 CHRISTIAN BIOETHICS 151, 151–52 (2001) (commenting that during the last third of the twentieth century, Christian health care, but especially Catholic health care, experienced “a dramatic loss in the spirit of commitment to religious service” resulting in the radical curtailment of religious administrative presence in hospitals, discovered “the provision of charity care ever more expensive” because of the dramatic rise in the cost of health care, confronted a “culture [that] was profoundly secularized,” and found the demography of medical and other staff changed so that it “is often no longer predominantly Roman Catholic.”) Scholars have observed that faith-based organizations and programs are of different types and that they exist on a continuum from faith-permeated organizations and programs to secular organizations and programs. See Ronald J. Sider & Heidi Rolland Unruh, *Typology of Religious Characteristics of Social Service and Educational Organizations and Programs*, 33 NONPROFIT & VOLUNTARY SECTOR Q. 109, 114–15 (2004). Sider and Unruh have identified the following six categories: faith-permeated organizations and programs; faith-centered organizations and programs; faith-affiliated organizations and programs; faith-background organizations and programs; faith-secular partnerships; and secular organizations and programs. *Id.* at 119–20.

<sup>21</sup> Although this argument presented in this Article has implications for state tax law, the focus will be upon federal income tax law.

501(c)(3) of the Internal Revenue Code, and the important role of nonprofit organizations in American society. This Article develops this argument in several steps. First, it traces some of the historical background regarding the tax exemption of nonprofit and religious hospitals in the United States, including the development of the community benefit standard.<sup>22</sup> Second, it examines recent federal legislative and regulatory initiatives, including the Affordable Care Act, that have amplified the community benefit standard with additional requirements that hospitals must meet to qualify for and retain tax-exempt status under federal income tax law.<sup>23</sup> Third, it offers a range of reasons that support counting the religious purpose of religious hospitals for determining tax-exempt status.<sup>24</sup> Fourth, it sets forth a typology of nonprofit hospitals and offers two sets of proposals—the first suggesting revisions to federal income tax exemption law and regulation, and the second encouraging religious hospitals to make their religious purpose more evident in their organizations and operations.<sup>25</sup>

## II. BACKGROUND REGARDING TAX EXEMPTION OF HOSPITALS IN THE UNITED STATES

The tax-exemption standards that govern nonprofit hospitals developed over many years and grew out of exemptions granted to charitable and religious institutions. This Section explores that history of development, but goes further by placing developments in tax-exemption standards in the broader context of the evolution of hospitals as institutions in America and other changes in the law that affected charitable and religious institutions generally.

### A. *A Very Short History of the Beginnings of the Federal Income Tax and Exemption*

In 1894, Congress enacted a statute that imposed an income tax,<sup>26</sup> which the Supreme Court declared unconstitutional soon

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<sup>22</sup> See *infra* Section II.

<sup>23</sup> See *infra* Section III.

<sup>24</sup> See *infra* Section IV.

<sup>25</sup> See *infra* Section V.

<sup>26</sup> Revenue Act of 1894, ch. 349, § 73, 28 Stat. 570 (1894). The Revenue Act of 1894, also known as the Wilson-Gorman Tariff Act, is not the beginning of the history of federal taxes and exemption. At the federal level, the authority of Congress to tax was slow in developing, and likewise tax exemption developed slowly. The United States Constitution, which was adopted in 1789, empowered Congress to “lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States,” and it required that “all

thereafter.<sup>27</sup> In the same legislation, Congress exempted from income taxation “corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes, including fraternal beneficiary associations.”<sup>28</sup> In 1909, Congress passed a new corporate income tax measure and modified the exemption standard to exempt “any corporation or association organized and operated exclusively for religious, charitable, or education purposes, no part of the net income of which inures to the benefit of any private stockholder or individual.”<sup>29</sup>

On February 3, 1913, the Sixteenth Amendment to the Constitution of the United States was ratified, and it empowered Congress to “lay and collect taxes on incomes, from whatever source derived, without apportionment among the several States, and without regard to any census or enumeration.”<sup>30</sup> In the Tariff Act of 1913, Congress imposed a tax on “net income,” and it granted certain exemptions and prohibited private inurement much like it had earlier.<sup>31</sup> The Act was designed to tax specific categories of activities and income and to exempt all others,<sup>32</sup> and the following comment by Senator Cordell Hull, one of the drafters of the legislation, reflects this intention: “[A]ny kind of society or corporation that is not doing business for profit and not acquiring profit would not come within the meaning of the taxing clause. . . . I see no occasion whatever for

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Duties, Imposts and Excises . . . be uniform throughout the United States.” U.S. CONST. art. I, § 8, cl. 1. Up to the time of the Civil War, the federal government largely relied upon high customs duties and the sale of public lands to generate revenue. U.S. Dept. of the Treasury, Fact Sheets: Taxes, History of the U.S. Tax System, <http://www.treas.gov/education/fact-sheets/taxes/ustax.shtml> (last visited Oct. 11, 2010). Congress enacted the Revenue Act of 1861 to pay expenses related to the Civil War, and included within the act was a tax on personal incomes. Revenue Act of 1861, § 49, 12 Stat. 292, at 309 (1861). However, this federal income tax was repealed by Congress in 1872.

<sup>27</sup> *Pollack v. Farmers' Loan & Trust Co.*, 157 U.S. 429 (1895). The Supreme Court declared unconstitutional the income tax provision of the 1894 Act because it was not apportioned according to the population of each state.

<sup>28</sup> Revenue Act of 1894, ch. 349, § 32, 28 Stat. 509, 556 (1894); see Kenneth Liles & Cynthia Blum, *Development of the Federal Tax Treatment of Charities*, 39 LAW & CONTEMP. PROBS. 6 (1974) (surveying the history of the charitable exemption).

<sup>29</sup> Revenue Act of 1909, ch. 6, § 38, 36 Stat. 11, 112 (1909).

<sup>30</sup> U.S. CONST. amend. XVI.

<sup>31</sup> Tariff Act of 1913, ch. 16, § II(G)(a), 38 Stat. 114. For Congress, extending tax exemption to certain nonprofit organizations synchronized tax policy with political theory and recognized in federal law well-established, longstanding exemptions. BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT ORGANIZATIONS* 14 (9th ed. 2007).

<sup>32</sup> 50 Cong. Rec. 1306 (1913).

undertaking to particularize.”<sup>33</sup>

In the War Revenue Act of 1917, Congress established an individual income tax deduction for contributions to tax-exempt organizations, which encouraged individuals to make charitable contributions despite difficult economic circumstances when they would otherwise be reluctant to give.<sup>34</sup> In the Revenue Act of 1918, Congress established a similar charitable deduction from the estate tax.<sup>35</sup> The Revenue Act of 1934 set limits on lobbying activities by exempt organizations by directing that “no substantial part” of an exempt organization’s activities could involve “propaganda” or attempt “to influence legislation.”<sup>36</sup> In the Revenue Act of 1936, Congress extended to corporations the deduction for charitable contributions.<sup>37</sup> In the Revenue Act of 1943, Congress required tax-exempt organizations to file 990 forms, although religious organizations, most schools, and publicly supported charitable organizations were exempt from this filing requirement.<sup>38</sup> In the Revenue Act of 1950, Congress imposed a tax on the “unrelated business income” of tax-exempt organizations to reduce the competitive advantage of exempt organizations over organizations that were required to pay taxes on income.<sup>39</sup> This unrelated business income tax (UBIT) was designed to tax income produced from activities of exempt organizations that are regularly carried on by trades and businesses and that are not substantially related to the

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<sup>33</sup> *Id.*

<sup>34</sup> War Revenue Act of 1917, ch. 63, § 1201(2), 40 Stat. 300 (1917). The Act provided a deduction for the following contributions or gifts:

Contributions or gifts actually made within the year to corporations or associations organized and operated exclusively for religious, charitable, scientific, or educational purposes, or to societies for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of fifteen per centum of the taxpayer’s taxable net income as computed without the benefit of this paragraph. Such contributions or gifts shall be allowable as deductions only if verified under rules and regulations prescribed by the Commissioner of Internal Revenue, with the approval of the Secretary of the Treasury.

*Id.* at 330.

<sup>35</sup> Revenue Act of 1918, ch. 18, § 1309, 40 Stat. 1143 (1918).

<sup>36</sup> Revenue Act of 1934, ch. 277, § 23, 48 Stat. 680, 690 (1934).

<sup>37</sup> Revenue Act of 1936, ch. 690, § 101(6), 49 Stat. 1674 (1936).

<sup>38</sup> Revenue Act of 1943, ch. 63, § 117, 58 Stat. 21 (1943). Churches, religious organizations, and certain other institutions were excluded from this filing requirement.

<sup>39</sup> Revenue Act of 1950, ch. 994, 64 Stat. 906 (1950). As originally enacted, the unrelated business income tax (UBIT) did not apply to churches and certain other tax exempt organizations. Revenue Act of 1950, § 421(b)(1), 64 Stat. 948.

organization's exempt purpose, whether or not the income from the activity was used solely for exempt purposes.<sup>40</sup>

*B. The Late Nineteenth and Early Twentieth Century Transformation of the American Hospital*

As these developments occurred in federal income tax law, hospitals in America were undergoing a dramatic transformation.<sup>41</sup> In the eighteenth and nineteenth centuries, the ill, the poor, and the homeless received care for illness in almshouses, many of which were operated as charitable institutions and funded in substantial part by religious organizations.<sup>42</sup> These almshouses were the predecessors to the American hospital system.<sup>43</sup> Toward the end of the nineteenth century and the beginning of the twentieth century, individuals with financial means received their care from physicians at their homes or their physicians' offices, but with developments in anesthesia, asepsis, and medical technology, hospitals gradually came to be viewed as treatment centers at which even wealthy individuals would receive

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<sup>40</sup> The report of the Senate Finance Committee stated:  
The problem at which the tax on unrelated business income is directed is primarily that of unfair competition. The tax-free status of section [501] organizations enables them to use their profits tax-free to expand operations, while their competitors can expand only with the profits remaining after taxes . . . . [The legislative proposal] merely impose[s] the same tax on income derived from an unrelated trade or business as is borne by their competitors. In fact it is not intended that the tax imposed on unrelated business income will have any effect on the tax-exempt status of any organization.

S. REP. NO. 81-2375 (1950), as reprinted in 1950 U.S.C.C.A.N. 3053, 3081 (new paragraph designation omitted).

<sup>41</sup> Nina Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 9 (1995).

<sup>42</sup> Crimm, *Evolutionary Forces*, *supra* note 41; see also Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 318 (1991) [hereinafter Hall & Colombo, *The Charitable Status*] ("Nonprofit hospitals have been characterized as voluntary since the nineteenth century, when they were organized by religious societies, heavily funded by donations, and staffed by doctors who worked without compensation and nurses who worked for room and board as part of their lifetime commitment to a religious order devoted to caring for the poor."). For comprehensive treatments of the history of hospitals in the United States, see generally J. DAVID SEAY & BRUCE C. VLADECK, EDS., *IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS* (1988); CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* (1987); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982); WILLIAM H. WILLIAMS, *AMERICA'S FIRST HOSPITAL: THE PENNSYLVANIA HOSPITAL 1751-1841* (1976).

<sup>43</sup> Crimm, *Evolutionary Forces*, *supra* note 41, at 9.

care.<sup>44</sup> However, wealthy patients were often treated at small physician-owned proprietary hospitals for a fee, but poor and middle class individuals received care at larger hospitals supported by religious organizations and government subsidies.<sup>45</sup>

During the first half of the twentieth century, the American hospital sector experienced significant transformation.<sup>46</sup> Medical education was also transformed, and many medical schools aligned with nonprofit hospitals.<sup>47</sup> The number of charitable, nonprofit hospitals grew, and the number of proprietary hospitals decreased.<sup>48</sup> This trend, which was aided by the 1946 enactment of the Hospital Survey and Construction Act (the Hill-Burton Act), continued for a couple of decades.<sup>49</sup>

Additionally, in the Depression era, as patients struggled to afford health care services and as hospitals and physicians experienced a shortage of patients to treat, health insurance emerged as a mechanism for financing health care in the United States.<sup>50</sup> Blue Cross (hospital services) and Blue Shield (physician services) plans, typically established as nonprofit organizations, were developed by hospitals and physicians to finance health care.<sup>51</sup> Blue Cross plans developed in local and regional areas in the late 1920s and early 1930s, and soon hospital associations established larger Blue Cross

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<sup>44</sup> Crimm, *Evolutionary Forces*, *supra* note 41, at 9.

<sup>45</sup> *Id.* at 10.

<sup>46</sup> Hall & Colombo, *The Charitable Status*, *supra* note 42, at 318–19 (“The role of hospitals as ‘almshouses for the poor’ changed rapidly during the first half of the twentieth century with developments in anesthesia, surgical technique and other aspects of medical science that suddenly transformed hospitals from the dumping ground of humanity to the pinnacle establishment of the health care delivery system. Still, nonprofit hospitals continued in their voluntary tradition, despite opening their doors to paying patients and a secular staff, by maintaining their commitment to treat all patients regardless of their ability to pay and by their continued, if partial, reliance on volunteer labor.”).

<sup>47</sup> Crimm, *Evolutionary Forces*, *supra* note 41, at 10–12.

<sup>48</sup> Some scholars have attributed the early twentieth-century expansion of the voluntary hospital sector to “the desire of diverse ethnic and religious groups to create institutions that would cater to their distinct treatment needs without discrimination.” Hall & Colombo, *The Charitable Status*, *supra* note 42, at 407 (“The early growth of voluntary hospitals after the turn of the century reflected the idiosyncratic qualities of the community they served. Thus, Catholics desired a hospital where last rites would be administered and Jews desired one where the staff spoke Yiddish and served kosher food.”) (quotation marks, footnotes, and citations omitted). The religious and ministerial components of this expansion should not be overlooked, and Catholic and Jewish hospitals were not the only religiously-affiliated hospitals expanding during this period.

<sup>49</sup> The Hospital Survey and Construction Act, ch. 958, 60 Stat. 1040 (1946).

<sup>50</sup> FURROW, *supra* note 2, at § 9-1.

<sup>51</sup> *Id.*

plans at the state level that provided room, board, and other services for a monthly fee.<sup>52</sup> Physicians quickly followed with Blue Shield plans that initially provided in-patient surgical services but then added a wider range of medical services.<sup>53</sup> The Blue Cross and Blue Shield plans expanded throughout the country, and commercial insurance companies soon entered the market.<sup>54</sup> As “service benefit” plans, the Blue Cross and Blue Shield plans directly and fully paid hospitals and physicians for the services rendered.<sup>55</sup> Commercial insurers offered “indemnity” plans that would indemnify or reimburse insureds for payments they had made to providers for services rendered.<sup>56</sup> As contracts for insurance, health insurance plans provided coverage for broad categories of services, such as hospital, physician, and diagnostic services, and with time, additional covered services were placed in the bundle.<sup>57</sup> Under these plans, hospitals and physicians received generous retroactive fee-for-service payment for the services they rendered.<sup>58</sup>

In the middle of the twentieth century, significant legal developments affected the charitable and religious hospital sector. In the 1950s and 1960s, most states revoked the doctrine of charitable immunity, which exposed charitable and religious organizations to tort liability for damages, such as medical malpractice liability.<sup>59</sup> Notably, a substantial number of the cases in which courts abrogated charitable immunity involved hospitals.<sup>60</sup> States also began to enact certificate-of-need laws, beginning with New York in 1964 and most

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<sup>52</sup> Randall R. Bovbjerg, Charles C. Griffin & Caitlin E. Carroll, *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 141, 143 (1993).

<sup>53</sup> *Id.*

<sup>54</sup> Bovbjerg, *supra* note 52, at 143.

<sup>55</sup> *Id.*; FURROW, *supra* note 2, at § 9-1.

<sup>56</sup> Bovbjerg, *supra* note 52, at 143; FURROW, *supra* note 2, at § 9-1.

<sup>57</sup> William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 605 (2003).

<sup>58</sup> Bovbjerg, *supra* note 52, at 143, 152.

<sup>59</sup> See generally Janet Fairchild, Annotation, *Tort Immunity of Nongovernmental Charities—Modern Status*, 25 A.L.R. 4th 517 (1983).

<sup>60</sup> See, e.g., *Abernathy v. Sisters of St. Mary's Hosp.*, 446 S.W.2d 599 (Mo. 1969); *Granger v. Deaconess Hosp. of Grand Forks*, 138 N.W.2d 443 (N.D. 1965); *Adkins v. St. Francis Hosp.*, 143 S.E.2d 154 (W. Va. 1965); *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 448 (Cal. 1963) (citing *Malloy v. Fong*, 232 P.2d 241 (Cal. 1951)); *Kojis v. Doctor's Hosp.*, 107 N.W.2d 131 (Wis. 1961); *Mullikin v. Jewish Hosp. Ass'n*, 348 S.W.2d 930 (Ky. 1961); *Gillum v. Good Samaritan Hosp.*, 348 S.W.2d 924 (Ky. 1961); *Parker v. Port Huron Hosp.*, 105 N.W.2d 1 (Mich. 1960); *Durney v. St. Francis Hosp., Inc.*, 83 A.2d 753 (Del. 1951); *Mississippi Baptist Hosp. v. Holmes*, 55 So.2d 142 (Miss. 1951), *aff'd* 56 So.2d 709 (Miss. 1952).



other states in the 1970s, after Congress passed the National Health Planning and Resources Development Act of 1974, which conditioned federal funding for a number of health care programs on states adopting plans to allocate health care resources and enacting certificate-of-need laws.<sup>61</sup> The purpose of state certificate-of-need laws was to restrain health care costs and foster coordination and planning regarding facility construction, new equipment, and expanded services. These state statutes required hospitals to apply for government approval to expand their facilities and purchase new equipment and to disclose their financial conditions as part of the approval process.<sup>62</sup> Additionally, in the Social Security Amendments of 1965, Congress established two public health insurance programs: the Medicare program, a nationwide, federally-funded health insurance program for elderly individuals; and the Medicaid program, a cooperative federal/state public health insurance program for low-income individuals and families.<sup>63</sup>

During this same period, religious hospitals, which had existed as constituent parts of their sponsoring religious organizations, formed separate corporate entities.<sup>64</sup> The cumulative effect of these legal developments involving nonprofit and tax-exempt hospitals combined to push them to separately incorporate.<sup>65</sup> Although this strategy seemed advisable for religious hospitals and their sponsoring religious organizations, the religious sponsors faced the serious challenge of incorporating while retaining control of religious hospitals, maintaining their religious identities, and pursuing their

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<sup>61</sup> National Health Planning and Resources Development Act of 1974, Pub. L. 93-641, 88 Stat. 2225 (1975).

<sup>62</sup> See FURROW, *supra* note 2, at §§ 1-18-20.

<sup>63</sup> See Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 102-11, 79 Stat. 286, 291-343 (codified as amended at 42 U.S.C. §§ 1395-1395kkk-1) (Medicare); Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (codified as amended at 42 U.S.C. §§ 1396-1396w-5) (Medicaid). In the Social Security Amendments, the Medicare and Medicaid programs were adopted as Title XVIII and Title XIX, respectively, of the Social Security Act, which Congress had enacted decades earlier to establish various federal social welfare programs, including Social Security retirement and disability insurance programs. Social Security Act, Pub. L. No. 74-271, ch. 531, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 300-1397).

<sup>64</sup> Donald H.J. Hermann, *Religiously Affiliated Health Care Providers: Legal Structures and Transformation*, in RELIGIOUS ORGANIZATIONS IN THE UNITED STATES: A STUDY OF IDENTITY, LIBERTY, AND THE LAW 728 (2006).

<sup>65</sup> *Id.* Professor Hermann cited the following legal developments that influenced the separate incorporation of religious hospitals: developments with the Internal Revenue Code; the enactment of the Medicare and Medicaid statutes and the reimbursement regulations; state certificate-of-need laws; and medical malpractice. *Id.*

proper missions. Religious sponsors employed several different approaches in governance in an effort to ensure adequate control. Some sponsors developed interlocking boards of directors so that the board of the sponsoring organization and the board of the hospital included some of the same members.<sup>66</sup> Some sponsors used the corporate articles of incorporation or charters to define membership in hospital organizations so that individual board members would also belong to and represent the religious sponsors and their interests.<sup>67</sup> The approach of some religious sponsors was to identify themselves as the sole corporate members of the related religious hospitals.<sup>68</sup> Controlling the members of the religious hospital corporation permitted the religious sponsors to retain some measure of decision-making authority, especially as to important corporate decisions such as the purchase and the sale of assets, the appointment and the removal of board members, the amendment of the fundamental corporate documents, the adjustment of corporate mission, and the retention of the sponsor's most important values.<sup>69</sup>

*C. The Development of the Community Benefit Standard*

The Internal Revenue Code of 1954 put in place a new structure for the federal Internal Revenue Code.<sup>70</sup> Section 501(c)(3) exempted from federal income tax organizations that are "organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes . . ." and that meet certain other requirements.<sup>71</sup> These requirements included a mandate that "no part of the net earnings . . . inure[] to the benefit of any private shareholder or individual" as well as prohibitions against an organization attempting to influence legislation as a substantial part of its activities and against participating or intervening in any political campaign activities on behalf of (or in opposition to) candidates for public offices.<sup>72</sup>

Section 501(c)(3) did not specifically address health care organizations such as hospitals, but over several decades the IRS provided standards and guidance that apply to hospitals. In 1956, the

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<sup>66</sup> Hermann, *Religiously Affiliated*, *supra* note 65, at 728.

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> Hermann, *Religiously Affiliated*, *supra* note 65, at 728–29.

<sup>70</sup> Internal Revenue Code of 1954, Pub. L. 83-591, ch. 736, 83rd Congress, 68A Stat. 3 (1954). The Internal Revenue Code of 1954 was later redesignated as the Internal Revenue Code of 1986.

<sup>71</sup> 26 U.S.C. § 501(c)(3).

<sup>72</sup> *Id.*

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IRS issued Revenue Ruling 56-185, which provided advice regarding the criteria or tests for “determining whether a hospital qualifies for exemption from Federal income tax” as a public charitable organization under § 501(c)(3).<sup>73</sup> The IRS stated that the “only ground” upon which a hospital may qualify for exemption under § 501(c)(3) is that “it is organized and operated primarily for educational, scientific or public charitable purposes.”<sup>74</sup> Consequently, for a hospital, the ground for exemption would ordinarily be “that it is organized and operated for public charitable purposes.”<sup>75</sup> The IRS explained its understanding that, as applied to hospitals, the term “charitable” “contemplates an implied public trust constituted for some public benefit, the income or beneficial interest of which may not inure to the benefit of any private shareholder or individual.”<sup>76</sup>

Revenue Ruling 56-185 outlined several requirements that hospitals must meet to qualify for the exemption, and it addressed both organizational and operational issues related to exemption.<sup>77</sup> First, the hospital must be “organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick.”<sup>78</sup> Second, “to the extent of its financial ability,” the hospital “must be operated” for those who are not able to pay for their services and “not exclusively” for those who can pay and are expected to pay.<sup>79</sup> Third, the hospital may not restrict use of its facilities to a specific group of physicians and exclude all others who are

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<sup>73</sup> Rev. Rul. 56-185, 1956-1 C.B. 202, *available at* <http://www.irs.gov/pub/irs-tege/rr56-185.pdf>.

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* In articulating this understanding, the IRS relied expressly upon *Helvering v. Bliss*, 293 U.S. 144 (1934), in which the Court held that federal income tax exemptions are begotten of public policy motives and are to be construed broadly as liberalizations of the law in the favor of taxpayers.

<sup>77</sup> *Id.*

<sup>78</sup> Rev. Rul. 56-185, 1956-1 C.B. 202.

