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TAX EXEMPT FINANCING OF HEALTH CARE FACILITIES AS A COMPONENT OF THE MARKET APPROACH TO HEALTH CARE COST CONTAINMENT

I. Introduction

The upward spiral of medical care costs[1] is a persistent national problem. The rate of inflation in the health care field has exceeded the overall Consumer Price Index for three decades.[2] The failure of cost containment attempts has resulted in an increase in the percentage of disposable income a taxpayer must now spend on health care expenses.[3] Stubborn health care inflation has buoyed the rise of the Consumer Price Index, thereby increasing expenditures tied to the Index,[4] including those not related to health care.[5] Consequently, the

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1. The Internal Revenue Code defines medical care as the "amounts paid: (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, (B) for transportation primarily for and essential to medical care referred to in subparagraph (A), or (C) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B)." I.R.C. § 213 (e)(1) (1976) (redesignated as § 213(d)(1) for taxable years beginning after Dec. 31, 1983. I.R.C. § 213 (West Supp. 1982)).

2. Schramm, *A State-Based Approach To Hospital Cost Containment*, 18 HARV. J. ON LEGIS. 603, 606 (1981) (chart compares annual increases of the Consumer Price Index to the health care component of the Index); Pear, *Health Care Costs Up 11%, Nearly Triple Inflation Rate*, N.Y. Times, Jan. 24, 1983, at A8, col. 1. In 1982, health care costs rose 11% and the overall Consumer Price Index (CPI) rose 3.9%. *Id.*; Freeland & Schendler, *National Health Care Expenditures: Short-Term Outlook and Long-Term Projections*, HEALTH CARE FINANCING REV., Winter 1981, at 112. Health care expenditures have increased in percentage terms at a faster rate than the Gross National Product (GNP) for every measured period since 1950. As a percentage of the GNP, health expenditures have risen from 4.4% in 1950 to 5.3% in 1960 to 7.6% in 1970. The increases continued in the last decade with an 8.6% rating in 1975 and a 9% rating in 1979. Projections are that the percentage will continue to climb through the 1980's, passing 9.9% in 1985 and 10.8% in 1990. *Id.*

3. Schramm, *supra* note 2, at 607 (health care expenditures accounted for 4% of disposable income in 1950, 6.5% in 1965 and 17% in 1978).

4. Stevenson, *Financing Not for Profit Organizations*, in FUNDAMENTALS OF FINANCE 401 (1980). Even in the context of a slower rate of inflation and a slight Consumer Price Index increase of 0.3% in August 1982, medical costs continued to rise more rapidly at a rate of 0.9% for the same period. In the twelve month period ending in August 1982, medical costs were up 11.4%. The CPI for the same period was up 5.9%. Fuerbringer, *Consumer Index In Modest Rise: 0.3% in August*, N.Y. Times, Sept. 24, 1982, at A1, col. 1. In September, the trend continued with a CPI increase of 0.2% and an increase in medical costs of 0.9%. Medical costs were the

government's historical emphasis on providing access to health care[6] has been supplemented by fiscal concern.[7] Moreover, the political difficulty in reaching a consensus on health policy has resulted in

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only component of the Index which was still rising at double digit annual rates as of the September figures. Fuerbringer, *Consumers' Prices Up 0.2% in Month; House Costs Down*, N.Y. Times, Oct. 27, 1982, at A1, col. 6. The pattern continued in October, Cowan, *U.S. Price Index Up By 0.5% in October; Area's Rise at 1.5%*, N.Y. Times, Nov. 24, 1982, at A1, col. 6 (medical care costs up 0.8%), and November, *November Consumer Prices Up By 0.1%*, N.Y. Times, Dec. 22, 1982, at D6, col. 1 (medical care costs up 1%; hospital room charges up 1.5%). During the calendar year 1982, health care costs rose 11% while the overall CPI rose 3.9%. Pear, *supra* note 2.

5. Johnson, *Consumer Price Index*, in ENCYCLOPEDIA OF ECONOMICS 186, 188 (D. Greenwald ed. 1982). The CPI measures price changes of goods and services. *Id.* at 186. The CPI is widely used as an adjustment measure in wage contracts, interest payments and social transfers. *Id.* at 188. To the extent health care costs increase the overall CPI, they cause inflation in these non-health expenditures.

6. Principal examples of this concern are (1) the Hill-Burton Act, *see* Comment, *The Hill Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316 (1979), (2) Medicare, insurance for the aged under the Social Security Act, Social Security Amendments of 1965, 42 U.S.C. § 1395 (1976) and (3) Medicaid, the jointly sponsored federal and state program providing medical aid for persons whose income is below a specified level, Social Security Amendments of 1965, 42 U.S.C. § 1396 (1976).

7. Rosenblatt, *Health Care Reform and Administrative Law, A Structural Approach*, 88 YALE L.J. 243, 286-303 (1978) (state level cutbacks on Medicaid); Wing & Silton, *Constitutional Authority for Extending Federal Control Over The Delivery of Health Care*, 57 N.C.L. REV. 1423, 1431-32 (1979) (review of different cost proposals offered during the 95th Congress). The Reagan Administration has indicated that it supports a competitive resolution to the problem of health care costs. Address by Secretary of Health and Human Services Richard Schweiker, American Hospital Association (Feb. 2, 1981), *cited in* Galblum & Triger, *Demonstrations of Alternative Delivery Systems Under Medicare and Medicaid*, in HEALTH CARE FINANCING REV., Mar. 1982, at 1.

Concerns for price as well as access have been reflected in the testing of competition claims using Medicare and Medicaid test programs. These programs examined the application of alternative health care systems to the needs of Medicare and Medicaid patients. Galblum & Triger, *supra*, at 1. The surge in health care as a component of the GNP and the impact of the price increases in the industry have attracted prominent attention in the press. Stevens, *High Medical Costs Under Attack As Drain On The Nation's Economy*, N.Y. Times, Mar. 29, 1982, at 1, col. 3. Alexander McMahon, President of the American Hosp. Association, described the costs of medical care as intolerable and stated that the strong opinion in government and business circles is that costs are going to be controlled in one way or another, either through competition or regulation. The alternative of maintaining the status quo and the annual increase in costs is not seen as viable. *Id. See also* Duncan, *What's Next On Health Cost Control*, NATION'S BUS., Nov. 1982, at 22, 27 (alternative policies stressing competition will succeed only when rising costs force legislators to choose between competition and substantially greater government intervention such as National Health Insurance).

government actions which redistribute health expenses rather than resolve the cost crisis.[8]

Commentators have responded to these fiscal concerns by focusing on the objectives of conserving and apportioning the amount of public funding allocated to health care and curbing inflation in health care costs.[9] Commentators in the health care industry and government officials, however, have not reached a consensus on how to achieve these goals.[10] There is agreement that the current health care delivery system encourages price increases.[11] A significant change in structure is needed to achieve an economically viable balance of health care quality, access, equity, and cost considerations.[12]

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8. A provision in the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, included a provision which reduced Medicare expenses by $350 million in 1982 and $530 million in 1983. The plan, however, merely switched the burden to the private sector by requiring employers of 20 or more workers to include those between the ages of 65 and 69 in their group health plans unless the employee specifically chooses to use Medicare as his principle insurance. *A New Health Tab for Business*, BUS. WEEK, Dec. 20, 1982, at 49. Some businesses fear the program may be extended to retirees 65 and over. *Id.* Others identify this provision as an emerging trend to shift medical charges from government to companies and individuals without solving the cost problem. Duncan, *supra* note 7, at 22.