<sup>79</sup> *Id.* at 2. With this requirement, the principal concern was that a hospital not deny “medical care or treatment to [those] unable to pay” or “refuse to accept patients in need of hospital care who cannot pay for such services.” *Id.* The IRS acknowledged that a hospital may qualify for the tax exemption even though it charges those who are able to pay, has a record of charity care that is relatively low, and sets aside earnings for purposes of improving and expanding hospital facilities. Under the ruling, charity care included the provision of services at reduced rates that are below cost, but not the mere failure of some patients to pay for services when these patients had been expected to make full payment. Thus, under this requirement, a hospital must admit and treat patients who are unable to pay, either by providing services free of charge or for reduced rates that are below cost.

qualified.<sup>80</sup> Fourth, the hospital's net earnings must not "inure directly or indirectly to the benefit of any private shareholder or individual."<sup>81</sup> In its ruling, the IRS focused upon the exemption of hospitals as public charitable institutions.<sup>82</sup> Absent from its ruling was any express recognition of religious purpose as a ground separate from public charitable purpose that warranted exemption of a religious hospital from federal income taxation.<sup>83</sup>

In 1969, after a wave of changes had altered the health care landscape in America, especially the increasing availability of public and private health insurance,<sup>84</sup> the IRS issued a new revenue ruling that modified the more restrictive Revenue Ruling 56-185 thereby adjusting the test for determining federal income tax exemption for hospitals.<sup>85</sup> This test came to be known as the "community benefit" standard.<sup>86</sup> In Revenue Ruling 69-545, the IRS considered the circumstances of two hospitals that were organized as nonprofit, charitable organizations but differed considerably in their operations,

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<sup>80</sup> *Id.* This requirement reflected the public benefit rationale and the private inurement prohibition but recognized the authority of hospitals to determine qualifications and privileges.

<sup>81</sup> *Id.*

<sup>82</sup> The IRS considered several other types of hospitals and addressed whether they qualified for the exemption. Rev. Rul. 56-185, 1956-1 C.B. 202. The ruling explained that community hospitals "supported partly by contributions from the general public and/or public grants from a city, county or state" ordinarily would meet the requirements, even when their record of charity care is low during periods of light demand, because they are organized to provide services "to all persons in the[ir] communit[ies] at the lowest possible costs" and accept "patients who are unable to pay . . . in order to retain the support of the[ir] communit[ies]." *Id.* at 2-3. The IRS explained that careful analysis of possible inurement is needed in the case of hospitals formed by physicians who own stock in the hospitals or rent the facilities to a corporation they control. As for hospitals organized to provide prepaid hospitalization to members at fixed rates, the IRS determined that such hospitals are not charitable under the statute, but that hospitals that maintain prepayment plans may still qualify for the exemption if the "plan is available to all persons living in the area" and the hospital makes its facilities "available . . . to the indigent" and to paying "patients to the same extent as any other hospital not operated for profit." *Id.* The IRS emphasized that, to qualify for the exemption, the hospital must be both organized and operated for a charitable purpose. Consequently, a hospital that operates primarily for a different purpose cannot qualify, but an exempt hospital would not lose its exempt status if its operations include additional purposes unrelated to its charitable purpose that are "merely incidental." *Id.*

<sup>83</sup> Rev. Rul. 56-185, 1956-1 C.B. 202.

<sup>84</sup> John D. Colombo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 WAKE FOREST L. REV. 215, 218 (1994) [hereinafter Colombo, *Health Care Reform*]; see also notes 50-58 and 63 and accompanying text.

<sup>85</sup> Rev. Rul. 69-545, 1969-2 C.B. 117, available at <http://www.irs.ustreas.gov/pub/irs-tege/rr69-545.pdf>.

<sup>86</sup> See Colombo, *Health Care Reform*, *supra* note 84, at 215.

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to determine whether both would qualify for exemption.<sup>87</sup> In its analysis, the IRS highlighted the basic requirements of § 501(c)(3) that hospitals be “organized and operated exclusively for charitable, scientific, or educational purposes,” that no part of the net earnings inure to the benefit of any private shareholder or individual, and that the hospitals serve public rather than private interests.<sup>88</sup> The IRS explained that it was using the term “charitable” in “the generally accepted legal sense” and that, “[i]n the general law of charity, the promotion of health is considered to be a charitable purpose.”<sup>89</sup> Revenue Ruling 69-545 thus recognized the promotion of health as a charitable purpose alongside other recognized exempt purposes:

The promotion of health, like the relief of poverty, and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the 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.<sup>90</sup>

Although the IRS in this ruling likened the promotion of health to other charitable purposes such as relief of the poor and pursuit of educational and religious purposes, the IRS in this ruling did not contemplate pursuit of a religious purpose as a ground of exemption for hospitals.

With Revenue Ruling 69-545, the focus of the exemption standard shifted from charity care and relief of the poor to the promotion of the health of the community. The IRS identified the following factors as part of the new analytical approach: (1) operating a full-time emergency room open to all persons regardless of a person’s ability to pay; (2) providing hospital care for those in a community who are able to pay either directly or through third-party reimbursement (including Medicare and Medicaid patients); (3) maintaining an open medical staff depending on the size and nature of the facility; (4) using surplus funds to improve patient care, facilities, equipment, and medical training, education, and research programs; and (5) being governed by a board comprised of

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<sup>87</sup> Rev. Rul. 69-545, 1969-2 C.B. 117.

<sup>88</sup> *Id.* at 2.

<sup>89</sup> *Id.* (citing RESTATEMENT (SECOND) OF TRUSTS §§ 368 & 372, and 4 SCOTT ON TRUSTS §§ 368 & 372 (3d ed. 1967)).

<sup>90</sup> *Id.* at 3 (citing RESTATEMENT (SECOND) OF TRUSTS §§ 368 cmt. b & 372 cmts. b & c; 4 SCOTT ON TRUSTS §§ 368 & 372.2 (3d ed. 1967)).

independent community leaders.<sup>91</sup> In applying this community benefit standard, the IRS weighs “all of the relevant facts and circumstances,” and neither the presence nor the absence of any particular factor is determinative.<sup>92</sup> Under this altered approach, a nonprofit institution organized and operated to provide hospital care is understood to promote health, which is a charitable purpose, and may qualify for the exemption from federal income taxation if it satisfies the community benefit standard and the other requirements of § 501(c)(3). Again, absent from the factors identified as part of this new approach was the religious purpose of religious hospitals.

The Tax Reform Act of 1969 extended the UBIT to all tax-exempt organizations described in § 501(c)(3) and required all tax-exempt organizations, with the exception of churches and their integrated auxiliary organizations, to complete annual returns.<sup>93</sup> In 1971, the IRS issued a revenue ruling that reflected the IRS’s general understanding of the terms “charity” and “charitable.” Revenue Ruling 71-447 explained that a private school that otherwise meets the requirements of § 501(c)(3) but does not have a racially nondiscriminatory policy does not qualify for the federal income tax exemption.<sup>94</sup> In its discussion of charitable purpose, the IRS stated:

Under common law, the term “charity” encompasses all

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<sup>91</sup> The IRS enumerated these criteria in the following:

By operating an emergency room open to all persons and by providing hospital care for all those person in the community able to pay the cost thereof either directly or through third party reimbursement, [a hospital] is promoting the health of a class of persons that is broad enough to benefit the community. . . . By using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs, the hospital is operating in furtherance of its exempt purposes. Furthermore, [the hospital] is operated to serve a public rather than a private interest. Control of the hospital rests with its board of trustees, which is composed of independent civil leaders. The hospital maintains an open medical staff, with privileges available to all qualified physicians. Members of its active medical staff have the privilege of leasing available space in its medical building. It operates an active and generally accessible emergency room. These factors indicate that the use and control of [the hospital] are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served.

*Id.* at 3 (paragraph separations and citation omitted).

<sup>92</sup> *Id.* at 4. The ruling states that “[t]he absence of [these] particular factors” “or the presence of other factors will not necessar[il]y be determinative.” *Id.* at 3.

<sup>93</sup> Tax Reform Act of 1969, Pub. L. No. 91-172, 83 Stat. 487 (1969). The Act extended the UBIT to churches.

<sup>94</sup> Rev. Rul. 71-447, 1971-2 C.B. 230, available at <http://www.irs.ustreas.gov/pub/irs-tege/rr71-447.pdf>.

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three of the major categories identified separately under section 501(c)(3) of the Code as religious, educational, and charitable. Both the courts and the Internal Revenue Service have long recognized that the statutory requirement of being “organized and operated exclusively for religious, charitable, . . . or educational purposes” was intended to express the basic common law concept. Thus, a school asserting a right to the benefits provided for in section 501(c)(3) of the Code as being organized and operated exclusively for educational purposes must be a common law charity in order to be exempt under that section. That Congress had such an intent is clearly borne out by its description in section 170(c) of the Code of a deductible gift to “a corporation, trust, fund, or foundation . . . organized and operated exclusively for educational purposes” as a “charitable contribution.” The Service has followed this concept[.]<sup>95</sup>

Thus, although § 501(c)(3) identifies religious, charitable, scientific, and educational purposes as distinct purposes, the term “charitable” can be used as a generic label for several different purposes.

In 1983, the IRS issued Revenue Ruling 83-157, which adjusted the community benefit standard for hospitals that do not operate an emergency room.<sup>96</sup> In this ruling, the IRS considered whether a nonprofit hospital that is organized and operated for a charitable purpose, but that does not operate an emergency room as contemplated by Revenue Ruling 69-545, can nevertheless qualify for federal income tax exemption. The IRS concluded that such a hospital can qualify when a state or local health planning agency has determined that operating an emergency room at the hospital would unnecessarily duplicate emergency services and facilities in the community. The IRS reiterated much of its analysis from Revenue Ruling 69-545 and observed that operating a full-time emergency room that provides “emergency medical services to all members of the public regardless of their ability to pay for such services is strong evidence that a hospital is operating to benefit the community.”<sup>97</sup>

The IRS acknowledged, however, that other significant factors may also establish community benefit, such as having a board of directors drawn from the community, maintaining an open medical

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<sup>95</sup> *Id.* at 1.

<sup>96</sup> Rev. Rul. 83-157, 1983-2 C.B. 94, *available at* <http://www.irs.ustreas.gov/pub/irs-tege//rr83-157.pdf>.

<sup>97</sup> *Id.* at 1.

staff policy, treating persons whose medical bills are paid through public programs like Medicare and Medicaid, and using surplus to improve facilities, equipment, patient care, and medical training, education, and research.<sup>98</sup> Consequently, some specialized hospitals, such as eye or cancer hospitals, may provide care that rarely requires emergency care, but under the 1983 ruling, these hospitals may still qualify for tax exemption when other significant factors are shown. In Revenue Ruling 83-157, the IRS did not discuss the religious purpose of religious hospitals as a basis for exemption of hospitals.

*D. The Further Development of Tax-Exemption Standards for Hospitals Under State Law*

Against this background, many states have developed standards that follow and even supplement the community benefit standard for determining tax exemption of nonprofit hospitals under state tax law. For instance, in 1985, the Utah Supreme Court determined that charitable and religious hospitals must meet a higher standard under state tax law.<sup>99</sup> In *Utah County v. Intermountain Health Care, Inc.*, the Utah Supreme Court held that the exemption of two nonprofit hospitals from state ad valorem property taxes violated the state constitution, which exempted property owned by a nonprofit entity that is “used exclusively for either religious worship or charitable purposes.”<sup>100</sup>

In its ruling, the court commented generally regarding the transformation of the American hospital industry. The court observed that early in the twentieth century, hospitals “were redefined from social welfare to medical treatment institutions; their charitable foundation was replaced by a business basis; and their orientation shifted to ‘professionals, and their patients,’ away from ‘patrons and the poor.’”<sup>101</sup> The court also found the distinction between nonprofit and for-profit hospitals to be “increasing[ly]

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<sup>98</sup> *Id.* at 3.

<sup>99</sup> *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985). Also in 1985, the Supreme Court of Pennsylvania upheld the ruling of a commonwealth taxing authority that a provider that performed statistical analysis of patient treatment and cost data was not entitled to a charitable exemption on sales and use taxes because it was not an institution of purely public charity. *See Hosp. Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985).

<sup>100</sup> *Utah County*, 709 P.2d at 268 (quoting UTAH CONST. art. XIII, § 2 (amended 1982)).

<sup>101</sup> *Id.* at 270 (quoting PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 150 (Basic Books 1982)).



irrelevant[t].”<sup>102</sup> The court reasoned that the element of a gift to the community was fundamental to what should qualify as charity and charitable, and a gift to the community could be shown “either by a substantial imbalance in the exchange between the charity and the recipient of its services or in the lessening of a government burden through the charity’s operation.”<sup>103</sup> The court considered a range of factors, including the stated purpose of the entity, the extent to which the entity relies on gifts and donations, the amount of charity care provided, the use of “profits” or surpluses, the extent to which the class of beneficiaries is restricted, and the extent to which private interests are benefited.<sup>104</sup> It then ruled that the two hospital entities had not proven that their property was used exclusively for charitable purposes by showing the essential element, namely, that it was making a gift to the community.<sup>105</sup> The court also concluded that the hospital entities did not function to relieve government of a burden.<sup>106</sup> In its analysis, the court chided the hospital and the state tax commission for confusing “the element of gift to the community, which an entity must demonstrate in order to qualify as a charity under [the Utah] Constitution, with the concept of community benefit, which any of countless private enterprises might provide.”<sup>107</sup>

The dissent highlighted a number of counterarguments that, like the arguments made by the majority, have been part of the debate regarding the community benefit standard in the ensuing decades.<sup>108</sup> The dissenting judge discussed the hospitals’ gifts to the community, highlighting that the hospitals provided free services to indigents and subsidized services to Medicare, Medicaid, and worker’s compensation patients.<sup>109</sup> The dissent observed that the amounts of charity care were greater than the amounts stated by the majority because bad debts and uncollectible accounts were not included.<sup>110</sup> The dissent noted that one of the hospitals existed only because it was given to the hospital’s corporate parent by the Church of Jesus Christ of Latter-day Saints, which had initially built the hospital, and that the other hospital was erected with taxpayer money

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<sup>102</sup> *Id.* at 271.

<sup>103</sup> *Id.* at 269 (citing *Salt Lake County v. Tax Comm’r ex rel. Laborers Local No. 295*, 658 P.2d 1192, 1198 (Utah 1983)).

<sup>104</sup> *Id.* at 269–70, 272–76.

<sup>105</sup> *Id.* at 276–78.

<sup>106</sup> *Utah County*, 709 P.2d at 277–78.

<sup>107</sup> *Id.* at 276.

<sup>108</sup> See *supra* notes 5–7 and accompanying text and *infra* Section III.A.

<sup>109</sup> *Id.* at 284.

<sup>110</sup> *Id.* at 284–85.

and taken over by the nonprofit hospital to relieve a Utah city of the burden.<sup>111</sup>

The dissenting judge emphasized that the distinction between nonprofit and for-profit hospitals remained viable.<sup>112</sup> For the dissent,

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<sup>111</sup> *Id.* at 285.

<sup>112</sup> *Utah County*, 709 P.2d at 285, 289–91. The dissent highlighted two fundamental differences between nonprofit and for-profit hospitals: (1) “a for-profit hospital must conduct its business to make a profit if it is to remain in business”; and (2) “a for-profit hospital’s investment decisions as to what markets or communities to enter and what kinds of equipment to invest in are made from a basically different motive [i.e., sufficient rate of return on investment] than a nonprofit hospital’s.” *Id.* at 289. Consequently, for-profit hospitals may provide easier, more remunerative kinds of care, such as pediatric, psychiatric, and obstetrical-gynecological services, and may invest in high-volume, low-cost services, but not higher-cost, lower-volume kinds of services. However, because they are not concerned with earning a return on their investment for the benefit of investors, nonprofit hospitals use their surpluses to lower their rates, acquire new equipment, improve facilities, and provide care in complex cases that are less remunerative. *Id.* at 290.

Recent research regarding hospital ownership and profitability appears to support the dissent’s assessment. See James R. Hines, Jr., Jill R. Horwitz & Austin Nichols, *The Attack on Nonprofit Status: A Charitable Assessment*, 108 MICH. L. REV. 1179, 1203 (2010) (“[F]or-profit hospitals show a dramatic increase in the likelihood of offering medical services when they are profitable that disappears when they are unprofitable. . . . [T]he findings suggest that for-profits chase profits at the expense of quality.”); Jill R. Horwitz & Austin Nichols, *Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives*, 28 J. HEALTH ECON. 924 (2009); Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139, 171 (2007) (“Taken together, the results show that hospital types specialize in services according to the profitability of those services.”). Furthermore,

[a]lthough for-profit hospitals were only somewhat more likely than nonprofits to offer profitable services, both for-profit and nonprofit hospitals were considerably more likely than government hospitals to offer profitable services; for-profits were *less* likely than nonprofits, which in turn were less likely than government hospitals, to offer unprofitable services. . . . [F]or-profits exhibited dramatic responsiveness to financial incentives, particularly in terms of investing in post-acute services as they became profitable and divesting from them as they became unprofitable.

*Id.* at 175; see also *id.* at 188 (“These findings—that different hospital types systematically offer different services according to their profitability—counter the claim that nonprofits and for-profits are alike in all important ways.”).

Medical service offerings vary markedly by ownership, likely because hospital types adopt or prioritize goals differently. Although all hospitals must earn sufficient profits to operate, the evidence here suggests that for-profits are more likely to respond to profitability than the other types are when making supply decisions. Since government hospitals are most likely to supply the unprofitable services that are disproportionately needed by poor and underinsured patients, the evidence also suggests that such hospitals are caregivers of last resort. Nonprofit hospitals are often the intermediate type in terms of balancing profit seeking and serving the poor through service choices.

Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and*

the practical significance of this distinction was illustrated by certain facts related to the hospital industry in Utah: all tertiary care hospitals in Utah were nonprofit institutions; there were no for-profit tertiary care hospitals in the state; and it was unlikely that for-profit tertiary care hospitals could survive in the sparsely populated regions served by the nonprofit hospitals.<sup>113</sup> Likewise, within the geographical markets served by these hospitals, the alternatives were not between nonprofit and for-profit hospitals but rather between nonprofit hospitals and no hospitals at all.<sup>114</sup> Consequently, if no nonprofit hospitals served those markets, state and local government would bear the burden of providing hospital services.<sup>115</sup>

Throughout the 1990s, several states enacted legislation to increase the accountability of nonprofit hospitals and the amount of charity care they provide by requiring them to conduct and report the results of community health needs assessments and to develop community health benefit plans.<sup>116</sup> For instance, in 1993, Texas enacted legislation that required nonprofit hospitals to provide a minimum level of charity care (i.e., four percent of their net patient revenue). Although this statute has since been amended, it continues to require a minimum level of charity care.<sup>117</sup>

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*Government Hospitals*, 24 HEALTH AFF. 790, 796 (2005).

<sup>113</sup> *Utah County*, 709 P.2d at 285–86.

<sup>114</sup> *Id.* at 289.

<sup>115</sup> *Id.* at 289.

<sup>116</sup> See Colombo, *Tax Exemption Policy*, *supra* note 2, at 442. Professor Colombo identified California, Indiana, Massachusetts, Missouri, and New York as states adopting community benefit reporting statutes during this period. For instance, Indiana law requires a nonprofit hospital to develop an organizational mission statement that identifies the hospital's commitment to serve community health care needs and an operational plan for serving community health care needs. IND. CODE § 16-21-9-4 (West 2011). The community benefits plan must consider community health care needs as determined by a community-wide needs assessment. § 16-21-9-5. The elements of the plan must include mechanisms to evaluate effectiveness, measurable objectives to be achieved within a specified time frame, and a budget for the plan. § 16-21-9-6. Each hospital must annually file a report regarding its plan with the Indiana Department of Health, provide a statement notifying the public of its annual report, and develop a written notice about any charity care program operated by the hospital and how to apply for charity care that is conspicuously posted. § 16-21-9-7. For a survey of state law governing property tax exemption for charities, see Evelyn Brody, *All Charities Are Property-Tax Exempt, but Some Charities Are More Exempt Than Others*, 44 NEW ENG. L. REV. 621, 671–732 (2010).

<sup>117</sup> Under Texas law, an organization that qualifies as a charitable organization “is entitled to an exemption from taxation of: [various types of real and personal property].” TEX. TAX CODE ANN. § 11.18(a) (West 2011). The organization must meet certain requirements to qualify as a charitable organization. The organization must be “organized exclusively to perform religious, charitable, scientific, literary, or educational purposes and . . . engage exclusively in performing one or more of the

following charitable functions”: “(1) providing medical care without regard to the beneficiaries’ ability to pay,” which means that a nonprofit hospital or hospital system must “provid[e] charity care and community benefits in accordance with Section 11.1801”; “(13) providing permanent housing and related social, health care, and educational facilities for persons who are 62 years of age or older without regard to the residents’ ability to pay”; or “(16) performing biomedical or scientific research or biomedical or scientific education for the benefit of the public.” TAX § 11.18(d). Charitable organizations in Texas are subject to the nondistribution constraint and the prohibitions against private inurement and private benefit. TAX § 11.18(e). The assets of a charitable organization must be used to perform charitable functions, and specific requirements apply on dissolution. TAX § 11.18(f).

The Texas statute sets specific requirements for nonprofit hospitals and hospital systems to qualify as charitable organizations under TAX § 11.18(d)(1). A hospital must provide charity care and community benefits as follows:

- (1) charity care and government-sponsored indigent health care must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital and hospital system, and the tax-exempt benefits received by the hospital or hospital system;
- (2) charity care and government-sponsored indigent health care must be provided in an amount equal to at least four percent of the hospital’s or hospital system’s net patient revenue;
- (3) charity care and government-sponsored indigent health care must be provided in an amount equal to at least 100 percent of the hospital’s or hospital system’s tax-exempt benefits, excluding federal income tax; or
- (4) charity care and community benefits must be provided in a combined amount equal to at least five percent of the hospital’s or hospital system’s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.

TAX § 11.1801(a). In addition to providing these four means of qualifying, the statute includes specific provisions for hospitals in unique circumstances, such as when a nonprofit hospital has been designated a disproportionate share hospital under Medicaid or operates in a county with a population of less than 58,000 and has a shortage of health professionals. *See* TAX § 11.1801(b) & (c).

Another Texas statute mandates that nonprofit hospitals and hospital systems annually satisfy certain requirements “to provide community benefits which includes charity care and government-sponsored indigent health care by complying with one or more of the [following] standards.” TEX. HEALTH & SAFETY CODE ANN. § 311.045(a) (West 2001). Nonprofit hospitals and hospital systems may provide community benefits by providing:

- (A) charity care and government-sponsored indigent health care . . . at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;
- (B) charity care and government-sponsored indigent health care . . . in an amount equal to at least 100 percent of the hospital’s or hospital system’s tax-exempt benefits, excluding federal income tax; or
- (C) charity care and community benefits are provided in a combined amount equal to at least five percent of the hospital’s or hospital system’s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount

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In the last decade, other states have taken legislative and regulatory action to tighten state tax-exemption standards for nonprofit hospitals, to increase governmental oversight and accountability, to restrict charging, billing, and collection practices, and to require a minimum amount of charity care. For instance, the Connecticut General Assembly passed legislation in 2003 concerning hospital billing and collection practices. The Connecticut Act imposed information reporting requirements, and it mandated that hospitals provide public notice and written summaries about hospital bed funds as well as written summaries of hospital policies and procedures concerning free or reduced-cost care. The act also limited the amounts that hospitals may collect from uninsured patients to the costs of the services provided, and it restricted the interest rates hospitals may charge patients for medical debts and the availability of property execution.<sup>118</sup>

In Illinois, in 2004, local and state taxing authorities denied a Catholic, nonprofit hospital's application to exempt property it owned from taxation, ruling that the property was not in exempt ownership or use. The ruling rested on findings that the hospital had billed uninsured patients for services and used aggressive debt collection tactics. Upon judicial review of the administrative action, the Supreme Court of Illinois upheld the decision of the taxing authorities.<sup>119</sup> Meanwhile, the Illinois General Assembly enacted legislation imposing notice requirements regarding financial assistance programs, regulating hospital billing and billing inquiry practices, mandating the creation of application procedures for financial assistance, requiring hospitals to offer a reasonable payment plan, restricting hospital debt collection practices, and granting the Attorney General enforcement authority under the act.<sup>120</sup> In 2012, Illinois enacted legislation establishing new criteria for nonprofit hospitals to qualify for exemptions under state property and sales

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equal to at least four percent of the net patient revenue.

HEALTH & SAFETY § 311.045(b)(1). The statute also requires each hospital or hospital system to file with a state bureau and a local official an annual statement indicating which of these standards the hospital has met. HEALTH & SAFETY § 311.045(a).

<sup>118</sup> Act of July 9, 2003, Pub. Act No. 03-266, 2003 Conn. Acts 266 (Reg. Sess.) ("An Act Concerning Hospital Billing of charity care programs Practices"). For an account of a highly publicized case in Connecticut that led to this legislation, see *supra* note 3.

<sup>119</sup> See *Provena Covenant Med. Ctr. v. Dep't of Rev.*, 925 N.E.2d 1131 (Ill. 2010). For additional discussion of this case and media coverage, see *supra* note 3.

<sup>120</sup> Pub. Act 94-885, 2006-3A Ill. Legis. Serv. 252 (West). For an account of a widely publicized case in Illinois that brought hospital practices to public attention and contributed to this legislation, see *supra* note 3.

taxes.<sup>121</sup> To qualify, the value of a hospital's qualified services or activities (charity care, health services to low-income and underserved individuals, subsidies of state or local governments, support for state health care programs for low-income individuals, dual-eligible subsidies, relief of the government's burden related to health care, and other activities) must equal or exceed the hospital entity's estimated property tax liability.<sup>122</sup>

In Minnesota, beginning in 2000, the state attorney general instituted compliance reviews of several tax-exempt hospitals and, in 2005, entered into a two-year agreement with the Minnesota Hospital Association and nonprofit hospitals regarding charges to uninsured patients and debt collection practices.<sup>123</sup> In 2007, this agreement was extended for an additional five years.<sup>124</sup> More recently, the Minnesota attorney general brought suit against a Chicago debt collection firm that used aggressive collection practices on behalf of several Minnesota hospitals.<sup>125</sup> Pursuant to the terms of the settlement agreement, the firm will not operate in the state of Minnesota for two years and can only operate in the state in the following four years with the approval of the state attorney general.<sup>126</sup>

### III. RECENT FEDERAL AMPLIFICATION OF THE COMMUNITY BENEFIT STANDARD

#### A. *The Legislative and Regulatory Initiatives*

Reports regarding pricing, billing, and aggressive debt collection practices, executive compensation practices, and the amount of

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<sup>121</sup> Pub. Act 97-688, 35 Ill. Comp. Stat. 3-8 (establishing criteria for hospital exemption from state use tax); 35 Ill. Comp. Stat. 200/15-86 (establishing criteria for hospital exemption from state property tax).

<sup>122</sup> 35 Ill. Comp. Stat. 3-8(b) & (c); 35 Ill. Comp. Stat. 200/15-86(c) & (e).

<sup>123</sup> Press Release, Minnesota Hospital Ass'n, Agreement Between Attorney General and Minnesota Hospitals Will Provide Fair Pricing to Uninsured Patients, Establish Code of Conduct for Debt Collection Practices (May 5, 2005), *available at* [http://www.mnhospitals.org/inc/data/pdfs/AG\\_agreement\\_press.pdf](http://www.mnhospitals.org/inc/data/pdfs/AG_agreement_press.pdf).

<sup>124</sup> Press Release, Attorney General Lori Swanson and Minnesota Hospitals Announce Continuation of Fair Medical Billing Agreement (Apr. 4, 2007), *available at* <http://www.ag.state.mn.us/consumer/pressrelease/fairmedicalbilling.asp>.

<sup>125</sup> Press Release, Attorney General Swanson Sues Accretive Health for Patient Privacy Violations (Jan. 19, 2012), *available at* <http://www.ag.state.mn.us/Consumer/PressRelease/120119AccretiveHealth.asp>.

<sup>126</sup> Press Release, Attorney General Swanson Says Accretive Will Cease Operations in the State of Minnesota Under Settlement of Federal Lawsuit (July 31, 2012), *available at* <http://www.ag.state.mn.us/Consumer/PressRelease/07312012AccretiveCeaseOperations.asp>.

charity care provided by nonprofit hospitals have heightened public concern and led to both state and federal legislative and regulatory initiatives.<sup>127</sup> At the federal level, legislators and administrators have analyzed the effectiveness of the community benefit standard in regulating tax-exempt hospitals, and they have offered proposals, enacted legislation, and adopted regulatory changes to increase the requirements nonprofit hospitals must meet to qualify for and retain tax-exempt status under federal income tax law.

On May 27, 2005, Senator Charles E. Grassley, then chair of the Senate Committee on Finance, sent letters to ten of the largest nonprofit hospitals in the United States inquiring about their service to their communities, care for the poor, charging and billing practices, collection practices, executive compensation and benefits practices, and ventures with for-profit companies and hospitals.<sup>128</sup> Senator Grassley's letter indicated that Congress was "considering the issues of tax-exempt organizations and particularly the duties and requirements of public charities in relation to the billions of dollars in tax benefits that tax-exempt organizations receive at the federal, state and local level."<sup>129</sup> In a press release issued the same day, Senator Grassley emphasized his "duty to make sure charitable donations actually help those in need" and his concern that exempt organizations "earn[] their general tax breaks."<sup>130</sup> The committee subsequently conducted a hearing regarding nonprofit hospitals and the charitable care and community benefits they provide.<sup>131</sup> In advance of the hearing, Senator Grassley released a summary of the hospitals' responses to his letter and provided copies of related

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<sup>127</sup> For a sampling of stories related to these practice, see *supra* notes 3 and 4. For a discussion of select state initiatives, see *supra* Section II.D.

<sup>128</sup> Press Release, Grassley Asks Non-profit Hospitals to Account for Activities Related to Their Tax-exempt Status (May 27, 2005), *available at* [http://www.grassley.senate.gov/news/Article.cfm?customel\\_dataPageID\\_1502=12892](http://www.grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=12892).

<sup>129</sup> *Id.*; Letter from Charles E. Grassley, Chairman of the Committee on Finance, to Reporters and Editors (Sept. 12, 2006), *available at* <http://finance.senate.gov/newsroom/chairman/release/?id=f9c0050b-521b-4577-9af9-9cdecabfa358>.

<sup>130</sup> Press Release, Senate Committee on Finance, Grassley Asks Non-profit Hospitals to Account for Activities Related to Their Tax-exempt Status (May 25, 2005), *available at* <http://finance.senate.gov/newsroom/chairman/release/?id=f9c0050b-521b-4577-9af9-9cdecabfa358>.

<sup>131</sup> *See Taking The Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before S. Comm. on Finance*, 109th Cong. (Sept. 13, 2006), *available at* <http://www.finance.senate.gov/hearings/hearing/?id=e6a6e518-bc40-78f7-ee63-a9993d182e5c>.

letters.<sup>132</sup>

Around the same time, Congress asked the Government Accountability Office (GAO) to review executive compensation issues at several private, nonprofit hospital systems to gain an understanding of the policies and practices related to the salaries, benefits, travel, gifts, and entertainment expenses paid by selected hospital systems. On June 30, 2006, the GAO issued its Report.<sup>133</sup> Additionally, the House Committee on Ways and Means requested that the Congressional Budget Office (CBO) study community benefits provided by nonprofit hospitals, for-profit hospitals, and government hospitals. The CBO examined differences in the provision of uncompensated care, the provision of Medicaid-covered services, and the provision of certain specialized services, such as emergency room services. In December 2006, the CBO issued its report.<sup>134</sup> In 2006, the Internal Revenue Service (IRS) also began a study of nonprofit hospitals, scrutinizing the community benefit provided by nonprofit hospitals and their executive compensation practices and reporting, and in 2009, the IRS issued its final report.<sup>135</sup>

In a background paper released in 2007, the staff of Senator Charles Grassley, then the ranking member of the Senate Committee on Finance, suggested that nonprofit hospitals should be required to develop and publicize a charity care policy and dedicate to charity

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<sup>132</sup> Memorandum from Senator Charles E. Grassley to Reporters and Editors, *Non-profit Hospital Responses to Finance Committee* (Sept. 12, 2006), available at <http://finance.senate.gov/newsroom/chairman/release/?id=f9c0050b-521b-4577-9af9-9cdecabfa358>.

<sup>133</sup> See U.S. GOV'T ACCOUNTABILITY OFFICE, NONPROFIT HOSPITAL SYSTEMS: SURVEY ON EXECUTIVE COMPENSATION POLICIES AND PRACTICES (2006), available at <http://www.gao.gov/new.items/d06907r.pdf>

<sup>134</sup> See CONG. BUDGET OFFICE, NONPROFITS HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>. In discussing tax exemption and the requirements for nonprofit hospitals to qualify for federal income tax exemption, the CBO observed:

Unlike for-profit hospitals, nonprofit hospitals are generally exempt from federal and state corporate income taxes, and local sales and property taxes. . . . For a hospital to qualify for exemption from federal income taxes, it must be organized and operated exclusively for a charitable, educational, or scientific purpose and meet Internal Revenue Service (IRS) requirements under section 501(c)(3) of the tax code.

*Id.* at 4. Notably, in its list of exempt purposes, the CBO does not expressly identify religious purpose.

<sup>135</sup> I.R.S., FINAL REPORT OF THE IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT (Feb. 12, 2009), available at <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>. For a discussion of this report, see *infra* notes 169–77 and accompanying text.



care a minimum of five percent of their annual patient operating expenses or revenues, whichever is greater.<sup>136</sup> The draft also proposed a requirement that hospitals conduct a community needs assessment every three years and recommended that policymakers consider whether hospitals should be required to provide a minimum amount of other community benefits, such as education, outreach, training, research, health protection, and health promotion for vulnerable populations.<sup>137</sup> The staff also proposed limits on hospital charges to the medically indigent who are uninsured or underinsured, hospital governance by a board of directors that represents the broad interests of the community, intermediate sanctions for hospitals that fail to meet the requirements, annual reports to the IRS providing certain information, and restrictions on unfair billing and collections practices.<sup>138</sup> None of the proposals addressed the religious purpose of religious hospitals as a factor for consideration in evaluating tax exemption.

In December 2007, the IRS issued a redesigned Form 990 and sixteen related schedules, including Schedule H for hospitals.<sup>139</sup> The redesigned Schedule H requires tax-exempt hospitals to provide information about their charity care policies, document their community benefits and community building programs, explain how they meet community health care needs, distinguish between charity care and bad debt, and describe other activities or characteristics linked to tax-exempt status.<sup>140</sup> The IRS redesigned Schedule H to obtain detailed information from hospitals regarding their compliance with the community benefit standard and their health professional education and research activities, but in Schedule H, the IRS has not sought information regarding the religious purpose of any hospitals.<sup>141</sup> IRS Form 1023, which was revised in 2006 and which organizations (not just hospitals) complete to apply for recognition of exemption under § 501(c)(3), seeks information regarding an organization's exempt purpose or purposes, such as charitable,

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<sup>136</sup> S. COMM. ON FIN.—MINORITY, 110TH CONG., TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT 6–7 (July 18, 2007), *available at* <http://grassley.senate.gov/releases/2007/07182007.pdf>.

<sup>137</sup> *Id.* at 12.

<sup>138</sup> *Id.* at 13–18.

<sup>139</sup> See Press Release, Internal Revenue Service, IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief (Dec. 20, 2007), *available at* <http://www.irs.gov/newsroom/article/0,,id=176722,00.html>.

<sup>140</sup> I.R.S. Form 990, Schedule H-Hospitals, *available at* <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>.

<sup>141</sup> *Id.*

religious, educational, and/or scientific, as well as its activities.<sup>142</sup> The related Schedule C for hospitals and medical research organizations likewise seeks information related to the community benefit standard, medical training, and medical research, but it makes no inquiry regarding the religious purpose of any hospital.<sup>143</sup>

On September 12, 2008, the GAO issued a report to Senator Grassley, the ranking member of the Senate Committee on Finance.<sup>144</sup> The GAO prepared this Report, *Nonprofit Hospitals: Variation in Standards and Guidance Limits; Comparison of How Hospitals Meet Community Benefit Requirements*, in response to Senator Grassley's request that the GAO describe the IRS's community benefit standard and the states' community benefit requirements and examine guidelines nonprofit hospitals use to define, measure, and report the components of community benefit.<sup>145</sup> The GAO observed that, among the standards and guidance used by nonprofit hospitals, "consensus exists to define charity care, the unreimbursed cost of means-tested government health care programs (programs for which eligibility is based on financial need, such as Medicaid), and many other activities that benefit the community as community benefit."<sup>146</sup> It noted, however, a lack of consensus regarding including "bad debt and the unreimbursed costs of Medicare" in the definition of community benefit.<sup>147</sup> The GAO found considerable variation among nonprofit hospitals regarding what activities qualify as a community

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<sup>142</sup> I.R.S. Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code, available at <http://www.irs.gov/pub/irs-pdf/fl023.pdf>.

<sup>143</sup> See I.R.S. Form 1023 Schedule C, Hospitals and Medical Research Organizations, available at <http://www.irs.gov/pub/irs-pdf/fl023.pdf>. On June 6, 2012, the IRS's Advisory Committee on Tax Exempt and Government Entities recommended a redesign of IRS Form 1023 to make the form (1) "effective at identifying whether organizations meet the requirements for recognition of exemption," (2) "consistent with the structures and definitions of Form 990," (3) simple by using a short care form with supplemental schedules," and (4) "educational by organizing questions based on substantive exemption requirements and including explanatory information." *Advisory Committee on Tax Exempt and Government Entities, Exempt Organizations: Form 1023—Updating It for the Future*, in ADVISORY COMMITTEE ON TAX EXEMPT AND GOVERNMENT ENTITIES, REPORT OF RECOMMENDATIONS 2 (June 6, 2012), available at [http://www.irs.gov/pub/irs-tege/tege\\_act\\_rpt11.pdf](http://www.irs.gov/pub/irs-tege/tege_act_rpt11.pdf).

<sup>144</sup> U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS (Sept. 12, 2008), available at <http://www.gao.gov/assets/290/280709.pdf>.

<sup>145</sup> *Id.* at 4.

<sup>146</sup> *Id.* at 7.

<sup>147</sup> *Id.*

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benefit and how to measure charity care costs and the unreimbursed costs of government health care programs.<sup>148</sup>

On February 12, 2009, the IRS released its Final Report on its Exempt Organizations Hospital Compliance Project.<sup>149</sup> In this study, which began in May 2006, the IRS undertook to enhance its understanding of nonprofit hospitals and community benefit activities, hospital activities related to their tax-exempt status, and their executive compensation-setting practices. The central focus of the study was the community benefit standard under § 501(c)(3). The Report summarized the data collected during the multi-year study and analyzed the reported community benefit expenditures of the surveyed nonprofit hospitals. The IRS found considerable diversity in the demographics, community benefit activities, and financial resources of the surveyed hospitals, and determined that the average and median percentages of total revenues reported to have been spent on community benefit expenditures were nine percent and six percent, respectively. The IRS also found that the largest reported community benefit expenditure was uncompensated care, followed by medical education and training, research, and community programs, and that uncompensated care and community benefit expenditures were concentrated in certain hospitals and unevenly distributed.<sup>150</sup> The Director of the IRS Exempt Organizations Division noted that health care and hospitals had changed dramatically since the IRS set forth the community benefit standard decades earlier.<sup>151</sup> She acknowledged that these changed circumstances had led some to believe that the community benefit standard no longer provided a useful standard for determining tax exemption.<sup>152</sup> She observed, however, that modification of the current “standard could have a significant impact on certain hospitals” and that many hospitals appeared “to be losing money or operating with tight margins” and could have “a very difficult time meeting quantitative tests” establishing precise charity care or

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<sup>148</sup> *Id.*

<sup>149</sup> INTERNAL REVENUE SERV., IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT (2009), *available at* <http://www.irs.gov/pub/irs-tege/frepthosproj.pdf>.

<sup>150</sup> INTERNAL REVENUE SERV., *supra* note 149, at 3–4.

<sup>151</sup> Statement from Lois Lerner, Director, IRS Exempt Organizations Division, Press Briefing, Statement on the IRS Report on Nonprofit Hospitals 1 (Feb. 12, 2009), *available at* [http://www.irs.gov/pub/irs-tege/lernerstatement\\_hospitalproject\\_021209.pdf](http://www.irs.gov/pub/irs-tege/lernerstatement_hospitalproject_021209.pdf).

<sup>152</sup> *Id.* at 2.

community benefit expenditure levels.<sup>153</sup>

On May 20, 2009, the Senate Committee on Finance issued a policy document describing options related to the financing of comprehensive health care reform.<sup>154</sup> Senators Max Baucus and Charles Grassley, the chair and the ranking member of the Senate Committee on Finance respectively, were the principal proponents of the policy options, which were aimed at raising revenue to finance comprehensive health care reform. One proposal involved modifying the organizational and operational requirements for nonprofit hospitals to qualify for § 501(c)(3) tax-exempt status. The following were among the requirements proposed: such hospitals must “regularly conduct a community needs analysis, provide a minimum annual level of charitable patient care, not refuse service based on a patient’s inability to pay, and follow certain procedures before instituting collection actions against patients.”<sup>155</sup> The proposal

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<sup>153</sup> Lerner, *supra* note 176, at 3.

<sup>154</sup> S. FIN. COMM., 111TH CONG., DESCRIPTION OF POLICY OPTIONS: FINANCING COMPREHENSIVE HEALTH CARE REFORM: PROPOSED HEALTH SYSTEM SAVINGS AND REVENUE OPTIONS (May 20, 2009), *available at* <http://finance.senate.gov/newsroom/ranking/release/?id=24d07772-b4b8-414d-811d-24cc1c75c2a8>.

<sup>155</sup> S. FIN. COMM., *supra* note 154, at 33. This Baucus-Grassley proposal drew opposition from interested groups. For instance, the American Hospital Association opposed the proposal, arguing that the new requirement would hinder the work of hospitals and penalize those hospitals that serve children or are teaching and research institutions. The Association for Healthcare Philanthropy (AHP) objected to the proposal’s requirement of a minimum level of free care and its refusal to count bad debts as part of a hospital’s charity care. The AHP recommended that the community benefit standard be maintained because under that standard hospitals can provide a broad range of services in their communities, such as promoting good health and offering preventive care. Holly Hall, *Nonprofit Hospitals Object to Senate Proposal to Add New “Charity Care” Requirements*, ASSOC. FOR HEALTHCARE PHILANTHROPY (June 3, 2009), [http://www.ahp.org/publicationandtools/News/InTheNews/AHPInNews\\_2009/Pages/ChronPhil6309.aspx](http://www.ahp.org/publicationandtools/News/InTheNews/AHPInNews_2009/Pages/ChronPhil6309.aspx). Trinity Health, the fourth largest Catholic health system in the United States, also responded to the proposed community needs analysis and the proposed minimum level requirement. Letter from Trinity Health to Max Baucus, Chairman, Sen. Comm. on Fin., and Charles Grassley, Ranking Member, Sen. Comm. on Fin. (May 28, 2009), *available at* [http://www.trinity-health.org/contentportal/groups/public/@wcmthho/documents/publicationsanddocuments/cportal\\_003272.pdf](http://www.trinity-health.org/contentportal/groups/public/@wcmthho/documents/publicationsanddocuments/cportal_003272.pdf). Trinity Health supported community needs assessment, but opined that federal legislation was not necessary because the new IRS reporting requirement (IRS Form 990, Schedule H) would encourage community needs assessment. *Id.* at 5. A minimum annual level of charitable care, in Trinity Health’s view, “is neither necessary nor advisable” for a number of reasons. *Id.* at 6. First, charity care is not the best or most efficient way to serve low-income persons in local communities; instead, primary and preventive care is more cost effective. Second, setting a minimum level of charity care is premature. Third, community needs differ from state to state and from community to community. Fourth, focusing

excluded from the minimum charity care requirement “[c]ertain hospitals that are critical to the communities they serve or which have an independent basis for tax exemption (e.g., as an educational or scientific research organization).”<sup>156</sup> The proposal also included excise taxes or “intermediate sanctions” that “could be imposed, for example, in situations where revocation of tax-exempt status is viewed as inappropriate” and thereby “encourage compliance with the operational requirements.”<sup>157</sup>

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, he signed the Health Care and Education Reconciliation Act (HCERA).<sup>158</sup> In the PPACA and the HCERA, collectively referred to as the Affordable Care Act (ACA), Congress increased governmental oversight of exempt hospitals, mandated that they report certain information, and tightened the requirements for hospitals to qualify for and retain federal tax-exempt status.<sup>159</sup> More specifically, the ACA amended § 501 of the Internal Revenue Code by inserting a new subsection (r) and imposed requirements that are similar to measures instituted by various states over the last two decades and proposals considered by members of the Senate Committee on Finance.<sup>160</sup>

The new requirements imposed by Congress involve the

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on an amount of charity care and other community benefit activities diverts attention from the real health improvement issue—low-cost, preventive health programs to manage chronic illness and prevent illness. Trinity Health emphasized that the better question to ask is what impact hospitals are having on the health of their communities. *Id.*

<sup>156</sup> See S. FIN. COMM., *supra* note 154, at 33. Although the proposal recognized educational and scientific purposes as alternatives grounds for tax exemption, it did not note religious purpose as another alternative ground.

<sup>157</sup> See *id.* at 33–34.

<sup>158</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. 11-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 11-152, 124 Stat. 1029 (2010). On June 28, 2012, the Supreme Court of the United States issued its decision in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566, 2600 (2012), upholding the PPACA and the HCERA against two challenges to their constitutionality. The Court held that Congress validly exercised its taxing power in requiring individuals to purchase a health insurance policy providing a minimum level of coverage or pay a financial penalty, *id.* at 2584, 2593–2600, and its spending power in providing funds to the States for expanding the Medicaid program to all citizens whose income falls below a certain threshold, *id.* at 2601–08, although the Court limited the application of the Medicaid expansion, *id.* at 2607.

<sup>159</sup> The provisions discussed here are found in Title IX, the revenue provisions of the ACA.

<sup>160</sup> PPACA § 9007(a). The act redesignated the current subsection (r) as subsection (s). *Id.* For a discussion of these state measures, see *supra* Section II.D.

following issues: community health needs assessments; financial assistance policies; charges; and billing and collection practices.<sup>161</sup> Under the ACA, a hospital must conduct a community health needs assessment every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.<sup>162</sup> The assessment must take into consideration input from a broad range of representatives from the community (including public health experts) served by the hospital facility.<sup>163</sup> The hospital must also make the assessment available to the public.<sup>164</sup>

The ACA requires a hospital to establish a written financial assistance policy that includes several components. First, it must set forth eligibility criteria for financial assistance and specify whether such assistance includes free or discounted care.<sup>165</sup> Second, it must provide the basis for calculating charges to patients.<sup>166</sup> Third, it must indicate the method for applying for financial assistance.<sup>167</sup> Fourth, if the hospital does not have a separate billing and collections policy, it must specify the actions (such as instituting collection actions and submitting information to credit agencies) that the hospital may take when a patient fails to pay.<sup>168</sup> Fifth, the policy must state the measures the hospital takes to publicize its financial assistance policy within the community.<sup>169</sup> Along with a written financial assistance policy, a hospital must establish a written policy regarding the provision of care for emergency medical conditions regardless of an individual's eligibility under the hospital's written financial assistance policy.<sup>170</sup>

Additionally, the ACA mandates that a hospital must limit its charges to individuals under its financial assistance policy to amounts

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<sup>161</sup> PPACA § 9007(a). With a hospital organization that operates more than one facility, these requirements apply to each facility, and when a facility fails to meet these requirements, the hospital organization may not be treated as exempt with respect to that facility. *Id.* § 9007(a)(2)(B).

<sup>162</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(3)(A)).

<sup>163</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(3)(B)(i)).

<sup>164</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(3)(B)(ii)).

<sup>165</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(A)(i)).

<sup>166</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(A)(ii)).

<sup>167</sup> PPACA § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(A)(iii)).

<sup>168</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(A)(iv)).

<sup>169</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(A)(v)).