9. Blumstein & Sloan, *Redefining Government's Role in Health Care: Is a Dose Of Competition What The Doctor Should Order?*, 34 VAND. L. REV. 849, 852 (1981). The authors identify the two objectives of conservation and apportionment as central to establishing market incentives. *See* Schramm, *supra* note 2, at 641 (stressing that changes in health care financing are necessary for a long term containment program). *See generally* REGULATING HEALTH CARE, THE STRUGGLE FOR CONTROL (A. Levin ed. 1980). This book is a collection of essays by contributors from government and the health care field. It recognizes the wide range of issues affected by health care costs including legislation, regulation, components of costs, competition theories, and imposed controls.

10. Levin, *The Search for New Forms of Control*, in REGULATING HEALTH CARE, THE STRUGGLE FOR CONTROL 1, 5 (A. Levin ed. 1980) (recent debate over types of regulation is being replaced with proposals for non-regulatory forms of policy implementation); Duncan, *supra* note 7, at 27 (the eventual policy choice will be competition or substantial government intervention); Stevens, *supra* note 7 (current health policy is not acceptable).

11. Freeland & Schendler, *supra* note 2, at 126. As the percentage of health care paid by insurance increases, consumers tend to view health care services as "free." In addition, providers are reimbursed for increased levels of services. The current system does not reward innovative delivery processes which are associated with increased productivity and lower costs. *Id. See generally* notes 2 & 4 *supra* (statistics on price increases).

12. Shapiro, *Learning to set a limit on health care*, BUS. WEEK, Feb. 14, 1983, at 20. Irving Shapiro has proposed a national commission on health care to recommend structural changes to address these problems. *Id.*; Cook, *Why Medical Care Costs Are Out of Control, An interview with Michael Bromberg*, FORBES, Feb. 28, 1983, at 104 (Executive Director of the Federation of American Hospitals notes that the health care system must be designed to provide incentives to limit cost increases).

The Market Approach and other procompetition theories have been offered as a solution to the health care cost dilemma.[13] The Market Approach encourages consumer desire for decreasing health costs[14] and suggests new cost saving incentives. One faction of Market Approach proponents suggests that individuals rather than insurance companies should shoulder a greater burden of medical costs as a necessary means to encourage patients to consider cost containment when using the health care system.[15] Another faction focuses on the increased use of marketplace competition between traditional health providers and innovative, less expensive alternative delivery systems.[16]

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13. Blumstein & Sloan, *supra* note 9, at 849-926 (explanation of Market Approach theory and development); Pollard, *Fostering Competition in Health Care*, in REGULATING HEALTH CARE, THE STRUGGLE FOR CONTROL 159 (A. Levin ed. 1980) (describing Market Approach concepts as competition theory); Schramm, *supra* note 2, at 603-78 (offering a model statute which promotes competition as a cost containment mechanism).

14. The current tax subsidy for insurance and the third party payment system do not encourage consumer concern for health costs and have been cited as the major disincentives to cost consciousness. Duncan, *supra* note 7, at 23. The insurance benefits are tax free income for the employee and tax deductible expenses for the employer. I.R.C. § 106 (1976) ("Gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness"). I.R.C. § 162(a)(1) (1976 & West Supp. 1982) provides a method for a business to deduct health insurance premiums under the concept of "a reasonable allowance for salaries or other compensation for personal services actually rendered." I.R.C. § 162(i) (West Supp. 1982) limits distinctions among employees covered by a Group Health Plan (discrimination against persons with end stage renal disease is prohibited). Jan Peter Ozga, Health Care Director for the U.S. Chamber of Commerce, has stated that third party payment through insurance has encouraged excessive costs on all levels.

> Doctors and hospitals are only too glad to provide this care. Insurance companies are happy to write the coverage. Employees, especially those in unions, demand more and more health benefits. And employers, who are eager to attract and retain labor and are given a tax subsidy to provide health benefits, do so willingly.

Ozga, *quoted in* Duncan, *supra* note 7, at 23. *See* Freeland & Schlender, *supra* note 2, at 126 (consumers perceive insured health care as "free"). *See also* Greenspan & Vogel, *Taxation and Its Effect Upon Public and Private Health Insurance and Medical Demand*, HEALTH CARE FINANCING REV., Spring 1980, at 39 (arguing that tax subsidies for insurance raise the price of health care); Cook, *supra* note 12, at 104 (Executive Director of the Federation of American Hospitals says there are no normal market restrictions on health insurance because the tax laws make health insurance free for both the employer and the employee). President Reagan has proposed a new tax on health insurance provided by employers as part of the Administration's comprehensive plan to control health costs. Pear, *Reagan's Budget Will Seek To Tax Health Premiums*, N.Y. Times, Jan. 27, 1983, at A1, col. 6.

15. *See* note 141 *infra*. For a complete discussion of the Market Approach, see notes 136-62 *infra* and accompanying text.

16. *See* notes 142-43 *infra*. For a comparison of the two factions, see notes 140-45 *infra* and accompanying text. For a discussion of alternative delivery systems, see notes 39-52 *infra* and accompanying text.

The latter group states that alternative systems which can offer lower costs will force prices down toward the minimum necessary level as they attract the business of individual patients and group insurance plans which previously utilized other more expensive providers.[17]

Theories based on a competitive model of the health care system are useful in studying the health care industry. Specific proposals, however, are necessary to make the Market Approach a practical policy alternative.[18] One such proposal includes the use of targeted tax exempt financing to establish the competitive forces which are the basis of the Market Approach.[19]

Three principal themes contribute to the attractiveness of tax exempt financing for alternative delivery systems as a means to introduce competitive economic principles to the health care system. First, from an investor's viewpoint, health care facilities are unattractive investment opportunities.[20] The introduction of tax exempt status for the investment is a powerful equalizer in the competition for investor capital.[21] Second, the health care industry requires large capital ex-

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17. *See* Lindsey, *California Seeks To Cut Cost Of Health Care With Bidding*, N.Y. Times, Nov. 29, 1983, at A1, col. 5. California recently adopted such an approach, initiating competitive bidding in awarding contracts to hospitals and doctors to treat the private patients covered by insurance companies. Similar arrangements are being made in the case of indigents who receive state aid for medical costs. *Id.*

18. Blumstein & Sloan, *supra* note 9, at 891 (noting that Market Approach theories, like many planning goals, are "long on aspiration but short on implementation"). *But see* Schramm, *supra* note 2, at 641. Schramm has proposed a plan for implementing his cost containment proposals. He advocates short run government intervention through the medium of his model statute while stressing that over the long term, only fundamental reform in health care financing can stimulate competition and cost awareness. *Id.* By May, 1982, 17 states had passed a form of cost containment legislation. *See* Esposito, Hopfer, Mason & Rogler, *Abstracts of State Legislated Hospital Cost Containment Programs*, HEALTH CARE FINANCING REV., Dec. 1982, at 129 (summarizes the principal characteristics of each state program). *See also* Duncan, *supra* note 7, at 23-24 (the Reagan Administration is currently formulating a health care cost containment proposal).

19. This Comment makes such a proposal. *See* notes 300-54 *infra* and accompanying text.

20. *See* STATE OF OHIO HOSPITAL IMPROVEMENT REVENUE BONDS (The Cleveland Clinic Project), OFFICIAL STATEMENT (June 1, 1982) [hereinafter cited as STATE OF OHIO HOSPITAL IMPROVEMENT REVENUE BONDS (The Cleveland Clinic Project)]. Even established health facilities are a risky investment. *Id.* at 16-19.