<sup>170</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(B)). This subsection of the act references the federal Emergency Medical Treatment and Active Labor Act (EMTALA). *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(4)(B)). EMTALA was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, Title IX, § 9121(b), 100 Stat. 82, 164-67 (codified at 42 U.S.C. § 1395dd).

charged to individuals who have health insurance coverage.<sup>171</sup> The ACA prohibits a hospital from using gross charges.<sup>172</sup> A hospital is also prohibited from engaging in “extraordinary collection actions” until it has first made reasonable efforts to determine whether an individual is eligible for assistance under the hospital’s financial assistance policy.<sup>173</sup>

In the ACA, Congress directed the Secretary of the Treasury to issue regulations and guidance to implement § 9007(a) of the act.<sup>174</sup> To increase federal regulatory oversight, it required the Secretary to review the community benefit activities of each hospital subject to § 501(r) at least once every three years.<sup>175</sup> It also mandated that hospitals submit the following information to the IRS: (1) a hospital must describe how the organization is addressing needs identified through its community health needs assessments, what needs are not being addressed, and why these needs are not being addressed;<sup>176</sup> and (2) a hospital must provide audited financial statements of the organization.<sup>177</sup>

When an exempt hospital fails to satisfy the § 501(r) hospital exemption requirements for any taxable year, Congress authorized an excise tax of \$50,000 to be imposed.<sup>178</sup> The ACA requires the Secretaries of the Treasury and of Health and Human Services to submit to select House and Senate committees annual reports providing information regarding the various types of hospitals (i.e., private tax-exempt, taxable, and public hospitals) and their levels of charity care, bad debt expenses, unreimbursed costs, and unreimbursed costs for services provided under the Medicare and Medicaid programs.<sup>179</sup> The reports must also provide information regarding costs incurred by private tax-exempt hospitals for community benefit activities.<sup>180</sup> As for the effective dates, the community health needs assessment requirement applies to taxable years after March 23, 2012, and the other provisions apply to taxable

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<sup>171</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(5)(A)).

<sup>172</sup> PPACA § 9007(a) (codified at 26 U.S.C. § 501(r)(5)(B)).

<sup>173</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(6)).

<sup>174</sup> *Id.* § 9007(a) (codified at 26 U.S.C. § 501(r)(7)).

<sup>175</sup> *Id.* § 9007(c).

<sup>176</sup> *Id.* § 9007(d)(1) (codified at 26 U.S.C. § 6033(b)(15)(A)). Section 6033(b) of the Internal Revenue Code regulates returns submitted by exempt organizations, including 990 forms.

<sup>177</sup> *Id.* § 9007(d)(1) (codified at 26 U.S.C. § 6033(b)(15)(B)).

<sup>178</sup> PPACA § 9007(b) (codified at 26 U.S.C. § 4959).

<sup>179</sup> *Id.* § 9007(e)(1)(A)(i)–(iv).

<sup>180</sup> *Id.* § 9007(e)(1)(B).

years after March 23, 2010.<sup>181</sup>

*B. The Current Requirements for Tax-Exempt Hospitals Under Federal Income Tax Law*

As the prior Sections have shown, the standards used to determine whether a nonprofit hospital is exempt from federal income tax developed over several decades through various legislative and regulatory actions. This Section restates the current federal statutory and regulatory standards and requirements that apply to exempt hospitals.

Under § 501(c)(3), the following organizations are exempt from federal income taxation:

Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation . . . , and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.<sup>182</sup>

Consistent with § 501(c)(3), IRS regulations identify the following exempt purposes among others: religious, charitable, scientific, or educational.<sup>183</sup> Under IRS regulations, the term “charitable” includes “[r]elief of the poor and distressed or of the underprivileged; advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes . . . .”<sup>184</sup> IRS regulations do not specifically define the term “religious” purpose. Thus, even though § 501(c)(3) of the Code and IRS regulations identify religious, educational, charitable, and scientific purposes as distinct purposes, IRS regulations also collapse these distinct purposes under the broader category of “charitable” purpose.

Pursuant to § 501(c)(3) and the related regulatory rulings, a

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<sup>181</sup> *Id.* § 9007(f).

<sup>182</sup> 26 U.S.C. § 501(c)(3).

<sup>183</sup> 26 C.F.R. § 1.501(c)(3)-1(d)(1).

<sup>184</sup> *Id.*



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hospital organization must satisfy the following requirements to be exempt from federal income taxation:

(1)The hospital must be organized and operated for a charitable purpose (such as relieving the poor or promoting health). To show that it is organized and operated for this charitable purpose, the hospital must provide care to patients without charge or at rates below cost, or it must meet the community benefit standard by showing facts and circumstances that support a finding that it promotes health for the benefit of the community as a whole. These factors include:

- (a)A full-time emergency room open to everyone regardless of their ability to pay;
- (b)A medical staff open to all qualified physicians consistent with the size and the nature of the facility;
- (c)A provision of services to a broad cross section of the community, including those who are able to pay for the services themselves and through third-party payers, including Medicaid and Medicare;
- (d)A use of any surplus to improve facilities, equipment, patient care, and medical training, research, and education programs; and
- (e)An independent governing board that is composed of a broad base of members in the community.

(2)The hospital may not permit any part of its net earnings to inure to the benefit of any private shareholder or individual.

(3)The hospital may not participate in or attempt to influence legislation as a substantial part of its activities or participate in campaign activities for or against political candidates.<sup>185</sup>

Under the recently enacted ACA, a tax-exempt hospital must do the following:

(1)Conduct a community health needs assessment at least every three years and adopt an implementation strategy to meet the needs identified through the assessment. The assessment must take into consideration input from persons who represent the broad interests of the community served by the hospital, including those with specialized knowledge in public health. The assessment must be made widely available to the public.

(2)Annually report to the IRS on Form 990 how it is

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<sup>185</sup> For a discussion of the development of these requirements, see *supra* Section II.C.

addressing the needs identified through the community health needs assessment. If the hospital is not addressing all of the identified needs, it must disclose why such needs are not being addressed. The hospital must also provide the IRS with a copy of its audited financial statements.

(3) Implement a written, publicized financial assistance policy. This policy must indicate:

(a) The eligibility criteria for receiving financial assistance, including whether the assistance includes free or discounted care;

(b) The basis for determining the amounts charged to patients who are eligible for assistance;

(c) The procedure for applying for financial assistance; and

(d) The action taken against patients for failing to make payment, including collection actions and reports to credit agencies.

(4) Implement a written emergency medical treatment policy for providing care without discrimination regardless of an individual's eligibility under the financial assistance policy.

(5) Limit its charges for emergency and other medically necessary care provided to individuals who qualify for financial assistance to amounts generally charged to those with health insurance. The hospital may not use gross charges when billing those who qualify for financial assistance.

(6) Refrain from taking extraordinary collection actions, such as placing liens on residences or seeking arrests or body attachments, without first making reasonable efforts to determine whether an individual is eligible for financial assistance under the hospital's policy. Reasonable efforts include providing notice of its assistance policy before initiating any collection action or making a report to a credit rating agency.<sup>186</sup>

These new requirements in federal income tax exemption law, especially when coupled with additional requirements imposed by state law, will have a significant impact upon the tax-exempt hospital sector. The new requirements increase the pressure on tax-exempt hospitals to demonstrate their qualification for tax-exempt status and heighten the accountability of nonprofit hospitals to federal and state legislative bodies and regulatory agencies. Furthermore, if one of the

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<sup>186</sup> For a discussion of the ACA and these new requirements, see *supra* Section III.A.

principal aims of the ACA is eventually achieved, namely, that 30 million or so uninsured Americans gain access to public and private health insurance coverage,<sup>187</sup> there will be a corresponding decrease in the number of citizens needing and receiving charity health care. As a result, one of the principal means for tax-exempt hospitals to show their qualification for tax-exempt status will evaporate. Moreover, with many state and local governments facing substantial budget shortfalls, citizens and government officials may increasingly view repeal of tax exemptions for religious and charitable hospitals as a viable means of generating additional revenue.<sup>188</sup>

#### IV. REASONS FOR THE RELIGIOUS PURPOSE OF RELIGIOUS HOSPITALS COUNTING FOR TAX EXEMPTION

The religious purpose furthered by many of America's nonprofit hospitals has received little consideration in public discussion regarding tax exemption for nonprofit hospitals. Even if religious purpose is assumed to be part of the broader charitable purpose, a more direct and express recognition of religious purpose as a ground for tax exemption of nonprofit hospitals is warranted. The

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<sup>187</sup> See CONG. BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT (Mar. 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>; Michael J. DeBoer, *Access Without Limits? Revisiting Barriers and Boundaries After the Affordable Care Act*, 44 CONN. L. REV. 1239, 1242 (2012).

<sup>188</sup> See, e.g., Brody, *supra* note 116, at 623 (quoting E-mail from Tim Delaney, Exec. Dir. of the Nat'l Council of Nonprofits, to Evelyn Brody, Professor of Law, Chicago-Kent Coll. of L., Ill. Inst. of Tech. (Apr. 29, 2009, 10:16 EST) (observing that "[t]he current desperate financial situation of many local governments might find sympathetic ears in equally desperate statehouses" and quoting an Executive Director, Tim Delaney's e-mail expressing his "fear[] that state and local governments, with their constitutional mandates to balance budgets, will suddenly attempt to take away the property tax exemptions, sales tax exemptions (in states that provide them to nonprofits), and any other tax exemptions that nonprofits historically have received, thus drastically increasing costs of operating nonprofits at a time when demands for [their] services are up and [their] ability to get funds to pay more in new taxes is zero"); Cowan, *supra* note 1, at 1084 ("There is a great temptation, in times of fiscal distress, to simply eliminate nonprofit tax exemptions (including sales/use tax exemptions). Such an approach would reek of a revenue grab, devalue the contributions of nonprofits to the public, and raise political issues."); *Top Ten State and Local Policy Issues*, NAT'L COUNCIL OF NONPROFITS (2012), available at <http://www.councilofnonprofits.org/files/top-ten-nonprofit-policy-issues-2011.pdf> ("Nothing reveals the challenges tax-exempt nonprofits face at the local level better than their experiences dealing with policymakers who were so desperate for money that they seized at any justification for grabbing charities' funds without resort to consistent principles. . . . However, in the overwhelming number of cases in 2011, the majority of policymakers successfully fought back short-sighted efforts to take resources away from nonprofit missions through sales taxes, property taxes, and other new taxing mechanisms.") (last visited Oct. 4, 2012).

educational and scientific purposes are already given more direct and express recognition for nonprofit hospitals,<sup>189</sup> and thus the proposal in this Article is simply that the religious purpose furthered by religious hospitals should factor into tax-exemption qualification as educational and scientific purposes do for other nonprofit hospitals. A number of reasons support granting religious purpose such explicit recognition in tax-exemption decisions for nonprofit hospitals.

A. *The Religious Liberty Protections and the Tax-Exemption Provisions in State and Federal Constitutions*

1. A Brief Survey of Constitutional History and Texts

For millennia, governments have used taxes to generate revenue in order to function and fund projects and services, and they have also provided exemptions from taxes. The history of exemptions from taxes extends back to the ancient worlds of Egypt, Israel, and Rome and continues up through the Middle Ages in Europe.<sup>190</sup> In the Western world, governments have long extended exemptions from taxes to certain nonprofit organizations.<sup>191</sup> However, governments have also used taxes and exemptions as forms of official discrimination, especially as to disfavored religious traditions and related organizations.<sup>192</sup> As was true throughout much of Europe and England, established churches financed by revenues generated from taxes were part of the colonial experience in early America.<sup>193</sup> However, proponents of religious freedom in the New World increasingly challenged religious establishments, advocated disestablishment, and developed constitutional protections of the religious freedom of individuals and institutions.<sup>194</sup>

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<sup>189</sup> See *supra* notes 134, 137, 141, 142, 150, and 156 and accompanying text.

<sup>190</sup> Edward McGlynn Gaffney, Jr., *Exemption of Religious Organizations from Federal Taxation*, in RELIGIOUS ORGANIZATIONS IN THE UNITED STATES: A STUDY OF IDENTITY, LIBERTY, AND THE LAW 412–24 (James A. Serritella ed., 2006).

<sup>191</sup> *Id.*

<sup>192</sup> *Id.* at 425–26.

<sup>193</sup> *Id.* at 427–28.

<sup>194</sup> *Id.* at 428–30. During the Revolutionary period, emerging states adopted constitutions that reflected the tension between religious liberty and religious establishment. For instance, the Constitution of Maryland, adopted on November 11, 1776, provided as follows in its Declaration of Rights:

That, as it is the duty of every man to worship God in such manner as he thinks most acceptable to him; all persons, professing the Christian religion, are equally entitled to protection in their religious liberty; wherefore no person ought by any law to be molested in his person or estate on account of his religious persuasion or profession, or for his religious practice; unless, under colour of religion, any man shall

In the United States, the freedom of religion and religious institutions is safeguarded by the double protection of state constitutions and the United States Constitution.<sup>195</sup> Historically, state constitutions led the way by ensuring the protection of religious liberty.<sup>196</sup> Indeed, before the Constitution of the United States was

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disturb the good order, peace or safety of the State, or shall infringe the laws of morality, or injure others, in their natural, civil, or religious rights; nor ought any person to be compelled to frequent or maintain, or contribute, unless on contract, to maintain any particular place of worship, or any particular ministry; yet the Legislature may, in their discretion, lay a general and equal tax for the support of the Christian religion; leaving to each individual the power of appointing the payment over of the money, collected from him, to the support of any particular place of worship or minister, or for the benefit of the poor of his own denomination, or the poor in general of any particular county: but the churches, chapels, globes, and all other property now belonging to the church of England, ought to remain to the church of England forever. . . .

MD. CONST. Decl. of Rights § 33 (1776).

<sup>195</sup> See Randall T. Shepard, *The Maturing Nature of State Constitution Jurisprudence*, 30 VAL. U. L. REV. 421, 433–36 (1996) (explaining the “double protection” and “double security” concept inherent in vertical separation of powers); James A. Gardner, *What Is a State Constitution?*, 24 RUTGERS L.J. 1025, 1044–45 (1993) (examining James Madison’s vision of the “double security” of individual rights that arises from the separation of powers among governmental branches (horizontal) and the division between two distinct governments (vertical)); William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 503 (1977) (advocating that, as “the federal locus of our double protections [is] weakened,” the states must “expand constitutional protections”).

<sup>196</sup> The Virginia Declaration of Rights, adopted on June 12, 1776, as part of the Virginia Constitution, provided:

[R]eligion, or the duty which we owe to our Creator and the manner of discharging it, can be directed by reason and conviction, not by force or violence; and therefore, all men are equally entitled to the free exercise of religion, according to the dictates of conscience; and . . . it is the duty of all to practice Christian forbearance, love, and charity towards each other.

VA. CONST. Decl. of Rights § 16 (1776). Similarly, the Pennsylvania Constitution, adopted on September 28, 1776, declared:

That all men have a natural and unalienable right to worship Almighty God according to the dictates of their own consciences and understanding; And that no man ought or of right can be compelled to attend any religious worship, or erect or support any place of worship, or maintain any ministry, contrary to, or against, his own free will and consent: Nor can any man, who acknowledges the being of a God, be justly deprived or abridged of any civil right as a citizen, on account of his religious sentiments or peculiar mode of religious worship: And that no authority can or ought to be vested in, or assumed by any power whatever, that shall in any case interfere with, or in any manner control, the right of conscience in the free exercise of religious worship.

PA. CONST. Decl. of Rights § 2 (1776).

ratified, most new states in America protected religious freedom in their state constitutions,<sup>197</sup> and as new states joined the union, they included religious freedom protections in their constitutions.<sup>198</sup>

Religious liberty protection was added to the United States Constitution by the First Amendment,<sup>199</sup> which bars Congress from making any “law respecting an establishment of religion” or

<sup>197</sup> See Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 HARV. L. REV. 1409, 1455–66 (1990). For instance, the New York Constitution of 1777 stated:

[T]he free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever hereafter be allowed, within this State, to all mankind: *Provided*, That the liberty of conscience, hereby granted, shall not be so construed as to excuse acts of licentiousness, or justify practices inconsistent with the peace or safety of this State.

N.Y. CONST. of 1777, art. XXXVIII, available at [http://avalon.law.yale.edu/18th\\_century/ny01.asp](http://avalon.law.yale.edu/18th_century/ny01.asp); see also *supra* notes 167–68 and sources cited therein.

<sup>198</sup> For a collection of the religion provisions in state constitutions, see *State Constitutions*, THE RJ&L RELIGIOUS LIBERTY ARCHIVE, <http://www.churchstatelaw.com/stateconstitutions/index.asp>. (last visited Oct. 5, 2012). The Indiana Constitution of 1851, the state’s second constitution, illustrates well the robust religious freedom protections safeguarded by state constitutions:

Section 2. All men shall be secured in the natural right to worship Almighty God, according to the dictates of their own consciences.

Section 3. No law shall, in any case whatever, control the free exercise and enjoyment of religious opinions, or interfere with the rights of conscience.

Section 4. No preference shall be given, by law, to any creed, religious society, or mode of worship; and no man shall be compelled to attend, erect, or support, any place of worship, or to maintain any ministry, against his consent.

Section 5. No religious test shall be required, as a qualification for any office of trust or profit.

Section 6. No money shall be drawn from the treasure, for the benefit of any religious or theological institution.

Section 7. No person shall be rendered incompetent as a witness, in consequence of his opinions on matters of religion.

Section 8. The mode of administering an oath or affirmation, shall be such as may be most consistent with, and binding upon, the conscience of the person, to whom such oath or affirmation may be administered.

IND. CONST. of 1851, art. I, §§ 2–6, available at <http://www.in.gov/history/2870.htm>. The Indiana Constitution provided a model for constitutions adopted by western states, such as the State of Washington. See ROBERT F. UTTER & HUGH D. SPITZER, *THE WASHINGTON STATE CONSTITUTION: A REFERENCE GUIDE* 9 (2002) (observing that the Washington Constitution borrowed from the Oregon Constitution, which borrowed heavily from the Indiana Constitution).

<sup>199</sup> Gaffney, *Exemption*, *supra* note 190, at 426–31; Symposium, *The Williamsburg Charter*, 8 J.L. & RELIGION 5, 6 (1980) (stating that the First Amendment religion provisions are “mutually reinforcing provisions [that] act as a double guarantee of religious liberty”).

“prohibiting the free exercise” of religion (commonly referred to as the Establishment Clause and the Free Exercise Clause).<sup>200</sup> The protection provided by these Religion Clauses serves both to impose a structural/jurisdictional restraint on government and to protect individual rights.<sup>201</sup> As originally adopted in the First Amendment, this protection applied only against the federal government, and consequently established religions remained in some states for a few decades after the adoption of the federal Bill of Rights.<sup>202</sup> However, the religious liberty protection of the First Amendment now applies to the states.<sup>203</sup>

The robust protection of religious liberty in the state and federal constitutions led to a fairly consistent legal regime throughout the country that conferred exempt status “on an evenhanded basis to all religious communities.”<sup>204</sup> Although tax exemptions are not American innovations, law-making bodies had after all granted such exemptions for centuries,<sup>205</sup> the system of exemptions that has existed throughout the United States is nevertheless “constitutional in the sense that [it] reflect[s] core beliefs of society.”<sup>206</sup> Indeed, this system of exemptions “is rooted deeply in the principle of religious freedom, a value at the very core of the American constitutional order. This

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<sup>200</sup> U.S. CONST. amend. I; *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp’t Opportunity Comm’n*, 132 S.Ct. 694, 702 (2012) (referring to these clauses in the First Amendment as the Establishment Clause, and the Free Exercise Clause, and as the Religious Clauses).

<sup>201</sup> See Carl H. Esbeck, *The Establishment Clause as a Structural Restraint on Governmental Power*, 84 IOWA L. REV. 1, 8–9 (1998). Thomas Jefferson reflected the structural restraint expressed in the First Amendment in a letter to Reverend Samuel Miller: “[T]he government of the United States is interdicted by the Constitution from intermeddling with religious institutions, their doctrines, discipline, or exercises.” Letter from Thomas Jefferson to the Rev. Samuel Miller (Jan. 23, 1808), in II THE WORKS OF THOMAS JEFFERSON 7 (Paul Ford ed., 1905).

<sup>202</sup> See Michael J. DeBoer, *Seek a Right View of the Bible—A Biblical and Theological Response to Herbert W. Titus and Some Lessons for Christian Law Students*, 2 LIBERTY U. L. REV. 339, 364 n.135 (2008) (noting that “Vermont, Connecticut, New Hampshire, Maine, and Massachusetts retained some semblance of their religious establishments until 1807, 1818, 1819, 1820, and 1832/1833, respectively”) (citing Carl H. Esbeck, *Dissent and Disestablishment: The Church-State Settlement in the Early American Republic*, 2004 BYU L. REV. 1385, 1458 (2004)).

<sup>203</sup> See *Everson v. Bd. of Educ.*, 330 U.S. 1 (1947) (making the establishment provision applicable to the states); *Cantwell v. Connecticut*, 310 U.S. 296 (1940) (making the free exercise provision applicable to the states).

<sup>204</sup> Gaffney, *Exemption*, *supra* note 190, at 431.

<sup>205</sup> HOPKINS, *supra* note 31, at 14 (citing James J. McGovern, *The Exemption Provisions of Subchapter F*, 29 TAX LAW. 523, 524 (1976) (“[The] history of mankind reflects that our early legislators were not setting precedent by exempting religious or charitable organizations.”)).

<sup>206</sup> Gaffney, *supra* note 190, at 410.

value is, in turn, deeply imbedded within traditions and practices that long antedate the Republic.”<sup>207</sup>

State constitutional texts clearly manifest this value. For instance, when the people of Indiana adopted their second constitution in 1851, they required the General Assembly to “provide, by law, for a uniform and equal rate of assessment and taxation” and to “prescribe such regulations as shall secure a just valuation for taxation of all property, both real and personal, excepting such only for municipal, educational, literary, scientific, religious or charitable purposes, as may be specially exempted by law.”<sup>208</sup> In their third constitution, which was adopted in 1891, the people of Kentucky employed a different approach but to the same end. The Kentucky Constitution protected individual liberty by prohibiting government from exempting property from taxation except as specifically provided in the state constitution.<sup>209</sup> The constitution then provided for the following exemptions: “public property used for public purposes”; “places of burial not held for private or corporate profit”; “real property owned and occupied by, and personal property both tangible and intangible owned by, institutions of religion”; and “institutions of purely public charity, and institutions of education not used or employed for gain by any person or corporation, and the income of which is devoted solely to the cause of education, public libraries, their endowments, and the income of such property as is used exclusively for their maintenance.”<sup>210</sup>

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<sup>207</sup> Gaffney, *supra* note 190, at 410.

<sup>208</sup> IND. CONST. art. X, § 1 (1851). Article X of the Indiana Constitution has been amended, but it still authorizes the General Assembly to exempt from property taxation any property “being used for municipal, educational, literary, scientific, religious, or charitable purposes.” *Id.* § 1(a). The Indiana Code exempts from property taxation all or part of a building that “is owned, occupied, and used by a person for educational, literary, scientific, religious, or charitable purposes.” IND. CODE § 6-1.1-10-16(a).

<sup>209</sup> KY. CONST. § 3 (1891). This provision of the state bill of rights declared: All men, when they form a social compact, are equal; and no grant of exclusive, separate public emoluments or privileges shall be made to any man or set of men, except in consideration of public services; but no property shall be exempt from taxation except as provided in this Constitution, and every grant of a franchise, privilege or exemption, shall remain subject to revocation, alteration or amendment.

*Id.*

<sup>210</sup> KY. CONST. § 170 (1891). A Kentucky statute provides that “[a]ll property shall be subject to taxation, unless it is exempted by the Constitution or in the case of personal property unless it is exempted by the Constitution or by statute.” KY. REV. STAT. ANN. § 132.190(1).