21. HEALTH CARE FINANCING STUDY GROUP, THE USES AND IMPACTS OF HOSPITAL TAX EXEMPT FINANCING 18 (May 1982) [hereinafter cited as HEALTH CARE FINANCING STUDY GROUP]. In the most general sense, interest rates for taxable hospital bonds are estimated to be two to five percent higher than tax exempt rates. *Id. See* PUBLIC SECURITIES ASSOCIATION, FUNDAMENTALS OF MUNICIPAL BONDS 8 (1980) (comparison chart of municipal bond and corporate bond yields for 1970-1979).

penditures. Alternative delivery systems cannot merely lease a storefront and commence operation. Equipment, labor and insurance costs are high. Moreover, future expenditures for upgrading facilities and equipment must be considered before entering the health care market.[22] Therefore, alternative health care facilities need the economic stimulus which tax exempt financing will provide. Third, the industry traditionally has received assistance in developing health facilities from philanthrophic sources, religious orders and educational institutions.[23] However, the government has assumed a major role since World War II, replacing declining gifts with government sponsored financial support.[24] Only recently have health care facilities competed in the municipal bond market for capital.[25] The use of tax exempt financing is a manifestation of traditional government financial assistance for health care facilities.

Alternative delivery systems are an essential component of a Market Approach to health care cost containment. They are viewed as a competitive alternative to the current delivery system rather than a total replacement for it.[26] Yet to be effective, they must have access to

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The exemption increases the effective rate of return on an investment. To calculate the taxable equivalent of a tax free bond, divide the tax exempt yield (e.g., 10%) by the number resulting from 100% minus the marginal tax bracket (e.g., 100%-50% = 50%). Therefore, 10% divided by 50% equals a 20% taxable yield equivalent. *See id.* at 7-9.

22. Koenig, *Big Concerns Take An Interest In Fast Growing Clinical Labs*, Wall St. J., Apr. 30, 1982, at 33, col. 1 (start-up expenses of laboratories are making it impossible for small companies to compete). *See* HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 36 (innovative organization of health care institutions and new modes of patient care have been cited as contributing to large capital needs).

23. Philanthropy provided the primary source of capital for hospital financing before World War II. Bradford, Caldwell & Goldsmith, *The Hospital Capital Crisis: Issues for Trustees*, HARV. BUS. REV., Sept.-Oct. 1982, at 56 [hereinafter cited as *The Hospital Capital Crisis*]; Hilferty, *Capital Financing for Hospitals: The New York Experience*, 57 N.C.L. REV. 1383, 1385 n.9 (1979). *See generally* HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 6 (philanthropy has continued to decline as a source of funding for hospital construction, accounting for 10.4% of such funding in 1973 and 6.2% in 1978).

24. *The Hospital Capital Crisis*, *supra* note 23, at 56. The Great Depression and World War II disrupted the capital accumulation of the hospital industry. The Hill-Burton Program was the congressional response to the deficiency of private funds. *Id.* *See* note 6 *supra* (examples of government support).

25. *The Hospital Capital Crisis*, *supra* note 23, at 57. Government programs were not seen as requiring supplemental funding sources until the late 1960's and early 1970's. Tax exempt financing authorities were created at that time to issue revenue bonds. *Id.*

26. Blumstein & Sloan, *supra* note 9, at 894 (some form of regulation would be retained in a Market Approach, but its role would be limited to facilitating competitive goals rather than dictating the structure of the health care market). *See generally*

the same advantages that their established competition enjoys. Tax exempt financing is an existing vehicle which may be used to encourage the entry of specific alternative providers into the health care marketplace.

This Comment will discuss the current health delivery system in the context of a Market Approach to health care cost containment. Political and financial issues in health care as well as current judicial and tax policies affecting Market Approach theory will be examined. The Comment concludes that targeted tax exempt financing must play a major role in establishing competitive forces in the health care delivery system.

II. The Health Care Environment

The health care system in the United States has achieved great success. The average life expectancy of Americans has risen steadily.[27] Diseases such as pneumonia, influenza, tuberculosis and gastritis, which accounted for about one-third of all deaths in the United States in 1900, were nearly eliminated as causes of death by 1976.[28] In addition, the vast majority of Americans suffer no disability which impairs their regular activities.[29] There are some areas, however, such as the successful treatment of circulatory disease, where American health achievements trail those of other countries by substantial margins.[30] Nevertheless, a majority of American adults are engaging in

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Pollard, *supra* note 13, at 158-59 (controls on market forces would be appropriate to protect the interests of the poor and the aged).

27. PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH: UNITED STATES 1981, at 1 (1981) [hereinafter cited as HEALTH: UNITED STATES 1981]. The average life expectancy in 1979 was 73.8 years. *Id.*; *Good News, Bad News Again*, Wall St. J., Jan. 18, 1980, at 8, col. 1. The average life expectancy in 1900 was 47 years. *Id.*

28. Percent of All Deaths, by Specified Causes of Death, (Chart B-6), *reprinted in* MEDICAL CARE CHARTBOOK 20 (A. Donabedian, S. Axelrod & L. Wyszewianski eds. 7th ed. 1980) [hereinafter cited as MEDICAL CARE CHARTBOOK]. Pneumonia and influenza still accounted for slightly less than five percent of all deaths in the United States in 1976. Tuberculosis and gastritis effectively have been eliminated as causes of death in the United States. *Id.*

29. Percent Distribution of Population by Degree of Chronic Activity Limitation, 1974, (Chart B-14), *reprinted in id.* at 28. 85.9% of the United States population had no disability in 1974. Only 3.3% were unable to carry on major activity. *Id.*

30. *80's Health Care Developments Will Stress Efficiency, Prevention, Maintenance*, HOSPITAL TOPICS, July-Aug. 1980, at 4 [hereinafter cited as *80's Health Care Developments*]. Twenty-six countries have lower death rates from circulatory disease. *Id.* In addition, the 1976 United States infant mortality rate was higher than that of 14 other countries. The U.S. rate was 15.1 deaths per 1000 live births. Sweden had the lowest rate of 8.3 deaths per 1000 live births. Infant Mortality Rates (Chart B-7), *reprinted in* MEDICAL CARE CHARTBOOK, *supra* note 28, at 21.

positive health practices as measured by the U.S. Department of Health and Human Services.[31]

These achievements have coincided with the development of the health care industry as a major factor in the American economy. Between 1960 and 1980, investment in health research and development increased at an average annual rate of 11.6%.[32] The number of Americans employed in the health services industry and as physicians has steadily increased.[33] The number of hospitals in the United States has stabilized at a high level.[34] In 1980, health expenditures constituted 9.4% of the Gross National Product[35] and totaled $1,067 for each American.[36] These funds purchased health services and supplies as diverse as hospital care, dental service, drugs, and eyeglasses.[37] In almost every specific health category, expenditures by Americans in-

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31. HEALTH: UNITED STATES 1981, *supra* note 27, at 2.

32. National funding for health research and development and average annual change, according to source of funds: United States, selected years 1960-1980 (Table 78), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 215. In dollar terms, expenditures have increased from $884 million in 1960 to $7.89 billion in 1980. *Id.*

33. In 1980 over seven million Americans were employed in the health service industry. Persons employed in the health service industry, according to place of employment: United States, 1970-1980 (Table 47), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 176. These figures included employees in offices of physicians, dentists, chiropractors, other health practitioners, hospitals, and convalescent institutions. Hospitals accounted for nearly 4 million of the nearly 7.2 million employees of the health service industry. *Id.*

In 1980 almost 500,000 physicians were professionally active. Professionally active physicians . . . selected 1950-1980 estimates and 1985, 1990 and 2000 projections (Table 48), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 177. The number of professionally active physicians has more than doubled from 219,000 in 1950. By the year 2000 an estimated 704,000 physicians will be active in the United States. The number of active physicians per 10,000 population increased from 14.2 in 1950 to 20.2 in 1980. By 2000 the rate is estimated to be 27.1. *Id.*

34. In 1979, there were over 7,000 hospitals in the United States with over 1,250,000 beds. These figures are drawn from two tables: Short-stay hospitals and beds, according to type of hospital and ownership: United States, 1974 and 1979 (Table 53), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 183 [hereinafter cited as Table 53], and Long-stay hospitals and beds, according to type of hospital and ownership: United States, 1974 and 1979, (Table 58), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 192 [hereinafter cited as Table 58]. Short-stay hospitals accounted for 6,525 of the total (Table 53, *supra*) while there were 560 long-stay hospitals in 1979 (Table 58, *supra*).

35. HEALTH INSURANCE ASS'N OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA, 1981-1982, at 43 (1982) [hereinafter cited as SOURCE BOOK 1981-1982]. The health care share of the Gross National Product has grown steadily from 5.4% in 1960 to 7.5% in 1970 to 9.4% in 1980. *Id.*

36. *Id.* at 42.

37. National health expenditures average annual percent change, according to type of expenditure: United States, selected years 1950-1980 (Table 69), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 204.

creased at an average annual rate of at least ten percent for the period of 1975 to 1980.[38]

A. Alternative Delivery Systems

As medical care expenditures have increased, media coverage and political proposals began to focus on the issue of cost containment.[39] As a result, Americans are increasingly aware of health care costs and interest in the concept of preventive medicine has expanded.[40] Health facilities have responded with changes in medical and administrative policy.

Some health care facilities have accumulated significant savings by instituting cost reductions in service areas such as mailing charges, sales tax payments and laundry services.[41] Medical benefit plans and procedures for authorizing payments for certain tests also have been modified.[42] In some cases, entirely new medical plans stressing direct financial incentives to individual doctors have achieved encouraging results. One such plan involves a special account for each patient which is managed by the family doctor.[43] An insurance company

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38. *Id.* The average annual cost increase from 1975-80 in the one exception, "eyeglasses and appliances," was 9.8%. *Id.*

39. *See* notes 76-85 *infra* and accompanying text.

40. *See* Weinraub, *Schweiker Says Social Security Is His 'Top Priority,'* N.Y. Times, Feb. 3, 1981, at A16, col. 1 (Health and Human Services Secretary Richard Schweiker has cited preventive health care programs as an essential component of any plan to reduce health costs; *New Health Plans Focus On 'Wellness,'* N.Y. Times, Aug. 24, 1981, at D1, col. 1 (a growing number of businesses have turned to prevention programs in an effort to reduce costs). *But see* Hoagland, *The Conquest of Disease,* N.Y. Times, Apr. 4, 1981, at A23, col. 2 (emphasis on preventive medicine questioned).

41. Bronson, *To Cut Costs, Many Hospitals Ask Their Workers For Economizing Ideas, and the Savings Add Up,* Wall St. J., Apr. 24, 1979, at 48, col. 1.

42. *Curb on Payments For Certain Tests By Hospitals Urged,* Wall St. J., Feb. 7, 1979, at 26, col. 4 (Blue Cross and Blue Shield recommended that member plans not pay for routine diagnostic tests for non-surgical hospital admissions unless a physician specifically ordered each test); *Small Medical Bills Are Seen As Culprits In Health Care Costs,* Wall St. J., Dec. 27, 1979, at 21, col. 3 (emphasizing restraint in the use of technology). *See* Waldholtz, *Medical Benefit Costs Are Rising Sharply; Firms Tighten Controls, Redesign Plans,* Wall St. J., Sept. 25, 1980, at 56, col. 1 (large corporations are using their leverage to force physicians, hospitals and insurers to hold costs down).

43. Bishop, *Sharp Reduction in Hospital Expenses Is Achieved By Novel Medical Care Plan,* Wall St. J., June 14, 1979, at 10, col. 2. The plan, called United Healthcare, was organized by Safeco Insurance Co. in 1975. By 1979 the Plan had 23,000 subscribers. *Id.*

sends the doctor a monthly check for the account. The doctor shares in any surplus left in the account at the end of the year.[44]

Alternative delivery systems stressing lower cost health care have become more common. The development of Health Maintenance Organizations (HMOs), for example, is evidence of this trend. HMOs are alternative delivery systems which charge a fixed, prepaid annual fee. In exchange, the consumer receives unlimited access to a variety of health services.[45] HMOs also provide member physicians with an incentive to reduce costs because their income is not linked to greater use of facilities and reimbursement from insurance companies and government programs. Some HMOs give doctors a bonus and profit sharing if patients are kept out of the hospital during the year.[46] In the decade from 1970 to 1980, the number of persons enrolled in Health Maintenance Organizations increased by 300% to a total of 9.5 million.[47]

While HMOs are the most common type of alternative delivery system, other innovations have been developed. Ambulatory surgical centers emphasize specific aspects of surgical procedures which are too complicated to perform in a doctor's office, but are not significant enough to require hospitalization.[48] In addition, home health care

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44. *Id.* If the patient's account has a deficit at the end of the year, the doctor must return up to five percent of the payments he has received from the Insurance Company. If the account has a surplus, United Healthcare and the doctor share that amount equally. *Id.*

45. Meyers, *Growth in Health Maintenance Organizations*, in HEALTH: UNITED STATES 1981, *supra* note 27, at 76. Meyers defines an HMO as "an organization that provides at least ambulatory and inpatient services to a voluntarily enrolled population on a prepaid basis." *Id.* In May 1971 a paper by the Dep't of Health, Education and Welfare articulated a broader definition, citing HMOs as "organized systems of health care, providing comprehensive services for enrolled members, for a fixed, prepaid annual fee. . . . [T]hey all provide a mix of outpatient and hospital services through a single organization and a single payment mechanism." *Id.* at 75, *quoting* Towards a Comprehensive Health Policy for the 1970's (HEW White Paper May, 1971). The HEW paper listed three areas where HMOs differed from traditional fee for service health care providers: (1) use of inpatient services was 40-50% lower; (2) overall costs were 15-20% lower; (3) quality of care was better or at least equal. *Id.*

46. Hedberg, *Health Care: Getting The Best Value*, MONEY MAG., Sept. 1982, at 55, 58. The HMOs pay these bonuses directly from profits derived from healthy subscribers who did not require extensive health care in the previous year. The HMOs essentially "bet" that they can keep their subscribers healthy. *Id.*

47. Meyers, *supra* note 45, at 77. The first HMO was started in 1929. *Id.* at 76. By 1980, HMOs were operating in 37 states. *Id.* In 1981 there were 240 HMOs serving 10 million persons. Chell, *Health Maintenance Groups May Find Haven in Tax-Exempts*, The Daily Bond Buyer, Aug. 31, 1981, at 11, col. 1. *See* notes 119-21 *infra* and accompanying text (discussion of HMOs growth and their relationship to tax exempt financing).

48. A surgical center in Arizona lowered costs for eight routine operations by 43 to 61% including room and board. Surgeon's fees were 19 to 39% lower than

providers,[49] hospices for terminally ill persons[50] and birthing rooms[51] are attempting to enter the health care market.