## 2. A Review of Applications to Religious Hospitals

Religious hospitals are religious institutions. They trace their founding to religious organizations and religious figures who inspired others to follow.<sup>211</sup> The faith traditions with which they are affiliated and the religious organizations that sponsor them define and shape their identities and missions as religious organizations.<sup>212</sup>

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<sup>211</sup> For instance, Saint Francis Medical Center (SFMC), a Louisiana nonprofit corporation, is a general medical and surgical hospital in Monroe, Louisiana. *See Message from CEO, ST. FRANCIS MEDICAL CTR.*, [http://www.stfran.com/index.php?option=com\\_content&view=article&id=47&Itemid=58](http://www.stfran.com/index.php?option=com_content&view=article&id=47&Itemid=58) (last visited Oct. 14, 2012). SFMC traces its history back to early in the twentieth century when Father Ludovic Enaut, a retired priest in Monroe, promised to build a sanitarium if some Catholic sisters would embrace the mission and seek nothing in return. *Id.* On November 14, 1911, six Sisters from the Franciscan Missionaries of Our Lady arrived from France to begin a health ministry in Monroe. *Id.* Saint Francis Sanitarium and Training School for Nurses received its first patients on July 22, 1913, and it has been incorporated since 1941 (although under different names). *Id.* SFMC is a system member participant in the Catholic Health Association of the United States (CHAUS), and it is a part of the Franciscan Missionaries of Our Lady Health System. *Id.*; *Fact Sheet, FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM*, [http://www.fmolhs.org/fact\\_sheet2.htm](http://www.fmolhs.org/fact_sheet2.htm) (last visited Oct. 14, 2012).

Lutheran Medical Center (LMC), a general medical and surgical hospital in Brooklyn, New York, is another example. LMC was founded by a Norwegian Lutheran deaconess nurse in 1883, and it has been incorporated as a non-profit institution since 1963. *See LUTHERAN HEALTHCARE, ANNUAL REPORT 29 (2009), available at* <http://www.lutheranmedicalcenter.com/Data/Documents/LHCAnnualReport2009.pdf>. LMC is a part of the Lutheran HealthCare system, which is a social ministry of the Evangelical Lutheran Church in America (ELCA) and a Lutheran Services in America (LSA) member. *Mission Statement, LUTHERAN HEALTHCARE*, <http://www.lmcmc.com/AboutUs/MissionStatement/> (last visited Oct. 14, 2012).

<sup>212</sup> According to mission statement of SFMC, see *supra* note 213, the hospital is “[i]nspired by the vision of St. Francis of Assisi,” and “in the tradition of the Roman Catholic Church, [it] extend[s] the healing ministry of Jesus Christ to God’s people, especially those most in need.” *Mission Statement, ST. FRANCIS MEDICAL CTR.*, [http://www.stfran.com/index.php?option=com\\_content&view=article&id=48&Itemid=59](http://www.stfran.com/index.php?option=com_content&view=article&id=48&Itemid=59) (last visited Oct. 14, 2012). The hospital also calls on “all who serve in this healthcare ministry, to share their gifts and talents to create a spirit of healing—with reverence and love for all of life, with joyfulness of spirit, and with humility and justice for all those entrusted to our care,” and it expresses a prayer that, “with God’s help, [it is] a healing and spiritual presence for each other and for the communities we are privileged to serve.” *Id.* SFMC has identified the following core values that it embraces: service, reaching out to meet the needs of others; reverence and love for all of life, acknowledging that all of life is a gift from God; joyfulness of spirit, being aware of God’s blessing in all things; humility, being authentic in serving as an instrument of God; and justice, striving for equity and fairness in all relationships with special concern for those most in need. *Id.* The hospital also links its mission and core values to the well-known instruction of St. Francis of Assisi to “[p]reach the Gospel at all times. If necessary, use words.” *Id.*

The system in which SFMC participates is sponsored by the Franciscan

Missionaries of Our Lady, which is an international congregation of women religious in the Catholic Church who participate in the healing ministry of Jesus through health care, social, and community services. *Mission*, FRANCISCAN MISSIONARIES OF OUR LADY, <http://www.fmolhsisters.com/who-we-are> (last visited Oct. 14, 2012). The system operates three medical centers in Louisiana, and each traces its history back to the Franciscan Missionaries of Our Lady. FRANCISCAN MISSIONARIES OF OUR LADY HOSPITAL SYSTEM, FACT SHEET (2004), *available at* [http://www.fmolhs.org/fact\\_sheet2.htm](http://www.fmolhs.org/fact_sheet2.htm). The system serves patients throughout Louisiana through a network of hospitals, clinics, elderly housing, and integrated information systems. *Id.* The health system takes pride that its sponsored organizations and subsidiaries are “places where the spirit of God, our Catholic identity and our Franciscan heritage are evident and celebrated.” *FMOLHS Corporate Profile*, FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM, [http://www.fmolhs.org/corp\\_profile2.htm](http://www.fmolhs.org/corp_profile2.htm) (last visited Oct. 14, 2012). Its mission statement and core values are the same as those of SFMC; it strives to “deliver compassionate care to all persons, especially those most in need, by promoting health, wellness and spiritual wholeness.” *FMOLHS Mission & Values*, FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM, <http://www.fmolhs.org/mission2.htm> (last visited Oct. 14, 2012). The system has adopted an ethics statement that emphasizes remembering the mission, being of service, and taking care of resources. *FMOLHS Ethics Statement*, FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM, <http://www.fmolhs.org/ethics2.htm> (last visited Oct. 14, 2012). The system identifies itself as a faith-based, mission-driven organization and a law-abiding corporate citizen whose organizational ethics are “molded and shaped by the examples of Jesus, St. Francis of Assisi, our Franciscan sisters, and the Roman Catholic Church.” *Id.*

The board of LMC and Lutheran HealthCare, see *supra* note 213, has adopted the following mission statement, which reflects both the religious identities of the hospital and the system and the religious foundation of their missions:

Lutheran HealthCare has no reason for being of its own; it exists only to serve the needs of its neighbors. Lutheran HealthCare defines health as the total well-being of the community and its residents. Beyond the absence of individual physical illness, this includes, at least, decent housing, the ability communicate effectively, employment, educational opportunities and civic participation. Lutheran HealthCare understands that a hospital is not a collection of buildings, machines and beds, but a staff of talented, creative and committed people who serve the community as they are needed. Lutheran HealthCare works in partnership with its neighbors, each relying on the other as friends who care about and assist each other. Motivated to serve by its own history within the biblical tradition of faith and teaching, and organized as a not-for[-]profit organization according to the uniquely American heritage of democratic voluntary association, Lutheran HealthCare’s purpose is to serve as the corporate vehicle for its trustees, medical and dental staff, nurses, employees, volunteers and others, to care for the needs of our neighbors.

*Mission Statement*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/AboutUs/MissionStatement/> (last visited Oct. 14, 2012) (new paragraph designations omitted). According to Lutheran HealthCare’s website, the system has intentionally aligned “its missional life and practices with the primary tenets” of the ELCA social statement on health, healing, and health care. *Mission and Spiritual Care*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/GuideForPatients/Mission/> (last visited Oct 14, 2012).

In their ministries, they manifest the impulse of faith communities to live out and practice their faith and to perform works of service beyond their faith communities.<sup>213</sup>

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In addition to operating an emergency department and Level I trauma center, LMC serves as an academic teaching institution. *Welcome to Lutheran Medical Center*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/OurFacilities/LutheranMedicalCenter/> (last visited Oct. 14, 2012). The system in which LMC participates provides a range of services through various facilities, including the LMC; the Family Health Centers network; the Augustana Center for Extended Care and Rehabilitation; Health Plus, a managed care program; senior housing facilities; and home care services. *Our Facilities*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/OurFacilities/> (last visited Oct. 14, 2012).

<sup>213</sup> See Mary Ann Glendon & Raul F. Yanes, *Structural Free Exercise*, 90 MICH. L. REV. 477, 526–27 (1991).

For Americans in the eighteenth century, and “indeed for generations thereafter, free exercise of religion included freedom of religious groups to take an active part in regulating family responsibilities, education, health care, poor relief, and various other aspects of social life that were considered to have a significant moral dimension.” Gradually, the state has taken over many of the functions formerly left to religious communities, achieving control over the provision of most primary and secondary education in the nineteenth century, and increasing its presence in the social service area as the American version of the welfare state developed in the twentieth.

*Id.* (quoting Harold J. Berman, *Religious Freedom and the Challenge of the Modern State*, in ARTICLES OF FAITH, ARTICLES OF PEACE: THE RELIGIOUS LIBERTY CLAUSES AND THE AMERICAN PUBLIC PHILOSOPHY 42 (James D. Hunter & Os Guinness eds., 1990)). Faith communities engage in educational, health care, and social service ministries, as one commentator has explained:

Most religious communities do not engage only in worship and preaching; they seek to practice their faith in other aspects of life as well. Two of their most common such activities are educating the young and caring for people who are in need because of illness, poverty, or other misfortune. These three areas of ministry—education, health care, and social services—are high priorities for many religious bodies.

Thomas C. Berg, *Affiliated Ministries: Education, Social Services, Health Care*, in RELIGIOUS ORGANIZATIONS IN THE UNITED STATES: A STUDY OF IDENTITY, LIBERTY, AND THE LAW 671 (James A. Serritella ed., 2006). The desire of religious communities to live out their faith through works of service and social ministries is reflected in the following social statement on health, healing, and health care by the Evangelical Lutheran Church in America (ELCA), the second largest mainline Protestant Christian denomination in the United States:

For generations, Lutheran individuals and congregations have identified unmet needs in their communities and worked to meet them. As congregational programs of service have grown, they often have become more formalized to engage resources and partners beyond the congregation. These social ministry organizations continue to arise from congregations and are an integral part of our church’s work in the world. By coordinating efforts and sharing strengths, congregations, social ministry organizations, synods, and other partners reach out more effectively to meet the health needs of the

As religious institutions, religious hospitals carry out and extend the healing ministries of their sponsors, and they “bring their distinctive values to . . . [their] health care ministries.”<sup>214</sup> Indeed, religious hospitals exist for a religious purpose—to conduct a ministry of healing that cares for both the body and the soul.<sup>215</sup> Their

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neighbor. Lutheran social ministry organizations provide a wide range of services. These services help to treat acute and chronic illnesses of body and mind, provide care for the whole person in need, and strengthen and empower individuals and families to care for themselves, for one another, and for their communities. Within these and other health-related ministries, staff members and volunteers exercise vocations of healing in administrative, direct care, pastoral care, and governance roles. Supporting and developing these institutions and vocations are the work of our whole church. As institutions of this church serving in Christ’s name, social ministry organizations are accountable to live out that identity in their daily work and decision-making. Lutheran social ministry organizations witness to a church in action in many ways: by protecting the health and well-being of those who serve; by careful stewardship of resources; by respectful and equitable attention to the physical, mental, and spiritual needs of those persons serve; and by establishing ways to ask and answer questions of ethics, identity, and relationship. . . .

EVANGELICAL LUTHERAN CHURCH IN AMERICA, HEALTH AND HEALTHCARE—CARING FOR HEALTH: OUR SHARED ENDEAVOR (2003), *available at* <http://www.elca.org/What-We-Believe/Social-Issues/Social-Statements/Health-and-Healthcare.aspx> (new paragraph designations omitted). For the ELCA, its social ministry organizations, including its hospitals, are a vital part of the church’s ministry and its witness to the world.

Professor Berg has also observed that the interests of governments and religious institutions often overlap. He wrote:

[E]ach area also implicates interests of government and the broader society, which are concerned with the education of children and the quality of care that sick or needy people receive. As a result, religiously affiliated entities in education, health care, and social services organize themselves and conduct their operations against a background of federal, state, and local regulation . . . .

*Id.* He also noted:

[R]eligious hospitals are often regulated and supported by the government in much the same way as secular hospitals are, on the premise that medical treatment is largely the same no matter what the patient’s faith. More than a century ago, the Supreme Court approved of federal funding to a Catholic hospital on the ground that the hospital was not a “religious corporation” but simply “a secular corporation being managed by people who hold to the doctrines of the Roman Catholic Church, but who nevertheless are managing the corporation according to the law under which it exists.”

*Id.* at 672 (quoting *Bradfield v. Roberts*, 175 U.S. 291, 298–99 (1899)).

<sup>214</sup> *Id.* at 672.

<sup>215</sup> The Roman Catholic Church, the largest Christian denomination in the United States, has hospitals and health care facilities in all fifty states. *The Catholic Church in the United States at a Glance*, U.S. CONF. OF CATHOLIC BISHOPS, <http://old.usccb.org/comm/catholic-church-statistics.shtml> (last visited Oct. 14,

healing ministries have an intensely personal component as they serve individual patients and their families, administer the sacraments, and provide spiritual assistance and moral counsel to families making difficult health decisions involving loved ones.<sup>216</sup> However, their healing ministries also have a more social component in terms of their service to their communities (whether rural or urban), their educational and public health programs, their relationships with local, regional, and national religious and social services organizations, and their advocacy on moral issues in the public square.<sup>217</sup> Additionally, religious hospitals are overseen and

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2012) [hereinafter, USCCB, *The Catholic Church*]. The Catholic Church understands Catholic health care to be the healing ministry of the church and an extension of “Jesus’ mission of love and healing in the world today.” CATHOLIC HEALTH ASS’N OF THE U.S., WHO WE ARE (2012), available at [http://www.chausa.org/Pages/About\\_CHA/Overview/](http://www.chausa.org/Pages/About_CHA/Overview/); see also *infra* note 281. In its social statement on health, healing, and health care, the ELCA explained the church’s view that, by caring for the health of others, people express love for their neighbors and responsibility for a just society. EVANGELICAL LUTHERAN CHURCH IN AMERICA, HEALTH AND HEALTHCARE—CARING FOR HEALTH: OUR SHARED ENDEAVOR (2003), available at <http://www.elca.org/What-We-Believe/Social-Issues/Social-Statements/Health-and-Healthcare.aspx>. The statement provides the following articulation of the church’s ministry of healing:

A ministry of healing is integral to the life and mission of the Church. It expresses our faith in the power of God to create and to save, as well as our commitment to care for our neighbor. The Holy Spirit empowers us so that we can care for all people as God’s children and seek their healing. The Church promotes health and healing and provides health care services through its social ministry organizations and congregation-based programs. The Church’s ministry may offer healing and forms of health care in ways not found or adequately addressed within a health care system. The Church also supports the just obligations of a society to serve those who are often left out and to be present with those who suffer. Because it originates and carries out Christ’s healing work, the Church’s ministry is freed to contribute to the health care system as well as to address its injustices.

*Id.* In the statement, the church also articulates: biblical and theological perspectives on health, illness, healing, and health care; a vision of health care and healing as a shared endeavor involving personal responsibilities, the church’s ministry, congregations, social ministry organizations, advocacy, and efforts to develop a better system of health care services that promote public health, care for the whole patient, support caregivers, and foster the development of research and technology in ways consistent with the ELCA’s social statement and accepted bioethics standards; and ethical guidance for individuals and families in making difficult treatment decisions.

*Id.*

<sup>216</sup> For example, SFMC, see *supra* note 213, has a pastoral staff that includes priests and chaplains, and it provides a wide range of pastoral care services. See ST. FRANCIS MEDICAL CTR., ST. FRANCIS PASTORAL CARE DEPARTMENT, available at [http://www.stfran.com/images/stories/pastoral\\_care\\_orientation\\_flyer2.pdf](http://www.stfran.com/images/stories/pastoral_care_orientation_flyer2.pdf).

<sup>217</sup> See *supra* notes 214–15 & 217 and *infra* note 220–22. In the case of the Lutheran HealthCare system, it seeks to partner with congregations and other faith-based/community organizations to promote health ministries and address health

held accountable by sponsoring religious organizations, and members of the clergy and religious organizations often participate in the management of religious hospitals.<sup>218</sup> Religious hospitals also affiliate with faith-based hospital and social service associations, such as the Catholic Health Association in the United States (CHAUS)<sup>219</sup>

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disparities, and it has participated in the formation of an interfaith coalition for health and wellness aimed at improving the health and well-being of the south Brooklyn community by establishing new health ministry partnerships and initiatives. *Mission and Spiritual Care*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/GuideForPatients/Mission/> (last visited Oct. 14, 2012). Lutheran HealthCare also participates in the Lutheran Services New York Alliance, which seeks to provide a unified public face and voice of Lutheran social ministry services in the region, and it is actively involved in a collaborative clinical pastoral training program. *Id.*

<sup>218</sup> For instance, in the case of SFMC, see *supra* note 213, two Catholic sisters serve as members of the board of directors. *2012 Board of Directors*, ST. FRANCIS MEDICAL CTR., [http://www.stfran.com/index.php?option=com\\_content&view=article&id=49&Itemid=60](http://www.stfran.com/index.php?option=com_content&view=article&id=49&Itemid=60) (last visited Oct. 14, 2012). The SFMC executive team includes a vice president of mission integration. ST. FRANCIS MEDICAL CTR., ST. FRANCIS ADMINISTRATIVE TEAM, *available at* <http://www.stfran.com/images/stories/pastoral%20care%20orientation%20flyer2.pdf>. In the case of LMC, see *supra* note 213, the bishop of the ELCA Metropolitan New York Synod is a member of the board of trustees. *Board of Trustees*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/AboutUs/BoardMembers/> (last visited Oct. 14, 2012). Furthermore, the Lutheran HealthCare system, in which LMC participates, has an Office for Mission and Spiritual Care. An ordained minister heads this office, which works to invigorate the spiritual mission of the hospital and is responsible for its social ministry relationship with the denomination, its mission effectiveness, pastoral/spiritual care, volunteer services, and relationships with congregations and faith-based organizations. *Mission and Spiritual Care*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/GuideForPatients/Mission/> (last visited Oct. 14, 2012). Additionally, the Lutheran HealthCare board of trustees has a standing committee for mission and spiritual care that serves in a governance/advisory capacity to advance mission effectiveness and pastoral care and ensure that the hospital's mission and spiritual care reflect the church's social ministry policies and practices. *Id.*

<sup>219</sup> The Catholic Health Association of the United States (CHAUS) is a Catholic organization. The CHAUS plays an important role in informing and shaping the mission and identity of Catholic hospitals. *About CHA*, THE CATHOLIC HEALTH ASS'N OF THE U.S., [http://www.chausa.org/Pages/About\\_CHA/Overview](http://www.chausa.org/Pages/About_CHA/Overview) (last visited Oct. 4, 2012) [hereinafter CHAUS, *About CHA*]. The CHAUS is a membership organization that brings Catholic health care organizations together for collective action. *Id.* Leaders of Catholic health ministries established the organization in 1915 in an effort to ensure that Catholic hospitals remain faithful to their mission and identity and continued to carry out the health ministry of the Church. *How CHA Began*, THE CATHOLIC HEALTH ASS'N OF THE U.S., [http://www.chausa.org/Pages/About\\_CHA/How\\_CHA\\_Began/](http://www.chausa.org/Pages/About_CHA/How_CHA_Began/) (last visited Oct. 4, 2012). The organization was established during a time when the hospital sector was undergoing dramatic changes as a result of advances in technology and changes in health care. *Id.*

The CHAUS has a threefold mission: (1) being a passionate voice for Jesus'

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and Lutheran Services in America (LSA),<sup>220</sup> and these affiliations

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mission of love and healing; (2) being a valuable resource for information, services, and programs; and (3) being a vibrant community of members joined in a shared mission. The CHAUS has provided the following shared statement of identity for Catholic health ministry:

We are the people of Catholic health care, continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen—bringing together people of diverse faiths and backgrounds—our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind and spirit. We work to bring alive the Gospel vision of justice and peace. We answer God's call to foster healing, act with compassion and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved and most vulnerable. By our service, we strive to transform hurt into hope.

*A Shared Statement of Identity for the Catholic Health Ministry*, THE CATHOLIC HEALTH ASS'N OF THE U.S., [http://www.chausa.org/Pages/Our\\_Work/Mission/Mission\\_Resources/A\\_Shared\\_Statement\\_of\\_Identity/](http://www.chausa.org/Pages/Our_Work/Mission/Mission_Resources/A_Shared_Statement_of_Identity/) (last visited Oct. 4, 2012) (new paragraph designations omitted). The work and service provided by the CHAUS are predicated upon the following fundamental commitments: promoting and defending the dignity of every person; attending to the whole person; caring for poor and vulnerable persons; advancing the common good; acting on behalf of justice; stewarding resources; and acting in communion with the Catholic Church. *Id.* These same commitments are to be reflected in the healing ministry carried out by Catholic health care organizations, and they are to be guided by the Gospel and the moral teachings of the Catholic Church. CHAUS, *About CHA*, *supra*.

To be a CHAUS member, an organization must “(1) promote or foster the values of the Catholic health ministry and (2) embrace and support the mission and purposes of the association.” *About CHA—Membership and Dues*, CATHOLIC HEALTH ASS'N OF THE U.S., [http://www.chausa.org/Pages/About\\_CHA/Membership\\_and\\_Dues/](http://www.chausa.org/Pages/About_CHA/Membership_and_Dues/) (last visited Oct. 4, 2012). The CHAUS has several categories of membership. First, representative membership is for any nonprofit Catholic health system, sponsor, or free-standing Catholic entity in the United States. *Id.* Second, system participant membership is for any nonprofit or privately held for-profit entity in the United States that is controlled and recommended for membership by a representative member, and system-based representative members are the principal constituents and direct recipients of CHAUS services. *Id.* Third, affiliate membership is for any nonprofit or privately held for-profit entity that, while not controlled by a Catholic entity, has a direct or indirect relationship with a Catholic entity for the purpose of delivering health care services through a contract or other agreement. *Id.* Fourth, joint membership is for free-standing entities that are members of a national membership organization with which the CHAUS has a joint membership agreement. *Id.* Fifth, international membership is for an entity that would qualify for representative membership but is located outside the United States. *Id.*

<sup>220</sup> The ELCA, the Lutheran Church—Missouri Synod (LCMS), which is another Lutheran denomination, and several hundred health and human service organizations participate in an alliance called Lutheran Services in America (LSA). The mission of LSA is to love and serve its neighbors by helping Lutheran social ministry organizations live out their Lutheran identities, remain healthy, vital, and engaged in effective service and advocacy, maintain an integrated, results-driven capacity, express a spirit of possibility and a will that shapes the future, and lead a

enhance the accountability of religious hospitals to the faith traditions and organizations that sponsor them.<sup>221</sup>

As religious institutions, religious hospitals are protected under the religious liberty provisions of state constitutions and the First Amendment to the United States Constitution.<sup>222</sup> Nearly two

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movement of hope and grace toward a society that values generosity, inclusion, justice, and mutual care. *About Us—Mission*, LUTHERAN SERVICES IN AMERICA, <http://www.lutheranservices.org/mission> (last visited Oct. 14, 2012). LSA fills the following roles: strengthening the ministries of its members; bolstering the Lutheran identity of members; facilitating work done collectively rather than individually; training board members and staff; building connections among social ministry organizations; and stimulating collective action through advocacy and programs. LSA encourages member organizations to strengthen their religious identities in at least two ways: (1) connecting with churches and local congregations; and (2) seeking to understand and live out their Lutheran identities. *Id.* The ELCA supports its LSA-affiliated health and human service organizations in various ways, such as consulting on affiliation with the denomination, interpreting and supporting the relationship between church synods and bishops with the social ministry organizations, and facilitating liaison with LSA. *Social Ministry Organizations*, EVANGELICAL LUTHERAN CHURCH IN AMERICA, <http://www.elca.org/Growing-In-Faith/Ministry/Partner-Related-Organizations/Social-Ministry-Organizations.aspx> (last visited Oct. 14, 2012).

<sup>221</sup> For instance, Catholic hospitals are governed by Catholic religious congregations and some boards of lay trustees and more remotely by local diocesan bishops and the Holy See. Kevin O'Rourke, *Catholic Hospitals and Catholic Identity*, in 7 CHRISTIAN BIOETHICS 15, 15 (2007). In the case of the ELCA, the denomination may formally participate in the corporate governance of a Lutheran organization. *Social Ministry Organizations*, EVANGELICAL LUTHERAN CHURCH IN AMERICA, <http://www.elca.org/Growing-In-Faith/Ministry/Partner-Related-Organizations/Social-Ministry-Organizations.aspx> (last visited Oct. 14, 2012). The ELCA has explained the roles that church synods and bishops may fill in the corporate governance of Lutheran social ministry organizations:

Within the ELCA synods and bishops participate with social ministry organizations (SMOs) in a variety of ways, some of them quite informal and occasional while other relationships are formal and prescribed. . . . A more formal relationship might occur when a board seat is designated as having to be filled by the bishop of the synod in which the organization is located, whether in an ex-officio capacity, with or without full vote. . . . The highest level and most formal way in which a synod participates in an SMO is by being the sole corporate member or part of a group of corporate members.