Cost sensitivity, however, is not a blind pursuit. If medical service is oriented exclusively toward reducing expense, the chances for technological advances decrease. Blind cost cutting would foreclose those technological developments necessary to provide better health care.[52]

B. Insurance

Insurance has been a pivotal force in molding a health care system which lacks competitive characteristics.[53] The current insurance struc-

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hospital charges. In Florida, a cataract operation cost $300 at a surgical center instead of $1,000 at a hospital because of lower staff labor and routine laboratory charges. Other operations which can be performed in surgical centers on a one day basis include tonsillectomies, simple hernia repairs, vasectomies and removal of noncancerous cysts. HEALTH INSURANCE INSTITUTE, HOW TO MAKE HEALTH CARE BENEFIT PLANS MORE COST EFFECTIVE 2 (1980). Costs for some operations can be reduced as much as 50% by avoiding overnight patient care. HEALTH INSURANCE INSTITUTE, TECHNIQUES FOR REDUCING HOSPITAL COSTS 2 (1980).

49. Home health care programs are useful for chronically ill or disabled persons and patients who require maintenance care or mere monitoring during rehabilitation. Home health care includes skilled nursing, physical therapy, occupational therapy, medication and laboratory services. HEALTH INSURANCE INSTITUTE, TECHNIQUES FOR REDUCING HOSPITAL COSTS 4 (1980).

50. HEALTH INSURANCE ASS'N OF AMERICA, COST CONTAINMENT FEATURES IN NEW GROUP HEALTH INSURANCE POLICIES (1981). Thirty percent of U.S. insurance policies currently cover hospice care. These policies cover almost one-half of the employees in a recent survey. *Id.*

51. Birthing rooms are homelike maternity facilities. Since 1975, the number of facilities has grown rapidly and now over 1,000 of the country's 6,500 hospitals have these units. Many observers expect the number of facilities to double or triple in a few years. Direct savings to patients are said to be $80 million per year. Lublin, *The Birthing Room, More Hospitals Offer Maternity Facilities That Feel Like Home*, Wall St. J., Feb. 15, 1979, at 1, col. 1.

52. Some of the new medical advances include gene splicing technologies, diagnostic imaging equipment which combines sophisticated graphics and computer technology, new drugs and drug delivery systems, laser beams and implantable computers. Putnam Health Sciences Trust Pamphlet 8. (This pamphlet promotes investment in a Trust which will then purchase health related stocks and other instruments). At the same time, these advances are expensive. CAT scanners can cost in excess of one million dollars and new models are constantly outdating previous machines. Hedberg, *supra* note 46, at 56. Recent debate over the cost of artificial hearts for humans illustrates the competing concerns. Some doctors state that questions of cost are unthinkable because the primary issue is keeping the patient alive. Others view the issue as a question of resource allocation. Jay Cohn, M.D., has said that the time has passed when "we thought we could do everything." Carrell, *Costs mark debate on artificial heart*, American Medical News, Jan. 28, 1983 at 1, col. 1. The outcome of such debates will determine whether new technologies are developed.

53. MacKay, *The Regulation of Health Insurance*, in REGULATING HEALTH CARE, THE STRUGGLE FOR CONTROL 81, 86 (A. Levin ed. 1980). The insurance function has

ture has paid an increasing percentage of personal health care expenditures in the United States.[54] Direct private payments have decreased and a further reduction is expected.[55] Although these third party payments insulate consumers from direct payments of their medical bills, they serve as a disincentive for health care providers to keep costs down.[56]

Insurance is a convenient sharing of risk which substitutes for voluntary personal savings.[57] While the general activity of insuring is an established business, widespread health insurance is a recent phenomenon.[58] Providers of health services encouraged the use of insurance plans because the insurance system was a more reliable payment mechanism than individual collections.[59] The beneficial tax treatment of health benefits has also encouraged the use of insurance. Health benefits are exempt from the calculation of a person's income for tax purposes and the employer's premium payments are tax deductible.[60] Finally, increasingly complex and expensive care has placed even

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been separated from marketplace influences. This encourages providers and consumers to utilize treatments without sensitivity to the true cost of the health care. With a growing share of medical costs paid by insurance, the influence of this cost-insensitive approach is significant. *Id.*

54. *80's Health Care Developments*, *supra* note 30, at 6. Insurance paid 45% of personal health care expenditures in 1960, 60% in 1970 and 67% in 1980. These figures represent the combined total of government and private third party payments for personal health care expenditures. The balance for each year is accounted for by direct private payments. *Id.*

55. *Id.* By 1990 it is estimated that insurance will pay 75% of personal health care expenditures. *Id.*

56. Blumstein & Sloan, *supra* note 9, at 857. Without insurance, a person might decide not to consume medical services. However, when the individual receives no benefit for decreasing consumption, he is encouraged to consume the maximum service available. *Id. See* MacKay, *supra* note 53, at 86 (doctor has little incentive to reduce costs because he knows a third party will pay the patient's bill).

57. Fuchs, *Paying for Medical Care*, in MANAGING THE FINANCES OF HEALTH CARE ORGANIZATIONS 11 (G. Bishbee & R. Vraciu ed. 1980). Alternative methods for sharing risk include extended family and kinship obligations. *Id.*

58. MacKay, *supra* note 53, at 82. Twelve million Americans had hospital insurance in 1940 while 77 million had such coverage in 1950. *Id. See* SOURCE BOOK 1981-1982, *supra* note 35, at 6-7. By 1980, 186 million Americans had some form of health insurance. This figure represents 85% of the civilian noninstitutional population. *Id.* Estimates of the number of persons without private or public health insurance vary from 5% to 12.6%. *Id.* at 11. *See generally* Hertzberg, *Health Care Coverage For Small Firms Springs A Bad Leak*, Wall St. J., Sept. 8, 1982, at 1, col. 6. Not all insurance arrangements are reliable. A number of multiple employer trusts (MET) have experienced financial difficulty. METs are often used by small businesses to offer employees benefits similar to the group health plans of large corporations. *Id.*

59. Fuchs, *supra* note 57, at 12.

60. Duncan, *supra* note 7, at 23. *See* note 14 *supra* (discussion of I.R.C. sections which provide tax benefits to employees and employers).

routine medical treatment beyond affordable levels for many individuals, making insurance a necessity.[61]

Expenditures under both private health insurance benefit plans and government programs have increased in the last three decades.[62] In the 1970's, however, the costs of such benefits and programs expanded dramatically. From 1975 to 1980 benefits paid by insurance companies and hospital-medical plans such as Blue Cross/Blue Shield increased over 100%.[63] During the same period, federal, state and local government expenditures for health care increased eighty-six percent.[64] Federal expenditures constituted the majority of government outlays for health.[65]

In addition to the dramatic increase in medical costs, there has been a change in the source of payment for personal health care expenditures in the United States.[66] The government share of payments has increased substantially in the last twenty years.[67] Private third party insurance payments have been relatively consistent.[68] Direct private payments, however, have fallen from fifty-five percent in 1960 to thirty-three percent in 1980.[69] By 1990 even fewer personal health care expenditures will be paid by direct private payments. Private third party insurance payments will remain constant and the government share will continue to increase.[70]

Experimentation with cost containment in the insurance field has yielded some results, yet costs continue to increase at levels which

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61. Fuchs, *supra* note 57, at 12.

62. Personal health care expenditures and percent distribution, according to source of payment: United States, selected years 1929-1980 (Table 67), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 202 [hereinafter cited as Table 67]. The percentage of payments made directly by individuals dropped during this same period from 65.5% to 32.4%. *Id.* At the same time, the total bill for all personal health care expenditures (not limited to insurance payments) was growing dramatically from $10.9 billion in 1950 to $217.9 billion in 1980. *Id.*

63. SOURCE BOOK 1981-1982, *supra* note 35, at 6 (payments were $33 billion in 1975 and $70 billion in 1980).

64. *Id.* at 35 (government expenditures for health care were $56 billion in 1975 and $104 billion in 1980).