EVANGELICAL LUTHERAN CHURCH IN AMERICA, *ROLE OF SYNODS AS CORPORATE MEMBERS OF LUTHERAN SOCIAL MINISTRY ORGANIZATIONS*, available at [http://www.elca.org/~media/Files/Our%20Faith%20in%20Action/Service%20Opportunities/Social%20Ministry%20Organizations/cob\\_2003\\_corp\\_membership.ashx](http://www.elca.org/~media/Files/Our%20Faith%20in%20Action/Service%20Opportunities/Social%20Ministry%20Organizations/cob_2003_corp_membership.ashx). The affiliation of the ELCA with a social ministry organization is intended to establish a relationship of denominational accountability. *Social Ministry Organizations*, EVANGELICAL LUTHERAN CHURCH IN AMERICA, <http://www.elca.org/Growing-In-Faith/Ministry/Partner-Related-Organizations/Social-Ministry-Organizations.aspx> (last visited Oct. 14, 2012).

<sup>222</sup> For a discussion of state and federal constitutional protection of religious liberty, see *supra* Part IV.A.1.



centuries ago, Chief Justice of the United States John Marshall explained that “the power to tax involves the power to destroy.”<sup>223</sup> The power to tax also includes the power to control, change, and suppress behavior,<sup>224</sup> as well as the power to undercut the financial viability of organizations by exposing them to the “hazard” of losing property if they do not pay their taxes.<sup>225</sup> Although the wielding of these powers can have a benign effect, it can also have a more malignant effect, as the Supreme Court has recognized:

Governments have not always been tolerant of religious activity, and hostility toward religion has taken many shapes and forms—economic, political, and sometimes harshly oppressive. Grants of exemption historically reflect the concern of authors of constitutions and statutes as to the latent dangers inherent in the imposition of property taxes; exemption constitutes a reasonable and balanced attempt to guard against those dangers.<sup>226</sup>

Consequently, when religious organizations are affected, the taxing power of the government is a matter of constitutional significance, requiring special sensitivity and care.

Furthermore, a system of exemption from taxation for religious institutions protects against government becoming entangled with religion.<sup>227</sup> As Chief Justice Burger observed four decades ago, the exemption of church property from taxation safeguards “the autonomy and freedom of religious bodies,”<sup>228</sup> and it “creates only a minimal and remote involvement between church and state and far less than taxation of churches. It restricts the fiscal relationship between church and state, and tends to complement and reinforce the desired separation insulating each from the other.”<sup>229</sup> Accordingly, a system of tax exemption does not establish religion;

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<sup>223</sup> *McCulloch v. Maryland*, 17 U.S. 316, 431 (1819).

<sup>224</sup> *Murdock v. Pennsylvania*, 319 U.S. 105, 112 (1943) (“The power to tax the exercise of a privilege is the power to control or suppress its enjoyment.”) (citing *Magnano Co. v. Hamilton*, 292 U.S. 40, 44, 45 (1934)); Sheldon D. Pollack, *Tax Reform: The 1980's in Perspective*, 46 TAX L. REV. 489, 496 (1991) (“The power to tax provides a ready, albeit crude, means of public control over private behavior through a combination of economic incentives and disincentives permitting the state to alter, and thereby shape and manipulate, social and economic activity.”).

<sup>225</sup> *Walz v. Tax Comm'n of City of New York*, 397 U.S. 664, 672 (1970) (tax exemption reflects a policy judgment that certain organizations “should not be inhibited in their activities by property taxation or the hazard of loss of those properties for nonpayment of taxes”).

<sup>226</sup> *Id.* at 673.

<sup>227</sup> *Id.* at 674–76.

<sup>228</sup> *Id.* at 672.

<sup>229</sup> *Id.* at 676.

rather, it accommodates religion and “spar[es] the exercise of religion from the burden of property taxation levied on private profit institutions.”<sup>230</sup> Consequently, the long-established system of tax exemptions is predicated upon a belief that taxing religious institutions would undercut the religious liberty of such institutions by entangling the government in religious affairs. Moreover, although religious institutions are believed to contribute benefits to their communities,<sup>231</sup> tax exemptions for these institutions are not justified on a belief that they contribute some value or some good to society such that if the government or society were to deem the measure of that value or good inadequate, removal of the exemptions would be justified.<sup>232</sup> Tax exemption thus represents a means of

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<sup>230</sup> *Id.* at 673 (“The limits of permissible state accommodation to religion are by no means co-extensive with the noninterference mandated by the Free Exercise Clause. To equate the two would be to deny a national heritage with roots in the Revolution itself. We cannot read New York’s [property tax exemption] statute as attempting to establish religion; it is simply sparing the exercise of religion from the burden of property taxation levied on private profit institutions.”).

<sup>231</sup> *Walz*, 397 U.S. at 673.

The legislative purpose of a property tax exemption is neither the advancement nor the inhibition of religion; it is neither sponsorship nor hostility. [In granting property tax exemption, states have] determined that certain entities that exist in a harmonious relationship to the community at large, and that foster its “moral or mental improvement,” should not be inhibited in their activities by property taxation or the hazard of loss of those properties for nonpayment of taxes. [They have] not singled out one particular church or religious group or even churches as such; rather, [they have] granted exemption to all houses of religious worship within a broad class of property owned by nonprofit, quasi-public corporations that include hospitals, libraries, playgrounds, scientific, professional, historical, and patriotic groups. [They have] an affirmative policy that considers these groups as beneficial and stabilizing influences in community life and find[] this classification useful, desirable, and in the public interest.

*Id.* (citations omitted).

<sup>232</sup> *Id.* at 674.

We find it unnecessary to justify the tax exemption on the social welfare services or “good works” that some churches perform for parishioners and others—family counseling, aid to the elderly and the infirm, and to children. Churches vary substantially in scope of such services; programs expand or contract according to resources and need. As public-sponsored programs enlarge, private aid from the church sector may diminish. The extent of social services may vary, depending on whether the church serves an urban or rural, a rich or poor constituency. To give emphasis to so variable an aspect of the work of religious bodies would introduce an element of governmental evaluation and standards as to the worth of particular social welfare programs, thus producing a kind of continuing day-to-day relationship which the policy of neutrality seeks to minimize. Hence, the use of a social welfare yardstick as a significant element to qualify for tax

safeguarding religious liberty and reducing the potential of government entanglement.

These same concerns regarding religious freedom and government entanglement with religion and religious institutions extend to religious hospitals, and the regulation of religious hospitals poses religious freedom and entanglement concerns that the regulation of secular hospitals does not pose. Although taxing secular nonprofit and for-profit hospitals would not present an entanglement issue, eliminating exemptions and taxing religious hospitals would increase government entanglement with religious institutions and burden their efforts to advance their religious purpose.<sup>233</sup> In the religious hospital context, government could use taxes and tax policy as a backdoor means of regulating religious hospitals and their sponsoring organizations, involving government in religious matters, controlling religious and moral beliefs and practices, and defining the identities and missions of religious institutions.<sup>234</sup> Setting tax policy and imposing taxes could require

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exemption could conceivably give rise to confrontations that could escalate to constitutional dimensions.

*Id.*

<sup>233</sup> See *Waltz*, 397 U.S. at 674 (Both taxing churches and granting exemptions “occasion[] some degree of involvement with religion. Elimination of exemption would tend to expand the involvement of government by giving rise to tax valuation of church property, tax liens, tax foreclosures, and the direct confrontations and conflicts that follow in the train of those legal processes.”).

<sup>234</sup> The Supreme Court recently addressed similar concerns when it determined that the First Amendment protects a religious institution’s authority to select its own ministers, including employees such as a teacher at a church-operated school. See *Hosanna-Tabor Evangelical Lutheran Church & Sch., v. Equal Emp’t Opportunity Comm’n*, 132 S.Ct. 694 (2012). In *Hosanna-Tabor*, the Court was cognizant of the regulatory impact that employment discrimination laws have on religious institutions and their internal affairs. *Id.* at 699 (observing that the question before the Court was “whether the Establishment and Free Exercise Clauses of the First Amendment bar [violations by employees under certain employment discrimination laws for wrongful termination seeking reinstatement and damages] when the employer is a religious group and the employee is one of the group’s ministers”). The Court determined that “[b]oth Religion Clauses bar the government from interfering with the decision of a religious group to fire one of its ministers.” *Id.* at 702. The Court’s analysis rested upon earlier decisions of the Court regarding church property disputes and church autonomy. The Court wrote:

[In *Watson v. Jones*, 13 Wall. 679 (1872),] this Court—applying not the Constitution but a “broad and sound view of the relations of church and state under our system of laws”—declined to question [a denomination’s determination of a church property dispute]. *Id.* at 727. We explained that “whenever the questions of discipline, or of faith, or ecclesiastical rule, custom, or law have been decided by the highest of [the] church judicatories to which the matter has been carried, the legal tribunals must accept such decisions as final, and as

government to classify the ministries and services of religious hospitals as religious and “nonreligious.”<sup>235</sup> However, the First Amendment was intended, at least in part, to protect religious freedom and religious pluralism by preventing government from tightly or inflexibly defining religion and religious matters, regulating religious conduct, specifying criteria that treat religious communities as if every community is the same, and prohibiting government entanglement in religious matters and government probing into the affairs of religious organizations.<sup>236</sup> Additionally, in the American constitutional design, government, including tax authorities and courts, is restricted in its authority to define the nature and ministry of religious organizations.<sup>237</sup> Furthermore, the Free Exercise and Establishment Clauses of the First Amendment convey a principle that “all forms of religious ministry are entitled to equal treatment under the law,” such that government should treat the healing ministry of religious hospitals like other ministries provided by religious institutions.<sup>238</sup>

For these reasons, tax exemption of religious institutions and religious hospitals should be understood primarily as a means of protecting religious liberty, accommodating religion and religious institutions, and avoiding government entanglement with religion, not as an economic benefit or subsidy.<sup>239</sup> This view of tax exemption

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binding on them.” *Ibid.* As we would put it later, our opinion in *Watson* “radiates . . . a spirit of freedom for religious organizations, an independence from secular control or manipulation—in short, power to decide for themselves, free from state interference, matters of church government as well as those of faith and doctrine.” *Kedroff v. Saint Nicholas Cathedral of Russian Orthodox Church in North America*, 344 U. S. 94, 116 (1952). Confronting the issue under the Constitution for the first time in *Kedroff*, the Court recognized that the “[f]reedom to select the clergy, where no improper methods of choice are proven,” is “part of the free exercise of religion” protected by the First Amendment against government interference. *Ibid.*

*Id.* at 704 (new paragraph designation omitted). These same concerns regarding the autonomy and self-definition of religious entities and their authority to govern their own affairs and decide matters of faith, doctrine, and mission free from government control, manipulation, and interference arise in the context of government taxation and exemption of religious institutions, including religious hospitals.

<sup>235</sup> Berg, *supra* note 213, at 672 (observing that government regulation in health care “can affect the autonomy and self-definition of the religious entity”).

<sup>236</sup> Gaffney, *Exemption*, *supra* note 190, at 443–46.

<sup>237</sup> *Id.* at 455.

<sup>238</sup> *Id.* at 457.

<sup>239</sup> *Walz*, 397 U.S. at 674–75.

Granting tax exemptions to churches necessarily operates to afford an indirect economic benefit and also gives rise to some, but yet a lesser, involvement than taxing them. In analyzing either alternative the

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manifests a recognition that government regulation (including tax regulation), even when neutral on its face and generally applicable, can have a profound effect on religious organizations. Consequently, religious hospitals should be sheltered from the destructive force of taxation, the controlling influence of government, and the backdoor regulation of government.

*B. The Rationales for Favorable Treatment of Nonprofit Institutions*

Voluntary associations, charitable institutions, and religious organizations have been a valuable part of the social fabric of America. These organizations have pursued an array of purposes and performed various functions that have justified favorable treatment in Anglo-American law and exemptions from taxation.<sup>240</sup> Accordingly, the purposes and functions of nonprofit organizations in American society and the well-established rationales for tax exemption for these institutions warrant further consideration.

1. The Purposes and Functions of Nonprofit Organizations

People and groups form nonprofit organizations to confer public or mutual benefits or to advance religious purposes.<sup>241</sup>

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questions are whether the involvement is excessive, and whether it is a continuing one calling for official and continuing surveillance leading to an impermissible degree of entanglement. Obviously a direct money subsidy would be a relationship pregnant with involvement and, as with most governmental grant programs, could encompass sustained and detailed administrative relationships for enforcement of statutory or administrative standards, but that is not this case.

*Id.* For a discussion of the economic rationales for tax exemption, see *infra* Section IV.B.2.b.

<sup>240</sup> In England, the Statute of Charitable Uses of 1601, enacted during the Elizabethan period, provided exemptions to the following list of purposes for which charities could be established and brought under the supervision of the government:

some for Releife of aged impotent and poore people, some for Maintenance of sicke and maimed Souldiers and Marriners, Schooles of Learninge, Free Schooles and Schollers in Universities, some for Repaire of Bridges Portes Havens Causwaies Churches Seabankes and Highwaies, some for educacion and preferemente of Orphans, some for or towards Reliefe Stocke or Maintenance of Howses of Correccion, some for Mariages of poore Maides, some for Supportacion Ayde and Helpe of younge tradesmen Handicraftesmen and persons decayed, and others for reliefe or redemption of Prisoners or Captives, and for aide or ease of any poore Inhabitantes concerning payment of Fifteenes, setting out of Souldiers and other Taxes . . . .

43 Elizabeth I, c. 4 (1601) (Eng.).

<sup>241</sup> See *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp't Opportunity Comm'n*, 132 S.Ct. 694, 706 (2012) (“The right to freedom of

Nonprofit organizations, including tax-exempt organizations, collectively constitute a sector of American society that is distinct from both the government sector and the for-profit sector.<sup>242</sup> As one commentator has explained, the nonprofit sector serves as “a bulwark against the excesses” of government and for-profit entities and promotes balance in civil society.<sup>243</sup> Nonprofit organizations have also contributed to the governance, plural structure, and cultural enrichment of society.<sup>244</sup> They have helped to promote various freedoms that individuals enjoy, but the freedom of individuals to associate in accomplishing cultural, economic, educational, political, religious, scientific, and social goals can hardly be more clearly reflected than in the way that people come together to pursue a

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association is a right enjoyed by religious and secular groups alike. . . . [T]he text of the First Amendment . . . gives special solicitude to the rights of religious organizations.”); *id.* at 713 (“Religious groups are the archetype of associations formed for expressive purposes, and their fundamental rights surely include the freedom to choose who is qualified to serve as a voice for their faith.”) (Alito, J., concurring). These distinct reasons for forming nonprofit organizations (i.e., to confer a public benefit, to confer a mutual benefit, and to advance a religious purpose) translate into three different types of nonprofit corporations under organization law in some states. *See, e.g.*, CAL. CORP. CODE §§ 5110-6910 (West) (nonprofit public benefit corporations); CAL. CORP. CODE §§ 7110-8910 (nonprofit mutual benefit corporations); CAL. CORP. CODE §§ 9110-9690 (nonprofit religious corporations).

<sup>242</sup> HOPKINS, *supra* note 31, at 6.

<sup>243</sup> *Hosanna-Tabor*, 132 S.Ct. at 712 (“Throughout our Nation’s history, religious bodies have been the preeminent example of private associations that have ‘act[ed] as critical buffers between the individual and the power of the State.’”) (quoting *Roberts v. United States Jaycees*, 486 U.S. 609, 619 (1984)); HOPKINS, *supra* note 31, at 6. In 1973, the Secretary of the Treasury testified that tax-exempt organizations “are an important influence for diversity and a bulwark against over-reliance on big government.” DEP’T OF THE TREASURY, GPO BOOKSTORE STOCK NO. 4800-00210 PROPOSALS FOR TAX CHANGE (1973).

<sup>244</sup> In 1835, Alexis de Tocqueville, an early observer of America, provided the following reflection on the place of nonprofit organizations and voluntary associations:

Americans of all ages, all conditions, and all dispositions constantly form associations. They have not only commercial and manufacturing companies, in which all take part, but associations of a thousand other kinds, religious, moral, serious, futile, general or restricted, enormous or diminutive. The Americans make associations to give entertainments, to found seminaries, to build inns, to construct churches, to diffuse books, to send missionaries to the antipodes; in this manner they found hospitals, prisons, and schools. If it is proposed to inculcate some truth or to foster some feeling by the encouragement of a great example, they form a society. Wherever at the head of some new undertaking you see the government in France, or a man of rank in England, in the United States you will be sure to find an association.

2 ALEXIS DE TOCQUEVILLE, *DEMOCRACY IN AMERICA* 106 (Phillips Bradley ed., Henry Reeve trans., Alfred A. Knopf 1945) (1835).

common purpose through such organizations.<sup>245</sup> Importantly, these organizations have performed some functions that government would likely otherwise perform.<sup>246</sup>

## 2. The Rationales for Tax Exemption

In addition to the religious freedom and entanglement avoidance rationales that justify exemption of religious institutions, various rationales have been offered in support of tax exemption for nonprofit organizations, and various theories, including the public benefit, pluralism, subsidy, income measurement, capital subsidy, donative, historical, double taxation or immorality, and lobbying theories, have been constructed to analyze the grounds for exemption.<sup>247</sup> Although these theories are distinct, some overlap and common themes exist among them, but no one theory has consensus support among all legal scholars. Rather than restating the various rationales and summarizing these theories here, this Section clusters theories together under two headings based upon their basic thrusts and thereby shows the complementary roles of some of these theories.

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<sup>245</sup> De Tocqueville similarly observed that Americans understand religious institutions to play a constructive social and even political role in preserving freedom and promoting republican ideals. He wrote:

Religion in America takes no direct part in the government of society, but it must nevertheless be regarded as the foremost of the political institutions of that country; for if it does not impart a taste for freedom, it facilitates the use of free institutions. Indeed, it is in this same point of view that the inhabitants of the United States themselves look upon religious belief. I do not know whether all the Americans have a sincere faith in their religion, for who can search the human heart? But I am certain that they hold it to be indispensable to the maintenance of republican institutions. This opinion is not peculiar to a class of citizens or to a party; but it belongs to the whole nation, and to every rank of society.

*Id.* at 305–06.

<sup>246</sup> See *St. Louis Union Trust Co. v. United States*, 374 F.2d 427, 432 (8th Cir. 1967) (“One stated reason for a deduction or exemption of this kind is that the favored entity performs a public service and benefits the public or relieves it of a burden which otherwise belongs to it.”); *Duffy v. Birmingham*, 190 F.2d 738, 740 (8th Cir. 1951) (“The reason underlying the exemption granted by [the statutory section recodified as section 501(c)(3)] to organizations organized and operated for charitable purposes is that the exempted taxpayer performs a public service. The common element of charitable purposes within the meaning of the section is the relief of the public of a burden which otherwise belongs to it. Charitable purposes are those which benefit the community by relieving it pro tanto from an obligation which it owes to the objects of charity as members of the community.”).

<sup>247</sup> See generally NICHOLAS P. CAFARDI & JACLYN FABEAN CHERRY, UNDERSTANDING NONPROFIT AND TAX EXEMPT ORGANIZATIONS 51–60 (2006).

i. Public Benefits, Pluralism, and Tax Exemption

One set of rationales for tax exemption relates to the public benefits and the political, social, and cultural contributions conferred by exempt, nonprofit organizations. Tax exemption is granted to nonprofit organizations as a means to “facilitate an end of significance to the entirety of society.”<sup>248</sup> According to this understanding, by exempting from taxes nonprofit organizations that confer public benefits, society promotes goals that are important to the structure and function of society and ensures pluralism among organizations and institutions in society.<sup>249</sup> In this sense, granting tax exemptions to public benefit nonprofit organizations has a certain *quid pro quo* quality. As one court has explained, “the public is willing to relieve an organization from the burden of taxation in exchange for the public benefit it provides.”<sup>250</sup> Without the burden of tax

<sup>248</sup> HOPKINS, *supra* note 31, at 11.

<sup>249</sup> *Id.* at 12–21. In discussing the charitable deduction and the rationale for exempting some nonprofit organizations from taxes, one federal court has observed that the purpose of the charitable deduction “is rooted in helping institutions because they serve the public good.” *Green v. Connally*, 330 F. Supp. 1150, 1162 (D.D.C. 1971), *aff’d sub nom. Coit v. Green*, 404 U.S. 997 (1971). That court added:

[A]s to private philanthropy, the promotion of a healthy pluralism is often viewed as a prime social benefit of general significance. In other words, society can be seen as benefiting not only from the application of private wealth to specific purposes in the public interest but also from the variety of choices made by individual philanthropists as to which activities to subsidize. This decentralized choice-making is arguably more efficient and responsive to public needs than the cumbersome and less flexible allocation process of government administration. In a recent article Judge Friendly has stressed the value of this pluralism, noting the incongruity “if the extension of the helping hand of the government, even when the help is monetary, were to turn our lively pluralistic society into a deadly uniformity ruled by constitutional absolutes.” Philanthropy is a delicate plant whose fruits are often better than its roots[.] . . . It is the very possibility of doing something different than government can do, of creating an institution free to make choices government cannot—even seemingly arbitrary ones—without having to provide a justification that will be examined in a court of law, which stimulates much private giving and interest.

*Id.* at 1162–63 (footnotes omitted) (new paragraph designations omitted) (citing Edward H. Rabin, *Charitable Trusts and Charitable Deductions*, 41 N.Y.U. L. REV. 912, 920–25 (1966); Albert M. Saks, *The Role of Philanthropy: An Institutional View*, 46 VA. L. REV. 516, 524 (1960)); (quoting Henry J. Friendly, *The Dartmouth College Case and the Public-Private Penumbra*, 12 TEXAS Q. (2D SUPP.) 141, 171 (1969)).

<sup>250</sup> *IHC Health Plans, Inc. v. Comm’r of Internal Revenue*, 325 F.3d 1188, 1195 (10th Cir. 2003) (citing *Geisinger Health Plan v. C.I.R.*, 985 F.2d 1210, 1215 (3d Cir. 1993); *Flat Top Lake Ass’n v. United States*, 868 F.2d 108, 112 (4th Cir. 1989) (“In many ways, exemption from taxation may be seen as a democratic commonwealth’s method of acknowledging the conferral of a universal benefit.”)).



liability, these organizations can flourish in society and have the financial capability of providing public benefits, meeting some social needs, and improving society generally.<sup>251</sup>

The Supreme Court has articulated this understanding in a number of its decisions. In 1924, the Court acknowledged that exemption of certain nonprofit organizations from income tax is designed to assist these organizations based upon the benefit they confer on the public.<sup>252</sup> In 1970, the Court observed that tax exemptions conferred by state laws are predicated upon a policy determination “that certain entities that exist in a harmonious relationship to the community at large, and that foster its moral or mental improvement, should not be inhibited in their activities by property taxation or the hazard of loss of those properties for nonpayment of taxes.”<sup>253</sup> The Court added that tax exemption draws upon “an affirmative policy that considers [houses of religious worship and nonprofit, quasi-public corporations such as hospitals, libraries, playgrounds, and scientific, professional, historical, and patriotic groups] as beneficial and stabilizing influences in community life” and that states had found “this classification useful,

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<sup>251</sup> In 1938, a report of the House Committee on Ways and Means observed: 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.

H.R. Rep. No. 75-1860, at 19 (1939).