65. *Id.* (federal expenditures accounted for $70 billion of the total $104 billion).

66. Table 67, *supra* note 62. *See 80's Health Care Developments, supra* note 30, at 6 (chart on distribution of payments for personal health care costs).

67. *Id.* The government paid for 22% of personal health care expenditures in 1960 and 39% in 1980. *Id.*

68. *Id.* These payments have increased from 23% in 1960 to 28% in 1980. *Id.*

69. *Id.*

70. *Id.* By 1990 it is estimated that direct private payments will account for 25% of personal health care expenditures with private insurance payments at 30% and the government share at 45%. *Id.*

cannot be absorbed indefinitely.[71] While past growth in the government share of health expenditures has been at the expense of private payments,[72] the survival of the private health insurance industry may rest on the public's perception of its ability to provide services more efficiently than the government.[73]

The insurance system has been unable to contain rising health costs.[74] This ultimately affects individuals because in the final analysis there is no third party payor. Increased health costs result in higher premiums, whether through direct payment to insurance companies or higher taxes to finance government programs such as Medicare and Medicaid.[75]

III. Politics and Regulation

Health care is a major political issue in America.[76] President Carter promised a universal health insurance plan during his 1976 campaign.[77] President Reagan focused on cost containment pledges during

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71. *See* notes 40-48 *supra* and accompanying text (discusses experimentation with cost containment). *See also* Pear, *supra* note 2 (rising health costs could become insupportable and therefore threaten the quality and accessibility of the American health care system).

72. *See* notes 66-70 *supra* and accompanying text (discussion of percentages of health care expenditures paid by various sources).

73. MacKay, *supra* note 53, at 91. If the current insurance system cannot deal efficiently with areas such as fair and prompt payment, cost control and quality maintenance, the alternative is likely to be a form of socialized medicine. *Id.* Socialized medicine is generally described as government control of the medical facilities and government employment of medical personnel as civil servants. *Id.* at 86.

74. *Id.* at 90. MacKay cites an inadequate emphasis on the economic consequences of the third party payment system as a major contributor to this problem. *Id.*

75. Hedberg, *supra* note 47, at 56. *See* Stetson, *State Workers to Pay 10% Share of Insurance In Cost Saving Move,* N.Y. Times, Nov. 19, 1982, at A1, col. 4 (New York State has turned to increased premiums).

76. In 1982, the Reagan Administration considered a means test for Medicare. Pear, *U.S. Is Studying Limit On Income Under Medicare,* N.Y. Times, Sept. 19, 1982, at A1, col. 1. Senior officials had deliberately not investigated such Social Security issues before the Nov. 2 election. *Id.* The idea caused an outbreak of heated criticism and Richard Schweiker, Secretary of Health and Human Services, quickly assured that he would personally be opposed to the idea. Pear, *Schweiker Assails Curb On Medicare,* N.Y. Times, Sept. 22, 1982, at A22, col. 1. Despite the negative political effects of even raising the issue, there are indications that it may be a reasonable idea. Linda Miller, Executive Director of Volunteer Trustees of Non-Profit Hospitals, has said that (1) the concept of tying Social Security benefits to income is necessary for the System's survival and (2) opponents of the idea are more concerned with setting a precedent than with the merits of the specific proposal. Linda Miller, Letter to the Editor, Wall St. J., Dec. 29, 1982, at 7, col. 1.

77. *Carter Health Plan Asks Firms to Insure Employees for Costs Above $2,500 a Year,* Wall St. J., June 13, 1979, at 3, col. 2. The Carter plan was introduced with a

the 1980 election.[78] Senator Kennedy has long viewed health care as one of his primary concerns.[79]

Despite the importance uniformly accorded health care problems, congressional action reflects the lack of a national consensus on solutions.[80] The Senate has insisted on budget cutbacks[81] while the House has defeated bills aimed at cost containment.[82] Commentators have

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"Phase One" program which included a new federal insurance program called HealthCare which would consolidate Medicare and Medicaid. HealthCare would be government run but the private sector would compete in providing some aspects of the program. In addition, employers would be required to offer full time employees an insurance package covering health expenses above $2,500 per year. The final aspect of the program was to increase the emphasis on competition and preventive care. *Id.*

78. *See* Duncan, *supra* note 7, at 22. The Reagan plan is currently being formulated. *Id.* at 24.

79. Shabecoff, *Kennedy Offers Broad Health Plan And Challenges Carter to Support It*, N.Y. Times, May 15, 1979, at A1, col. 4. The Kennedy proposal would guarantee complete health care to every American. In addition, tight federal regulation of the insurance industry and tough cost controls were included. *Kennedy Offers Revised National Health Plan; Broad Role Set For Private Insurers*, Wall St. J., May 15, 1979, at 3, col. 2. *See also* T. KENNEDY, IN CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE (1972). The proposal outlined in this book, the Health Security Program, envisioned the federal government replacing the insurance industry totally and becoming the sole health insurance carrier for the entire nation. *Id.* at 238. The federal government would also set up controls and incentives to health providers to insure uniform quality care at a reasonable cost to all Americans. *Id.* at 239. Finally, the government would assume responsibility for training health care professionals and for building health facilities. *Id.*

80. *See* notes 77-79 *supra* & 81-82 *infra* and accompanying text (examples of different political proposals and lack of legislative consensus).

State level disagreements have also arisen. For example, in New York State, the Governor's office and New York City teaching hospitals were sharply divided on the need for new construction of health care facilities costing almost two billion dollars. Statewide planned construction was estimated at five billion dollars. Sullivan, *New York State Panel Due To Ask A Freeze On Hospital Construction*, N.Y. Times, Dec. 14, 1982, at A1, col. 3. Consequently, a one-year freeze was proposed on all new hospital construction in New York in an effort to evaluate all proposals thoroughly. Sullivan, *Cuomo to Freeze Hospital Building*, N.Y. Times, Jan. 6, 1983, at A1, col. 5; Sullivan, *Hospital Council Studies Freeze Urged by Cuomo*, N.Y. Times, Jan. 7, 1983, at B3, col. 1.

81. Hunt, *Senate Rejects Effort Made By Kennedy To Stop Budget Recissions in Health Area*, Wall St. J., Mar. 15, 1979, at 14, col. 3. Kennedy's effort was largely symbolic, but the conflict emphasized the political difficulty of reaching consensus on health care policies which involved a choice between medical lobbying groups and budget cutting. *Id.*

82. *House Defeats Cost Controls for Hospitals*, Wall St. J., Nov. 16, 1979, at 5, col. 1. The House rejected mandatory elements of Carter's cost control program for hospitals. The Administration cited hospital industry lobby pressure as the cause of the defeat. *Id.* Such legislative difficulties have led to searches for alternative means of influencing health care. Lublin, *Administration Studies Ways to Control Some*

stated that cost containment measures have no chance of popular support if they involve service cutbacks,[83] yet others have found that Americans are willing to accept significant changes in the current system in exchange for reduced costs.[84] While these debates take place, a continued increase in government outlays for health care is projected.[85]

Government programs have resulted in health care regulations at all levels.[86] The federal government is active through Medicare and Medicaid and other specialized programs.[87] State and local programs have proliferated through State Health Agencies.[88]

The federal government has been involved in regulating both supply and demand in the health care field.[89] Regulation of health care currently centers on Certificate of Need (CON) and Professional Standards Review Organization (PSRO) programs. CON strives to prevent new construction of unneeded facilities.[90] CON programs oversee major capital expenditures and regulate changes in the nature

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Hospital Costs Without Legislation, Wall St. J., Feb. 13, 1980, at 6, col. 2 (expanding current regulations to encompass more hospital services).