<sup>252</sup> *Trinidad v. Sagrada Orden de Predicadores de la Provincia del Santisimo Rosario de Filipinas*, 263 U.S. 578, 581 (1924). In reviewing a corporation’s claim to exemption as a corporation “organized and operated exclusively for religious, charitable, scientific or educational purposes” under the Tariff Act of 1913, the Court observed that “the exemption is made in recognition of the benefit which the public derives from corporate activities of the class named, and is intended to aid them when not conducted for private gain.” *Id.*

<sup>253</sup> *Walz v. Tax Comm’n of City of New York*, 397 U.S. 664, 672 (1970) (internal quotation marks omitted). Not granting exemptions to nonprofit organizations (and thus imposing taxes) would have an inhibiting effect on the benefits conferred, as one commentator has noted:

[In providing for exemptions and charitable deductions,] Congress is not merely “giving” eligible nonprofit organizations “benefits”; the exemption from income taxation (or charitable deduction) is not a “loophole,” a “preference,” or a “subsidy”—it is not really an “indirect appropriation.” Rather, the various provisions of the federal and state tax exempt system exist as a reflection of the affirmative policy of American government to refrain from inhibiting by taxation the beneficial activities of qualified tax-exempt organizations acting in community and other public interests.

HOPKINS, *supra* note 31, at 19–20.

desirable, and in the public interest.”<sup>254</sup> In 1983, the Court similarly recognized that “[c]haritable exemptions are justified on the basis that the exempt entity confers a public benefit—a benefit which the society may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues.”<sup>255</sup> In 1990, the Court affirmed that, with most nonprofit entities, “exemption from federal income tax is intended to encourage the provision of services that are deemed socially beneficial.”<sup>256</sup> Additionally, although no majority opinion of the Court has cited the promotion of pluralism in society as a justification for tax exemption, members of the Court have put forward this rationale in concurring opinions. For instance, Justice Lewis F. Powell, Jr. wrote:

[Tax exemption plays an important role] in encouraging diverse, indeed often sharply conflicting, activities and viewpoints. As Justice Brennan has observed, private, nonprofit groups receive tax exemptions because “each group contributes to the diversity of association, viewpoint and enterprise essential to a vigorous, pluralistic society.” Far from representing an effort to reinforce any perceived “common community conscience,” the provision of tax exemption to nonprofit groups is one indispensable means of limiting the influence of governmental orthodoxy on important areas of community life.<sup>257</sup>

Thus, one set of rationales for tax exemptions focuses on the public benefits and social contributions of nonprofit institutions.

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<sup>254</sup> *Walz*, 397 U.S. at 673. In his concurring opinion, Justice William T. Brennan, Jr. wrote that these organizations “are exempted because they, among a range of other private, nonprofit organizations contribute to the well-being of the community in a variety of nonreligious ways, and thereby bear burdens that would otherwise either have to be met by general taxation, or be left undone, to the detriment of the community.” *Id.* at 687 (Brennan, J., concurring).

<sup>255</sup> *Bob Jones Univ. v. United States*, 461 U.S. 574, 591 (1983).

<sup>256</sup> *Portland Golf Club v. Comm’r*, 497 U.S. 154, 161 (1990).

<sup>257</sup> *Bob Jones Univ.*, 461 U.S. at 609 (Powell, J., concurring). In support of his articulation of the pluralism rationale, Justice Powell quoted Justice Brennan’s opinion in *Walz*, where Justice Brennan wrote:

[G]overnment grants exemptions to religious organizations because they uniquely contribute to the pluralism of American society by their religious activity. Government may properly include religious institutions among the variety of private, nonprofit groups that receive tax exemptions, for each group contributes to the diversity of association, viewpoint and enterprise essential to a vigorous, pluralistic society.

*Walz*, 397 U.S. at 689 (Brennan, J., concurring).

ii. No Private Inurement, Economic Subsidy, and Tax Exemption

Although the origins of tax exemptions for nonprofit organizations are found in political and social philosophy and charitable trust, and not as much in economic theory,<sup>258</sup> economic theory is now commonly used to analyze and explain tax exemptions. As nonprofit organizations, tax-exempt organizations are restricted in their ability to generate revenues. Unlike for-profit organizations, which are operated for the benefit of their owners who receive distributions of profits, nonprofit organizations may not distribute profits or net earnings to those who control them.<sup>259</sup> In other words, no surpluses or “profits” of nonprofit organizations may inure to the benefit of any private individuals. This private inurement constraint is reflected in the language of § 501(c)(3) of the Internal Revenue Code—to be tax exempt under this section, an organization must be organized and operated exclusively for exempt purposes, and “no part of the net earnings . . . [may] inure[] to the benefit of any private shareholder or individual.”<sup>260</sup> Instead, surpluses generated by nonprofit organizations are to remain devoted to the purposes for which they are organized and operated or to ends that are beneficial to society.<sup>261</sup>

As a consequence, tax-exempt, nonprofit organizations are unable to attract investment from those who might seek return on invested capital, such as investors would with for-profit enterprises. Instead, tax-exempt bond financing,<sup>262</sup> tax-deductible gifts from

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<sup>258</sup> *Bob Jones Univ.*, 461 U.S. 574; *McGlotten v. Connally*, 338 F. Supp. 448 (D.D.C. 1972); Robert E. Atkinson, Jr., *Theories of the Special Tax Treatment of Nonprofit Organizations*, in *FEDERAL AND STATE TAXATION OF EXEMPT ORGANIZATIONS* ch. 15 (Barbara L. Kirschten & Frances R. Hill eds., 1994); HOPKINS, *supra* note 31, at 5 (stating that the law of tax exemption for nonprofit organizations “is grounded in a body of thought far distant from tax policy: political philosophy as to the proper construct of a democratic society”).

<sup>259</sup> *Camps Newfound/Owatonna, Inc. v. Town of Harrison*, 520 U.S. 564, 585 (1997) (observing that a “nonprofit entity is ordinarily understood to differ from a for-profit corporation principally because it ‘is barred from distributing its net earnings, if any, to individuals who exercise control over it, such as members, officers, directors, or trustees’”) (quoting Hansmann, *infra* note 264, at 838).

<sup>260</sup> 26 U.S.C. § 501(c)(3).

<sup>261</sup> HOPKINS, *supra* note 31, at 5.

<sup>262</sup> With tax-exempt bonds, the interest paid to bondholders is not includable in gross income for federal income tax purposes. 26 U.S.C. § 145. Thus, issuing tax-exempt bonds, such as municipal or governmental bonds, provides an effective means of tax-exempt financing for the furtherance of governmental and other qualified purposes.

individuals and other organizations,<sup>263</sup> and tax exemptions are the primary instruments to ensure that these organizations have the financial means to operate in society.<sup>264</sup> Income tax exemption thus permits these organizations, which struggle to raise capital, to retain and reinvest surpluses (net earnings) rather than paying taxes, which would have a crippling effect on the organizations. Similarly, exemptions under state law from property, sales, and use taxes serve to protect the long-term financial viability of these organizations by permitting them to build up reserves, reinvest in facilities, and confer additional benefits on society and beneficiaries.

Some have concluded that tax exemption is essentially a subsidy.<sup>265</sup> For instance, some have argued that tax exemption is a “shadow subsidy” that is necessary to support nonprofit organizations in addition to donations.<sup>266</sup> These same authors contend that the principal rationale behind the exemption of nonprofit hospitals from taxation “is to subsidize those organizations capable of attracting a substantial level of donative support from the public,”<sup>267</sup> and that “donative institutions deserve a tax subsidy because the willingness of the public to contribute demonstrates both worthiness and neediness.”<sup>268</sup> The Supreme Court has explained that “both tax exemptions and tax deductibility are a form of subsidy that is administered through the tax system. A tax exemption has much the same effect as a cash grant to the organization of the amount of tax it would have to pay on its income.”<sup>269</sup> The Court has, however, been

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<sup>263</sup> Under the Internal Revenue Code, donors contributing gifts to § 501(c)(3) organizations, with the exception of public safety testing organizations, may deduct certain percentages of their gifts from their federal income taxes. 26 U.S.C. § 170.

<sup>264</sup> Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 72 (1981) (stating that “the exemption serves to compensate for difficulties that nonprofits have in raising capital” and that “such a capital subsidy can promote efficiency when employed in those industries in which nonprofit firms serve consumers better than their for-profit counterparts”).

<sup>265</sup> *Id.* at 66–71 (analyzing the view that exemption is a subsidization of services).

<sup>266</sup> Mark A. Hall & John D. Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. 1379, 1385 (1991).

<sup>267</sup> Hall & Colombo, *The Charitable Status*, *supra* note 42, at 390.

<sup>268</sup> Hall & Colombo, *The Donative Theory*, *supra* note 266, at 1385.

<sup>269</sup> *Regan v. Taxation with Representation*, 461 U.S. 540, 544 (1983). In his dissenting opinion in *Walz*, Justice William O. Douglas reflected a similar understanding when he wrote:

Tax exemption, no matter what its form, is essentially a government grant or subsidy. Such grants would seem to be justified only if the purpose for which they were made is one for which the legislative body would be equally willing to make a direct appropriation from public funds equal to the amount of the exemption.

*Walz v. Tax Comm’n of City of New York*, 397 U.S. 664, 709 (1970).

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reluctant at other times to characterize exemptions as essentially direct government subsidies. For instance, the Court has stated that tax exemptions “constitute mere passive state involvement with religion and not the affirmative involvement characteristic of outright governmental subsidy.”<sup>270</sup> The question whether tax exemptions, especially exemptions from income taxation, constitute subsidies is complicated by the difficulty of identifying and measuring the income of nonprofit organizations when they rely on sources such as dues, endowment income, and gifts for funding to operate, and when they are organized and operated in pursuit of exempt purposes, not a profit motive.<sup>271</sup> A further complication relates to the effect on beneficiaries—taxing currently exempt nonprofit organizations would have the effect of reducing the public benefits conferred by these organizations, thereby depriving beneficiaries of services and aid.

iii. Application of These Rationales to Secular and Religious Nonprofit Hospitals

Understanding the nature and function of nonprofit organizations as well as the rationales for granting tax exemptions to certain nonprofit organizations leads to a clearer picture of why nonprofit institutions have received favorable treatment under tax law. These organizations, whether charitable, religious, educational, or scientific, and other voluntary associations, constitute communities, supply meaning to, and are stabilizing forces in society. They also foster moral, mental, and physical improvement, which contributes to the lives of individuals and to the communities of which they are a part.

The justifications for granting tax exemption to nonprofit organizations that operate as public benefit organizations also apply to secular nonprofit and religious hospitals. Secular nonprofit hospitals and religious hospitals contribute value to the communities they serve and confer public benefits. Their work promotes goals important to the structure and function of society. For instance, many nonprofit hospitals and many religious hospitals are teaching and research institutions and provide free and below-cost services.<sup>272</sup>

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<sup>270</sup> *Id.* at 691.

<sup>271</sup> See Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299, 301 (1976).

<sup>272</sup> For instance, LMC, see *supra* note 213, is an academic teaching institution. *Welcome to Lutheran Medical Center*, LUTHERAN HEALTHCARE, <http://www.lutheranmedicalcenter.com/OurFacilities/LutheranMedicalCenter/> (last visited Oct. 14, 2012).

The benefits they confer are among those that society itself may not be able or may not choose to provide but for the subsidy provided by tax exemption. For instance, nonprofit and religious hospitals that operate in rural communities may provide the only hospital services for an entire region, and nonprofit and religious hospitals relieve government of the burden of providing certain types of hospital services in many communities.<sup>273</sup> Additionally, they work with local, state, and federal authorities in serving their communities, and the benefits they confer supplement and advance the work of public institutions that are supported by tax revenues. For instance, through their work with public health authorities, they enhance efforts to control and prevent the spread of infectious disease,<sup>274</sup> and through their provision of services to patients covered by Medicare and Medicaid, they care for needy populations in society.<sup>275</sup> In the various communities where secular nonprofit and religious hospitals operate, they provide indispensable services such as emergency and ambulance services that are useful and socially desirable and that advance the public good.

Both secular nonprofit hospitals and religious hospitals that qualify for tax exemptions receive economic burdens and economic benefits associated with tax exemptions. Secular nonprofit hospitals and religious hospitals alike are subject to the non-distribution constraint, do not exist to earn a profit, and must devote surpluses to exempt purposes. Secular nonprofit hospitals and religious hospitals rely on tax-exempt bond financing and charitable gifts, in addition to fees charged for services provided, to generate funds to operate and expand their facilities and services. Given these constraints, requiring secular nonprofit and religious hospitals to pay taxes would reduce the funds available to provide free or discounted services to

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<sup>273</sup> The dissenting justice in *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985), highlighted these points. *See supra* notes 113–16 and accompanying text.

<sup>274</sup> As discussed earlier, under the Affordable Care Act, to qualify for the § 501(c)(3) exemption, hospitals must conduct a community health needs assessment every three years and adopted an implementation strategy, and their community health needs assessments must take into consideration input from a broad range of community representatives (including public health experts). *See supra* not 162–64 and accompanying text. In this requirement, Congress implicitly acknowledged the important role that hospitals play in the health of the communities they serve as well as the benefits they confer.

<sup>275</sup> Both Revenue Ruling 56-185 and Revenue 69-545 acknowledged that secular nonprofit and religious hospitals serve the needs of the poor and thus confer benefits on their communities. *See supra* notes 74–93 and accompanying text.

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beneficiaries.<sup>276</sup>

Furthermore, both secular nonprofit hospitals and religious hospitals contribute to a vigorous society by promoting pluralism among organizations and institutions in society. This pluralism of organizations is evident from the diversity of the American hospital sector, which has a wide array of government, nonprofit (both secular and religious), and for-profit hospitals and hospital systems.<sup>277</sup> Both secular and religious nonprofit hospitals present an alternative to government-funded hospitals and for-profit hospitals.

*C. The Uniqueness of Religious Hospitals Among Other Nonprofit Hospitals*

Although religious hospitals may be lumped together with other tax-exempt hospitals for many purposes, religious hospitals offer something unique in their communities and in the American hospital sector, and they differ from other nonprofit hospitals in important respects. These differences are especially apparent in the identities, missions, settings, perspectives, values, and accountability structures of religious hospitals.<sup>278</sup>

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<sup>276</sup> Cf. *supra* note 265 and source cited therein.

<sup>277</sup> This diversity is clearly reflected in the hospital statistics reported by the American Hospitals Association. See *supra* note 2.

<sup>278</sup> Although the differences between religious hospitals and other nonprofit hospitals contemplated here are more of the organizational and operational sort, a recent study found that Catholic and other church-owned health systems “are significantly more likely to provide higher quality performance and efficiency” than for-profit/investor-owned health systems and that Catholic health systems are “significantly more likely to provide higher quality performance” than secular nonprofit health systems. DAVID FOSTER, CTR. FOR HEALTHCARE IMPROVEMENT, RESEARCH BRIEF—DIFFERENCES IN HEALTH SYSTEM QUALITY PERFORMANCE BY OWNERSHIP 2 (2010), available at <http://100tophospitals.com/assets/100TOPSystemOwnership.pdf>. The report also stated:

The findings suggest a changing role for health system governance and leadership. Health systems were founded for economic purposes, including access to capital, economies of scale, and increased market share, and greater negotiating power with payers. The responsibility for quality of care in most health systems was delegated to local hospital governing boards. Our data suggest that the leadership teams (board, executives, and physician and nursing leaders) of health systems owned by churches may be the most active in aligning quality goals and monitoring achievement across the system. Investor-owned health system boards and/or executive leadership may be adopting a responsibility for quality more slowly. As the industry reacts to healthcare reform legislation, including pay-for-performance initiatives and new tax rules that could stress certain ownership types more than others and change the balance of ownership types, assessing relative alignment of system hospitals with corporate goals will become a

### 1. Faith-Shaped Identities and Ministry-Oriented Missions

Religious hospitals, at least those that take seriously their religious identities and missions, are religious organizations, and as healing and social ministries of faith communities, they are settings in which people of faith live out their faith and exercise their religion.<sup>279</sup> For this reason, the religious liberty of these institutions and their sponsors and the concerns of government entanglement with religion should be among primary rationales for exempting religious hospitals from taxation. Stated differently, with religious hospitals, the justifications for tax exemption extend beyond any *quid pro quo* exchange of tax exemption for public benefits and a provision of indirect economic subsidies to support socially valued institutions.

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critical tool for both system management and governance.

*Id.* at 3 (new paragraph designations omitted); *see also* Press Release, Thomson Reuters, Catholic and Other Church-Owned Health Systems Deliver Better Quality Care, According to Thomson Reuters Study (Aug. 8, 2010), *available at* [http://thomsonreuters.com/content/press\\_room/healthcare/catholic\\_and\\_other\\_church-owned\\_health\\_systems\\_deliver\\_better\\_quality\\_care](http://thomsonreuters.com/content/press_room/healthcare/catholic_and_other_church-owned_health_systems_deliver_better_quality_care).

<sup>279</sup> The Catholic identity of hospitals may be understood to include various constituent elements: (1) carrying on the healing ministry of Christ; (2) expressing Gospel values such as social justice, equality, and compassion; (3) respecting human dignity; (4) fostering a holistic vision of health care that cares for the physiological, psychological, social, and spiritual aspects of persons; (5) ensuring high quality health care; (6) demonstrating a preferential option for the poor by providing charity care and acting as advocates in political forums; (7) forming a community of employers and employees devoted to social justice; (8) fostering the common good; (9) observing the *Ethical and Religious Directives for Catholic Health Care Services*; (10) being a nonprofit organizations; and (11) being approved by the hierarchy of the Church (i.e., a local bishop, a national bishops conference, or a Vatican congregation) as a public juridic person within the Catholic Church. *See* O'Rourke, *supra* note 223, at 20–23. Professor O'Rourke generated this list of elements from various documents prepared by Catholic organizations to define the Catholic identity of hospitals. Another commentator has observed that a pastoral letter of the American bishops has highlighted the following areas “in which Catholic health care facilities can demonstrate their fidelity to the Catholic tradition”:

The first is personalized patient care. Catholic health care cannot be reduced to the “technico-professional aspect,” but must address “all the elements of the human being.” Second, Catholic identity involves faithful commitment to medical-moral issues. Third, Catholic health care institutions must play a prophetic role, and service to the poor is one particularly important way to do this. The bishops also encourage the development of alternative models of health care delivery that meet the needs of the poor and underserved, and further innovation in personal health education programs. Finally, the bishops call for justice in recognizing the rights and responsibilities of employers and employees.

William E. Stempsey, *Institutional Identity and Roman Catholic Hospitals*, in 7 *CHRISTIAN BIOETHICS* 3, 5–6 (2001) (citing Committee on Domestic Social Policy of the United States Catholic Conference 1982).



## 2. Religiously-Shaped Institutional Settings and Religiously-Regulated Services

In addition to the reasons related to religious freedom and entanglement,<sup>280</sup> several additional grounds for exemptions apply to religious hospitals that may not apply to other hospitals, and these differences warrant consideration and different treatment under tax-exemption laws. Religious hospitals do what the First Amendment to the United States Constitution and state constitutions prohibit government from doing through public hospitals. In the United States, the government can neither establish institutional settings to provide health care like religious hospitals do nor offer the explicitly religious perspectives and the full range of moral values that religious hospitals offer. Religious hospitals deliver health care services in environments where faith is a shaping and pervading influence, where religious motivation inspires the services provided, and where religious and moral values inform decisions and direct action. In other words, religious hospitals uniquely provide a blended mixture of both public or community benefits and religious services in religious institutional settings where their faith traditions shape their institutional identities and missions and motivate their healing ministries. Additionally, church or ecclesiastical law (such as the canon law of the Catholic Church) and the moral teachings of churches (such as the *Ethical and Religious Directives for Catholic Health Care Services*) often apply to and govern the affairs of religious hospitals.<sup>281</sup>

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<sup>280</sup> See *supra* Section IV.A.

<sup>281</sup> See Code of Canon Law, available at [http://www.vatican.va/archive/ENG1104/\\_INDEX.HTM](http://www.vatican.va/archive/ENG1104/_INDEX.HTM); U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVS. 43 (5th ed. 2009) [hereinafter, USCCB, ETHICAL AND RELIGIOUS DIRECTIVES], available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>. The *Ethical and Religious Directives for Catholic Health Care Services*, which have been approved by the United States Conference of Catholic Bishops and are recommended for implementation by local diocesan bishops, reflect the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services. USCCB, ETHICAL AND RELIGIOUS DIRECTIVES, *supra*, at 43. The *Directives* are intended to "reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person" and "provide authoritative guidance on certain moral issues that face Catholic health care today." *Id.* at 3–4. The *Directives* address a wide range of issues: the social responsibility of Catholic health care services; the pastoral and spiritual responsibility of Catholic health care services; the professional-patient relationship; beginning-of-life and end-of-life issues; and the formation of partnerships with other health care organizations and providers. *Id.* at 2. Although they apply primarily to institutionally-based Catholic health care services, the

### 3. Faith-Motivated Gifts and Sponsorships

Many religious hospitals obtained their facilities and assets through gifts and support received from religious adherents and religious sponsors. Thus, religious hospitals are distinguishable from secular nonprofit hospitals in that they have received and continue to receive gifts and support from adherents of their faith traditions and from their religious sponsors that the donors and sponsors intended for religious purposes.

### 4. Faith-Informed Perspectives and Values and Contrasting Moral Visions

Additionally, religious hospitals offer contrasting values, opposing viewpoints, unique services, and diverse institutional settings. Religious hospitals enhance the diversity of viewpoints and activities in communities. The religious and moral perspectives that religious hospitals offer will often be similar to those that are dominant in society, but their perspectives will at times contrast with and sometimes directly challenge dominant perspectives in society.<sup>282</sup> At times, religious hospitals must function as communities of conscientious objection and dissent that resist perceived injustices. By way of illustration, religious hospitals often offer unique and

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*Directives* contemplate that Catholic health care professionals in other settings will find them instructive. *Id.* at 4.

<sup>282</sup> Christian bioethicist H. Tristram Engelhardt, Jr. has observed:

As Christian health care institutions become secularized, moral commitments never to engage in abortion, artificial insemination by a donor, the medical assistance of sexual function for persons engaged in sexual activity outside the marriage of a man and a woman, physician-assisted suicide, and euthanasia will appear at tension with the primary secular moral focus of health care institutions on recognizing the dignity of all and on providing health care of excellence. Traditional moral prohibitions can then only appear as legalistic or external moral constraints, to be legalistically circumvented so that health care institutions can get about the business of discharging their obligations in social justice.

Engelhardt, *supra* note 20, at 157. Similarly, Christian bioethicist William E. Stempsey, S.J., has written:

As secular society tries to engulf sectarian institutions and homogenize them, Catholic health care institutions are increasingly becoming cognizant of the need to express their ideals and distinctiveness. The ideals that these hospitals must express are paradoxical in the eyes of secular society. Catholic hospitals embrace many of the methods of secular medicine as tools in carrying out the healing mission of Jesus Christ while simultaneously recognizing that ultimate healing comes only with the resurrection that follows death.

William E. Stempsey, *Institutional Identity and Roman Catholic Hospitals*, in 7 *CHRISTIAN BIOETHICS* 3, 13–14 (2001).

contrasting perspectives on matters such as what it means to be human, what human life is, when life begins and ends, what moral values are implicated by certain policies and particular choices or judgments, and how ethical principles apply in professional and clinical settings.<sup>283</sup> Consequently, their activities will reflect these contrasting perspectives and values, which are informed by their faith traditions and derived from sacred texts and theological resources.<sup>284</sup> Furthermore, the participation of religious hospitals in the hospital industry, their provision of health care services, and their advocacy as to matters that are of concern to the faith communities within which they operate serve to limit the influence of governmental orthodoxy

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<sup>283</sup> A faith-informed perspective on human life, illness, death, and health care is reflected in the following reflections of philosopher and ethics Margaret Monahan Hogan:

[H]ealing of physical illness is not always possible. Furthermore the exclusive focus on healing is too narrow and too exclusive a center. It is to buy into the Promethean myth of modern medicine that offers the promise of human salvation in more and better medicine. Jesus healed but he also suffered and died. Here Catholic health care institutions have special obligations because of the Jesus revealed in Scripture. Catholic health care institutions must be places of caring for the dying that is inevitable. And here they must offer visible witness to the truth of the finitude and promise of human existence. . . . Catholic health care institutions have to be places and have to provide services and spaces within which human beings who are experiencing crushing sorrow, anguish, and abandonment will find in attendance caring people to touch, and wash, and anoint their bodies, attentive people who do not turn away from them, loving people whose simple presence sustains them, and faithful people who do not abandon them in their dying.

Margaret Monahan Hogan, *Catholic Health Care Institutions: Dinosaurs Awaiting Extinction or Safe Refuge in a Culture of Death*, in 7 *CHRISTIAN BIOETHICS* 163, 166–67 (2001).

<sup>284</sup> Professor Engelhardt has highlighted the contrasting perspectives and values of Christian health care institutions:

The *raison d'être* of traditional Christian health care institutions is in secular terms counter-cultural. The focus on providing health care to those in need so understood is not primarily on satisfying their medical needs, but on reaching out to them in love. As St. John Chrysostom notes, almsgiving is first for the sake of love and only second for the sake of physical needs. . . . The accent is first on personal relationships and transformation and only second on welfare or justice. Indeed, “if I dole out all of my goods, and if I deliver my body that I may be burned, but I have not love, I am being profited nothing” (I Cor 13:3). Without love of God and neighbor, all is misguided. Traditional Christian health care institutions offer their services not just in order to treat the sick medically. They provide health care because illness provides an occasion for spiritual care, for rethinking life, repenting, indeed, converting.

Engelhardt, *supra* note 20, at 154–55.

in areas of individual and community life, such as the provision of reproductive services, the treatment provided at the end of life, the care for the poor and other vulnerable populations, and the meaning of life, illness, and death.<sup>285</sup> As religious institutions, they promote institutional diversity by providing alternatives to public, for-profit, and secular nonprofit hospitals, and thus they afford some patients alternative institutional settings that may better align with their own views of their world and human existence, reflect their own or similar values, and engender trust regarding the care provided.

#### 5. Noneconomic Constraints and Accountability Structures

Religious hospitals, like other nonprofit hospitals, are subject to the nondistribution constraint, which serves a defining role for nonprofit organizations and ensures that directors and officers stay true to organizational mission.<sup>286</sup> In the religious hospital setting, however, this economic constraint is often supplemented by additional constraints on mission imposed by sponsoring organizations. These supplemental noneconomic constraints come by way of the oversight and accountability required by sponsoring religious organizations and the involvement of clergy and members of religious organizations in the management of religious hospitals,<sup>287</sup> and they might include religious, organizational, moral, and ethical factors.<sup>288</sup> Consequently, the performance of sponsored hospitals may be evaluated using both economic considerations and noneconomic criteria derived from religious traditions.

### V. NONPROFIT HOSPITAL TYPOLOGY AND PROPOSALS FOR TAX-EXEMPTION LAW AND FOR RELIGIOUS HOSPITALS

This Section sets forth a typology of nonprofit hospitals and makes two sets of proposals: (1) proposals of a formal and legal nature to modify tax-exemption laws and regulations; and (2) proposals of an aspirational nature for religious hospitals to reform their organizations and alter their operations. These proposals are

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<sup>285</sup> Hospitals sponsored by the Catholic Church illustrate this well. In their provision of services, Catholic health care institutions operate within boundaries defined by the *Ethical and Religious Directives for Catholic Health Care Services* as to certain procedures and treatments, such as abortions, sterilizations, and terminations of life-sustaining treatments. See *supra* notes 281 & 283.

<sup>286</sup> See HOPKINS, *supra* note 31, at 4.

<sup>287</sup> See *supra* notes 220, 223, 281 & 283.

<sup>288</sup> The *Ethical and Religious Directives for Catholic Health Care Services* exemplify this well. See *supra* notes 281 & 283; see also *supra* notes 214, 217 & 221.

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premised upon an understanding that religious hospitals, at least those that take seriously their religious identities and missions, are religious institutions that should be treated and should act as such.

*A. Typology of Nonprofit Hospitals*

Consideration of the different exempt purposes identified in § 501(c)(3) of the Internal Revenue Code and the different combinations of purposes that nonprofit hospitals may pursue yields the following typology of nonprofit hospitals:

- (1) Secular nonprofit hospitals;
- (2) Secular research nonprofit hospitals;
- (3) Secular teaching nonprofit hospitals;
- (4) Secular research and teaching nonprofit hospitals;
- (5) Religious nonprofit hospitals;
- (6) Religious research nonprofit hospitals;
- (7) Religious teaching nonprofit hospitals; and
- (8) Religious research and teaching nonprofit hospitals.

Identification of these distinct types of nonprofit hospitals makes apparent that some nonprofit hospitals pursue only one exempt purpose (i.e., secular nonprofit hospitals, the first type of nonprofit hospitals listed above), but other nonprofit hospitals pursue multiple exempt purposes (i.e., the seven other types listed above).

Although this typology may seem somewhat commonsensical and pedantic, it highlights issues that legislators, regulators, courts, and scholars have overlooked in federal tax exemption law for more than half a century. Additionally, this typology provides assistance with organizing data, analyzing the community benefit standard and public policy, and fostering creative thinking.

*B. Proposals for Federal Income Tax Exemption Law and Regulation*

Based upon the foregoing discussion of the constitutional protection of religious institutions, the rationales for exempting nonprofit and religious organizations from taxation, and the religious identities and missions of religious hospitals, this Section recommends changes to federal and state tax law to recognize the religious purpose of religious nonprofit hospitals as a clear basis for granting tax-exempt status. Although the focus in this Section is primarily on modifications to federal corporate income tax law and regulations, the considerations offered here also apply to state laws and regulations involving income, property, and sales and use taxes. The proposals offered here are designed to promote institutional

pluralism, honor the religious identities and missions of religious hospitals, and accommodate religion and religious hospitals by offering them an alternative means of qualifying for tax-exempt status.

The IRS developed the community benefit standard in 1969 as a general standard to distinguish those nonprofit hospitals that further an exempt purpose from for-profit hospitals and nonprofit hospitals that do not. Although the IRS has made some minor adjustments to the community benefit standard and has recently required hospitals to report additional information regarding their community benefit activities and financial assistance policies, the standard has largely remained unchanged, and the recently enacted Affordable Care Act does not change the standard in any fundamental way, even though it imposes some new requirements. Nevertheless, health care and the hospital industry in America have changed dramatically since the IRS adopted the community benefit standard. Additionally, nonprofit hospitals are becoming increasingly more complex, and diversity abounds among them.

As the typology demonstrates, some hospitals, such as secular nonprofit hospitals, may be organized and operated for only one exempt purpose—i.e., the charitable purpose of promoting the health of the community—but other hospitals, such as religious hospitals that are also teaching and research institutions, may further more than one exempt purpose. Under the community benefit standard, the first type of nonprofit hospital has to demonstrate that it is organized and operated exclusively for a charitable purpose by promoting the health of the community, but the other seven types could show that, in addition to promoting the health of the community, they advance religious, educational, or scientific purposes, or a combination of these purposes.<sup>289</sup> In other words,

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<sup>289</sup> In 2003, the Tenth Circuit observed that, under the community benefit standard, “engaging in an activity that promotes health, *standing alone*, offers an insufficient indicium of an organization’s purpose.” *IHC Health Plans, Inc. v. Comm’r of Internal Revenue*, 325 F.3d 1188, 1197 (10th Cir. 2003). To qualify for tax exemption under federal law, an organization must offer some “plus” in addition to providing health-care products or services to the community. *Id.* In explaining what it meant by this “plus”-factor, the court highlighted two sets of benefits: (1) those that “the society or the community may not itself choose or be able to provide,” or (2) those that “supplement[] and advance[] the work of public institutions already supported by tax revenues.” *Id.* (quoting *Bob Jones Univ. v. United States*, 461 U.S. 574, 591 (1983)). Benefits in the first category include providing free or below-cost services, maintaining an emergency room open to all without regard to ability to pay, and devoting surpluses to research, education, and medical training. The court drew upon the IRS’s revenue rulings for these examples and identified the benefits in the first category as “positive externalities” or “public

religious, research, and teaching nonprofit hospitals further exempt purposes in addition to the more general charitable purpose of promoting the health of the community, and these additional purposes provide additional grounds for exemption. Consequently, it appears that the community benefit standard is best suited to the first type of nonprofit hospitals (i.e., secular nonprofit hospitals); it helps to distinguish those nonprofit hospitals that should qualify for favorable tax treatment from other nonprofit hospitals that should not. For this reason, requiring the first type of nonprofit hospitals to provide a minimum amount of charity care in addition to meeting the community benefit standard may help to ensure that these hospitals adequately confer a community benefit. With the other seven types of nonprofit hospitals, however, the community benefit standard helps to highlight important factors for regulators and hospitals to consider, but it does not adequately take into account the additional exempt purposes that these nonprofit hospitals further.<sup>290</sup> Furthermore, because these seven other types of nonprofit hospitals advance exempt purposes in addition to the promotion of the health of the community, less of a need exists to require them to provide a minimum amount of charity care.<sup>291</sup>

Considering the distinct purposes that nonprofit hospitals can

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goods.” *Id.* at 1197–98. Benefits in the second category include providing services to individuals in the Medicare and Medicaid populations. *Id.* at 1198. In considering the magnitude of the community benefit conferred, the court explained that the size “must be sufficient to give rise to a strong inference that the organization operates primarily for the purpose of benefitting the community.” *Id.* (emphasis omitted). The court summarized its test:

[U]nder section 501(c)(3), a health-care provider must make its services available to all in the community *plus* provide additional community or public benefits. The benefit must further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the *primary purpose* for which the organization operates. In conducting this inquiry, we consider the totality of the circumstances.

*Id.* Although the Tenth Circuit did not identify religious purpose as a “plus”-factor for religious hospitals, religious purpose should qualify as a “plus,” especially considering the Supreme Court’s recognition of the “special solitude to the rights of religious organizations” recognized by the text of the First Amendment. *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Employment Opportunity Comm’n*, 132 S.Ct. 694, 706 (2012).

<sup>290</sup> See IRS, *supra* note 135.

<sup>291</sup> Additionally, assuming the initiatives in the Affordable Care Act lower the number of uninsured Americans, the need to use tax policy to address the problem of the uninsured will abate, and one of the principal policy aims of requiring a minimum amount of charity care will dissipate.

advance and the multiple purposes that some nonprofit hospitals advance, the IRS should revise the community benefit standard to provide a better-calibrated test for evaluating the nonprofit hospital institutions that it governs. A more finely tuned standard would provide a better measure for determining which hospitals in the diverse nonprofit hospital sector should be exempt from federal income tax based upon the purposes they further. To effectuate this revision, no amendment to § 501(c)(3) is necessary, and the organizational and operations tests, the prohibition against private inurement and excess private benefits, and the restrictions on lobbying and political activities in § 501(c)(3) should remain unchanged. Similarly, Congress need not modify the new requirements imposed by the ACA, including the mandates to conduct a community needs assessment, to develop an implementation strategy, to have a written financial assistance policy and a written emergency care policy, and to limit charges and extraordinary collection practices. These new requirements, as well as the related reporting requirements, should continue to apply to all eight types of nonprofit hospitals.

Instead, the IRS should modify Revenue Rulings 56-185, 69-545, and 83-157 to enhance the requirements that secular nonprofit hospitals must meet. Accordingly, the IRS should require secular nonprofit hospitals to meet requirements that include the factors that comprise the community benefit standard and a “charity care factor” similar to the financial ability test under Revenue Ruling 56-185. Under this modified standard, secular nonprofit hospitals would be required to satisfy the community benefit standard and to operate, to the extent of their financial ability, for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay, or to provide a minimum amount of charity care, such as four or five percent of annual patient operating expenses or revenues.<sup>292</sup> Such revisions to the standard would ensure that secular nonprofit hospitals are organized and operated exclusively for a charitable purpose.

The IRS should also revise these revenue rulings to fine-tune the requirements for the other seven types of nonprofit hospitals organized and operated for multiple exempt purposes. These seven types of nonprofit hospitals should qualify for federal income tax exemption by demonstrating the following factors: (1) that they

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<sup>292</sup> This measure of charity care is within the range set by statute in Texas and proposed by the staff of Senator Grassley. *See supra* notes 116–17 and 136 and accompanying text.



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promote the health of the community and confer a public benefit by showing that they maintain a full-time emergency room open to all regardless of their ability to pay, that they admit those who are able to pay for medical care, including Medicare and Medicaid patients, or that medical staff privileges are available to all qualified physicians in the area, consistent with the size and nature of the facilities; (2) that they are also organized and operated for a religious, scientific, or educational purpose; and (3) that their excess funds are invested in patient care and facility improvement, in medical training, education, and research, or otherwise in the furtherance of their religious, scientific, or educational purpose. The community benefit standard factor regarding an independent governing board need not be applied to the seven types of nonprofit hospitals that further an exempt purpose in addition to promoting the health of the community by either operating a full-time open emergency room, providing care to those who are able to pay, or maintaining an open medical staff. With religious nonprofit hospitals in particular, the IRS should not apply the factors involving an independent governing board and an open medical staff in the interests of safeguarding the religious identities, missions, and values of religious hospitals and permitting them to construct governing boards and maintain medical staffs that understand, reflect, and promote institutional values.<sup>293</sup>

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<sup>293</sup> In a case involving the termination of a school teacher's employment by a Lutheran church school, the Supreme Court recently addressed the protected interest that religious institutions have in selecting and controlling those who act as their ministers, serve within their groups, express their beliefs, teach their faith, and carry out their missions when the Court recognized a ministerial exception from employment discrimination laws. See *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Employment Opportunity Comm'n*, 132 S.Ct. 694 (2012); cf. *Boy Scouts of America v. Dale*, 530 U.S. 640, 648 (2000) ("Forcing a group to accept certain members may impair [its ability] to express those views, and only those views, that it intends to express."). In the Court's view, a religious institution's selection of its ministers "concerns government interference with an internal church decision that affects the faith and mission of the church itself." *Hosanna-Tabor*, 132 S.Ct. at 707. The Court opined that "[t]he Establishment Clause prevents the Government from appointing ministers, and the Free Exercise Clause prevents it from interfering with the freedom of religious groups to select their own." *Id.* at 703. The Court added:

The members of a religious group put their faith in the hands of their ministers. Requiring a church to accept or retain an unwanted minister, or punishing a church for failing to do so, intrudes upon more than a mere employment decision. Such action interferes with the internal governance of the church, depriving the church of control over the selection of those who will personify its beliefs. By imposing an unwanted minister, the state infringes the Free Exercise Clause, which protects a religious group's right to shape its own faith and mission through its appointments. According the state the power to

The IRS should revise the relevant forms and schedules to implement this better calibrated standard. Specifically, the IRS should revise Schedule C (Hospitals and Medical Research Organizations) of Form 1023 (Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code) to ask whether a hospital is owned or sponsored by or affiliated with a church or religious tradition, to inquire whether a hospital is organized and operated for a religious purpose, and to invite religious hospitals to describe their relationship to a church or religious tradition, the effect of that relationship on the hospital's organization and operations, and the religious activities of the hospital.<sup>294</sup> Similarly, the IRS should revise Schedule H (Hospitals) of Form 990 (Return of Organization Exempt from Income Tax Under Section 501(c), 527, and 4947(a)(1) of the Internal Revenue Code) to invite religious hospitals to provide supplemental information regarding how they further a religious purpose.<sup>295</sup> These revisions would permit religious hospitals to show how they further a religious purpose when they apply for tax-exempt status and allow the IRS to collect facility information regarding the religious purpose furthered by religious hospitals.

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determine which individuals will minister to the faithful also violates the Establishment Clause, which prohibits government involvement in such ecclesiastical decisions.

*Id.* at 706; *see also id.* at 710 (“[T]he interest of religious groups in choosing who will preach their beliefs, teach their faith, and carry out their mission” “is undoubtedly important”; “[t]he church must be free to choose those who will guide it on its way.”). Although the Court recognized that “the ministerial exception is not limited to the head of a religious congregation,” it was “reluctant . . . to adopt a rigid formula for deciding when an employee qualifies as a minister.” *Id.* at 707. Nevertheless, the Court determined that the school teacher qualified as a minister for purposes of the exception. *Id.* at 707–09.

The First Amendment protection recognized by the Court in *Hosanna-Tabor* applies to religious hospitals. Consequently, the IRS should tread lightly and be careful to avoid interference with religious hospitals in their selection of their governing boards, their executive leadership, their medical staffs, and other employees.

<sup>294</sup> This measure of charity care is within the range set by statute in Texas and proposed by the staff of Senator Grassley. *See supra* notes 116–17 and 136 and accompanying text. It might be advisable for the IRS to implement a lower amount (such as a four percent requirement), to monitor the impact of the requirement on the secular nonprofit hospitals, and to adjust the requirement accordingly.

<sup>295</sup> IRS, Form 990, *available at* <http://www.irs.gov/pub/irs-pdf/f990.pdf>; IRS, Schedule H, *available at* <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>. The current version of Schedule C inquires about research activities and facilities and education activities.

*C. Proposals for Religious Hospitals*

As a result of the recent developments in state and federal tax-exemption law, tax-exempt hospitals must now meet additional qualification requirements, and they face increasing scrutiny and accountability to government regulators and the public. These developments, coupled with the prospect that the federal or state government could repeal tax exemption for nonprofit hospitals or impose tighter standards to qualify for exemptions, counsel tax-exempt hospitals to give careful attention to their organizations and operations, eliminate actual and perceived abuses, and be especially attentive to qualification standards. In addition to the external demands imposed by federal and state tax law and regulations, tax-exempt hospitals should also consider internal matters that are important to the vitality of their organizations. Nonprofit hospitals, including religious hospitals, should be mindful of the integrity of their organizations—they should work to ensure that their organizational identities, missions, and values are clearly and consistently integrated into organizational decision making, policies, behaviors, and operations at all levels.<sup>296</sup>

Although these matters concern all nonprofit hospitals, the following proposals are specifically directed to religious hospitals. These proposals are intended to encourage religious hospitals and religious hospital systems to enhance and clarify their own religious identities and missions, make organizational changes to reflect more clearly their religious identities and missions, and modify their operations to put their religious identities and missions into practice. By clarifying their own religious identities and missions and adjusting their organizations and operations to reflect accurately their religious identities and missions, religious hospitals will be able to communicate precisely who they are and what they uniquely offer to their communities.

Organizationally, religious hospitals must make the ascertainment and communication of their religious identities and missions a priority. Among the questions to consider are what it means to be a religious health care institution and carry on a ministry

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<sup>296</sup> See Ana Smith Iltis, *Institutional Integrity in Roman Catholic Health Care Institutions*, in 7 *CHRISTIAN BIOETHICS* 95, 102–03 (2001) (“Institutional integrity depends on the coherence between three central elements: the articulation of the institution’s moral commitments, the manifestation of those commitments in the institution’s activities, and the internalization of those commitments such that the institution holds those values at its core.”); Stempsey, *supra* note 282, at 10 (“How a hospital should make its identity evident in its practice is a matter of integrity.”).

of healing, where along the continuum of faith-based institutions they desire to be, and what this desire means for the governance and management of their institutions.<sup>297</sup> It is important for religious hospitals to audit their organizational documents, including articles of incorporation, hospital bylaws, mission statements, statements of core values, medical staff bylaws, medical staff rules and regulations, department rules, employee handbooks, and codes of conduct, to ensure that they accurately and clearly reflect the religious identities and missions of their organizations. Religious hospitals should carefully assess how to infuse their organizations with the beliefs and values of their faith traditions and their sponsors and how to translate their missions and core values into their day-to-day decisions, their activities, and their organizational cultures so that their decisions, activities, and cultures reflect their religious identities and values.<sup>298</sup> For religious hospitals, it is important that their staff and employees understand the mission, values, and ethical standards of the organizations,<sup>299</sup> and they should help staff and employees take ownership of their missions and internalize core values. Religious hospitals should also be forward looking and consider what steps to take to preserve their religious identities, promote their missions, and safeguard their values into the future.<sup>300</sup> Among the steps that religious hospitals can take to preserve, promote, and communicate the organizational importance of their religious identities and missions are creating standing committees on their boards and executive positions with responsibilities related to mission and values

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<sup>297</sup> See Sider & Unruh, *supra* note 20, at 119–20 (discussing a sixfold typology of faith-based social service and educational organizations and programs, including: faith-permeated; faith-centered; faith-affiliated; faith-background; faith-secular partnerships; and secular).

<sup>298</sup> See Stempsey, *supra* note 282, at 14.

Mission statements express [institutional] ideals [and distinctiveness] only imperfectly. Furthermore, even when an institution expresses its identity sincerely, the institution may not be able to live out its ideals perfectly. Nonetheless, mission statements . . . are the primary means by which institutions express their identity and serve as standards to measure the integrity with which the institution lives out its identity.

<sup>299</sup> See *Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp't Opportunity Comm'n*, 132 S.Ct. 694, 704 (2012) (recognizing that, under the First Amendment, government may not contradict a religious institution's "determination of who can act as its ministers"). Because religious hospitals engage in their ministries of healing through their hospital staff and employees, their staff and employees, in a sense, serve as ministers of healing.

<sup>300</sup> For some Catholic hospitals, this is becoming an increasingly serious challenge. See Kevin Sack, *Nuns, a "Dying Breed," Fade from Leadership Roles at Catholic Hospitals*, N.Y. TIMES, Aug. 20, 2011, at A12, available at <http://www.nytimes.com/2011/08/21/us/21nuns.html?pagewanted=all>.

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integration and maintaining departments of pastoral care and mission and values integration.

Operationally, religious hospitals must make implementation of their religious identities and missions a priority and take steps to put their religious identities and missions into practice. Each religious hospital should seek to integrate its religious identity and mission into every component of its organization and ensure that the organization's religious identity and mission inform decision-making and influence the behavior of those who manage the organization and work within the hospital. Religious hospitals should evaluate whether their religious identities and missions really are making a difference in how they operate, whether their actions accurately reflect their identities and advance or impede mission attainment, and what values and ethical principles truly direct their activities and day-to-day decisions. Furthermore, religious hospitals should ensure that their religious identities and missions shape and provide direction in the full range of operational matters, such as executive leadership and communication, staff and personnel management, patient services and care, community service, charity care, legal compliance, public relations, and facilities development. Additionally, each department of a religious hospital should consider whether it accurately embodies and reflects the religious identity and mission of the hospital and what specific actions it can take to accomplish the mission.

Because lay individuals who lack extensive religious backgrounds and formal religious training often serve on religious hospital boards and executive leadership teams, religious sponsors must play a role in assisting religious hospitals and hospital systems in clearly defining their religious identities, missions, and values; in training board members, officers, and staff regarding their religious traditions and values; and in communicating their missions and values to those who work within the institutions. Religious sponsors should also assist religious hospitals and hospital systems in putting their religious identities, missions, and values into practice and ensuring organizational integrity and mission faithfulness. Additionally, sponsoring organizations must hold religious hospitals accountable on these matters.

Religious hospitals should be prepared to show their uniqueness among other hospitals in the American hospital industry. They should develop data showing how their religious identities and missions make operational differences in their facilities and the services they provide. In other words, the data they develop should

not simply show the differences religion makes in their mission statements, the composition of their boards, the oversight by their religious sponsors, the ethics of their organizations, and the moral and ethical principles derived from their traditions. The data should also show the practical differences religion makes in matters such as organizational and departmental decision-making, staff and employee management, patient treatment and care, and charity care.

## VI. CONCLUSION

This Article has had several principal aims: to highlight the religious identities and missions of religious hospitals; to show the differences between religious hospitals and other types of hospitals, especially other nonprofit hospitals; and to argue that the religious purpose of religious hospitals should count for purposes of tax exemption. This Article has proposed modifications to tax-exemption laws and regulations and the community benefit standard that will permit a more thoughtful assessment of the charitable and religious purposes furthered by religious hospitals. Although this Article has focused primarily on the federal income tax exemption standard under § 501(c)(3) of the Internal Revenue Code, this Article's analysis and proposals also apply to exemption standards under state income, property, and sales and use tax laws, and the proposals may be adapted for purposes of modifying state tax exemption standards. This Article has also encouraged religious hospitals to refocus on their religious identities and missions, integrate their religious identities and missions into every aspect of their institutions, and put their religious identities and missions into practice in their day-to-day decision-making and activities. The time has come to count the religious purpose of religious hospitals as a factor for tax-exemption purposes.