83. Levin, *supra* note 10, at 4 (noting difficulty of altering established consumption patterns). *See* Feldstein, *The Political Environment of Regulation*, in REGULATING HEALTH CARE, THE STRUGGLE FOR CONTROL 8 (A. Levin ed. 1980) (a priority of health associations is legislation which increases the demand for their member's services).

84. Reinhold, *Majority in Survey on Health Care Are Open To Changes to Cut Costs*, N.Y. Times, Mar. 29, 1982, at A1, col. 3. The *New York Times* poll showed willingness to increase the use of doctor's assistants, substitute clinics for private physicians and pay higher deductibles. About one-third of those surveyed would be willing to wait longer for an appointment, limit the use of expensive technology or give up their right to sue for malpractice in exchange for lower health costs. *Id.* at D11, col. 1.

85. Freeland & Schendler, *supra* note 2, at 112. This report lists projections of $462 billion for national health expenditures in 1985 and $821 billion in 1990. *Id.* at 97.

86. *See* SOURCE BOOK 1981-1982, *supra* note 35, at 86-90 (historical overview of health legislation and programs).

87. *Id.* at 33-34. Specialized programs include provisions for military personnel and dependants, federal civilian employees, veterans, American Indians, Alaskan natives, and federal assistance for state payments under workers compensation laws in the various states. *Id.*

88. *Id.* at 34. There were 3,100 local health departments operating in 1980. Fifty-seven State Health Agencies were operative in the same period. *Id.*

89. *See* D. WARREN, PROBLEMS IN HOSPITAL LAW 289-97 (1978) (overview of the Hill-Burton Program, Medicare, and Medicaid).

90. The Certificate of Need program is a complex topic discussed at length in CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT (1978 & Supp. 1978) (compilation and analysis of federal and state laws and procedures). *See generally* Blumstein & Sloan, *supra* note 9, at 870-73 (overview

of the services offered by particular facilities.[91] By controlling the oversupply of health care facilities, CON programs strive to reduce excessive demand for health services and therefore third party payments through insurance and government programs.[92]

While CONs are principally concerned with capital cost containment,[93] PSROs review the quality and cost of actual medical services.[94] PSROs were designed to oversee the effectiveness of health care received by Medicare, Medicaid and Maternal and Child Health Program patients.[95] PSROs have been criticized as being tokens of the organized professional interests which dominate their membership.[96] Their positive effect on health care cost containment is unclear due to difficulties in measuring their contributions.[97]

The regulatory approach has dominated health care since World War II.[98] While regulation cannot be instantly or totally eliminated, there is widespread dissatisfaction with the current level of government intervention in the health care system.[99] The success of large government programs has been questioned while their contribution to inflationary pressures has been criticized. There is a growing recogni-

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of CON in a Market Approach context). CON laws were upheld as constitutional by the Supreme Court in North Carolina v. Califano, 435 U.S. 962 (1978), *aff'g* 445 F. Supp. 532 (E.D.N.C. 1977).

91. CHAYET & SONNENREICH, P. C., *supra* note 90, at v. *See* C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 53-76 (1982) (CON restrains unneeded investment in health care facilities).

92. C. HAVIGHURST, *supra* note 91, at 53-76. *See* CHAYET & SONNENREICH, P. C., *supra* note 90, at vi-vii (analysts have noted that hard data on the effectiveness of the CON program is not readily available).

93. C. HAVIGHURST, *supra* note 91, at 36.

94. Berman & Gertman, *Cost Containment and Quality Assurance: The Potential and Performance of the Professional Standards Review Organization Program*, in FEDERAL HEALTH PROGRAMS 43 (S. Altman & H. Sapolsky eds. 1981).

95. *Id.* at 46. When a PSRO determines that inappropriate care was given, it can impose sanctions including payment denials, exclusion from the Medicare and Medicaid programs, and fines up to $5,000. These penalties are seldom used, however, because the PSRO's emphasize peer pressure and voluntary compliance. *Id.* at 47.

96. C. HAVIGHURST, *supra* note 91, at 90. Another criticism of PSROs is that they are attempting to accomplish an impossible task by judging the medical merits of specific treatments for individual patients. *Id.* at 37.

97. Berman & Gertman, *supra* note 94, at 57-58; C. HAVIGHURST, *supra* note 91, at 26, *citing* Cong. Budget Office, The Effect of PSROs on Health Care Costs: Current Findings and Future Evaluations (Background Paper June 1979) (difficulty in determining measure of PSRO effectiveness).

98. *See* note 6 *supra* and accompanying text (examples of regulatory measures since World War II).

99. This dissatisfaction is expressed in the proposals to change the role of government involvement. *See* C. HAVIGHURST, *supra* note 91, at 14-15 (advocating short-term, competition-sensitive regulation); Blumstein & Sloan, *supra* note 9, at 925 (to foster competition means to redefine regulation, not eliminate it).

tion that new methods for directing the health care system are needed.[100]

IV. The Health Care Finance Market

Access to capital has been identified as a critical issue for health care providers in the 1980's.[101] In the 1970's the principal factors affecting health care financing were complex regulatory issues.[102] In the 1980's the financial requirements of a competitive health care market will shape health care finance.[103]

Health care financing has centered on hospitals, which until 1960 met their capital needs chiefly through gifts and internal sources.[104] This pattern gradually changed, however, as capital requirements outgrew traditional sources.[105] Since 1971, tax exempt hospital bonds have become an increasingly important source of capital.[106] Additional financing methods have emerged in both the taxable and tax

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100. Pollard, *supra* note 13, at 159 ("what really matters is the recognition that new methods for managing old problems are in order").

101. BLYTH EASTMAN PAINE WEBBER HEALTH CARE FUNDING, INC., HEALTH CARE POLICY: THE CRISIS IN CAPITAL FORMATION (1982) (Intro.) [hereinafter cited as THE CRISIS IN CAPITAL FORMATION]. This report was prepared to present an overview of the issues affecting health care financing in the 1980's.

102. *Id.* Regulation often sent conflicting instructions to the health care industry. For example, cost-based reimbursement encouraged growth in medical programs and facilities yet failed to recognize the true cost of capital. This resulted in what investment bankers argue is an undercapitalized health care industry. *Id.*

103. *Id.* The emphasis on competition will generate new requirements for capital to renovate outmoded facilities, convert beds and facilities to serve new markets, develop new technologies, and respond to competitive innovations from other providers. *Id.* at 2.

104. R. LAMB & S. RAPPAPORT, MUNICIPAL BONDS 185 (1980). Internal sources of capital were operations and depreciation. Some small federal grants, bank mortgages and taxable mortgage bonds from insurance companies or a bank were also utilized. *Id.*

105. Hospital construction costs, new technology, population shifts and increased utilization of health facilities stimulated the needs for new financing mechanisms. *Id.* The decline of federal grants and lower rates of philanthrophic donations also contributed to the trend. Hernandez, Griggs, Henkel & Howie (Health Finance Group, Kidder, Peabody & Co.), *Review of Health Care Finance, 1978*, in MANAGING THE FINANCES OF HEALTH CARE ORGANIZATIONS 471, 474 (1980).

106. HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 3. Tax exempt bonds issued in 1971 totaled $262 million. By 1974, $1.28 billion of such bonds were issued. In 1977 the amount surged to $4.7 billion. In 1981 the amount reached $5.04 billion. *Id. See* Yacik, *Hospital Volume Soars to Record $5 billion*, The Bond Buyer, Jan. 20, 1982, at 1, col. 2. Hospital and health care facility financings accounted for 11% of 1981 long-term tax exempt financing. Interest rates ranged from 17.13% to 8.1%. Forty-six states participated in the tax exempt market for health care in 1981. *Id. See also* Fury, *Interhospital Competition Fuels Year's Record Volume*, The Bond Buyer, Aug. 30, 1982, at 1, col. 1 (1982 projections are for another record year).

exempt contexts.[107] Recently, there has been increased concentration

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107.

MERRILL LYNCH WHITE WELD CAPITAL MARKETS GROUP
HEALTH CARE FINANCE DEPARTMENT

Financing Alternatives Comparison Chart

	Program Characteristics	Tax-Exempt Bonds	FHA Insured Mortgage Loan/ GNMA Guarantee	FHA Insured Mortgage Loan/Tax Exempt Bonds	Private Placement Of Conventional Mortgage
1.	Approximate Time Required	3-6 Months	6-12 Months	7-13 Months	2-6 Months
2.	Percentage Financing Available	Up to 100% of Project Cost	Approximately 90% of Project Cost	Approximately 90% of Project Cost	Up to 100% of Project Cost
3.	Eligible Project Costs	All Costs	All Costs Including Land, Buildings, Equipment and Working Capital	All Costs Including Land, Buildings, Equipment and Working Capital	Determined by Lender
4.	Debt Refinancing	Allowed: By Policy Up to 25% of Issue Size	Allowed: By Statute Up to 80% of Issue Size	Allowed: By Statute Up to 80% of Issue Size	Negotiable
5.	Loan Term	Typically 30 Years	Up to 25 Years After Completion of Construction	40 Years with Anticipated 25 Year Retirement After Completion of Construction	5-10 Years
6.	Maximum Interest Rate	Fixed by Law—Currently 12%	Prevailing FHA Coupon Rate: Currently 13.0%	Approximately Equal to FHA Debenture Rate	None
7.	Financing Fees	Underwriting Spread 3.0%	Financing and Placement Fees of 3.5-4.5% FHA Fee of .8%	• Financing and Placement Fees of 3.5-4.5% Includes Underwriters Spread of Approximately 2.5% • FHA Fee 8%	Financing Fee Negotiable Generally Commitment Fee of 1.0-2.0%
8.	Annual Fees	Authority Fee and Trustee Fee	.5% Annual Mortgage Insurance Premium on Outstanding Balances ("MIP")	Authority Fee, Trustee Fee, .5% MIP on Outstanding Balances	Servicing Fee Negotiable
9.	Other Front-End Fees	• Feasibility Study $40,000-$75,000 • Legal & Printing Expenses $100,000-$150,000	• Feasibility Study $40,000-$75,000 • Legal Fees $25,000-$35,000 • Points If Necessary to Adjust Yield to Current Market Conditions	• Feasibility Study $40,000-$75,000 • Legal & Printing Expenses $100,000-$150,000	• Legal Fees $5,000-$25,000

on short term financing methods in response to high interest rates.[108] Short term financings are advantageous in reducing borrowing costs by funding the various aspects of a project for different terms.[109] In addition, long term debt issues can be postponed during temporary periods of particularly high interest rates.[110] Since 1980, financing techniques have been developed or adapted specifically to address the requirements of volatile markets.[111]

From 1974 to 1978 tax exempt public offerings solidified their role as the principal debt financing source for hospitals.[112] By any measure

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MERRILL LYNCH WHITE WELD CAPITAL MARKETS GROUP
HEALTH CARE FINANCE DEPARTMENT

Financing Alternatives Comparison Chart

	Program Characteristics	Tax-Exempt Bonds	FHA Insured Mortgage Loan/ GNMA Guarantee	FHA Insured Mortgage Loan/Tax Exempt Bonds	Private Placement Of Conventional Mortgage
10.	Prepayment Provisions	Restrictive, Usually None for 8-10 Years. A Declining Penalty Thereafter	15% of the Original Principal Amount in Any Year With No Penalty. A Declining Premium Thereafter	15% of the Original Principal Amount in Any Year With No Penalty. A Declining Premium Thereafter	Negotiable

For an examination of innovations in the types of financing techniques available to hospitals, see Plimpton, *Financing Boom for Health Care Borrowers*, The Bond Buyer, Aug. 30, 1982, at 10, col. 1 (zero coupon bonds, municipal multipliers or "TECAs"—Tax Exempt Capital Accumulators—are discussed in depth). *See also New Types of Financing Techniques Spawned*, The Daily Bond Buyer, Aug. 31, 1981, at 10, col. 1 (FHA insured financings, bank letters of credit and intermediate term equipment financing); Health Care Institutions: Why Merrill Lynch Should Be Your Investment Banker, at 11-12 (examples of innovative financing techniques for financing two legally separate institutions and a nine hospital system with facilities located in three states. A federally insured mortgage was combined with tax exempt bonds).

108. MERRILL LYNCH WHITE WELD CAPITAL MARKETS GROUP HEALTH CARE FINANCE DEP'T, SHORT TERM FINANCING OPTIONS 1 (1982). Financing techniques which which are effective in the short-term market include demand notes, tender notes, day notes, tax exempt commercial paper and bond anticipation notes. *Id.*

109. *Id.* Construction funds and working capital are particularly suited to short-term financing. *Id.* at 2.

110. Short term financing also has negative features such as exposure to increased rates and reduced ability to project costs over extended periods.

111. MERRILL LYNCH WHITE WELD CAPITAL MARKETS GROUP HEALTH CARE FINANCE DEP'T, FINANCING TECHNIQUES FOR VOLATILE MARKETS 1 (1982). Principal methods include original issue discount bonds, zero coupon bonds, capital appreciation bonds, compound interest bonds, stepped coupon bonds, and tender bonds. *Id.*

112. R. LAMB & S. RAPPAPORT, *supra* note 104, at 195. In 1974 tax exempt public offerings constituted 58.3% of hospital debt financing. Private placements, 11.2%,

they are the dominant financing method used by health care institutions.[113] Tax exempt bond financings are implemented through an issuing authority created by state or local governments.[114] Although tax exempt bonds are issued by an authority, they are backed by the financial strength of the hospital for which they are intended.[115] Therefore, the hospital's ability to repay the obligation provides the basis for the rating given by the rating agencies.[116] Without an adequate investment grade rating, the bond issue will be rejected by the market of potential purchasers.[117]

During the decade of the 1970's, hospitals increased their reliance on tax exempt revenue bonds as a source of capital.[118] Recently,

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taxable public offerings, 11.3%, government sponsored programs, 12.4%, and mortgages with commercial banks, 6.8%, constituted the remainder of the market. By 1978 tax exempt financing's share had increased to 73.9%. Private placements fell to 8%, taxable public offerings to 6.5%, government sponsored programs to 6.9%, and mortgages with commercial banks to 4.7%. *Id.*

Tax exempt bonds also achieved prominence when measured as a source of funding specifically for hospital construction. In 1973 tax exempt bonds accounted for 20.9% of hospital construction financing. By 1978 the level had risen to 49.3%. Internal funds represented 18.5% of construction financing while philanthropy, 6.2%, taxable bonds, 2.8% and direct loans, 8%, all suffered declines in their share of construction funding. Government grants and appropriations fell from 23.5% in 1973 to 8.6% in 1978. HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 6.

113. *Id.*

114. R. LAMB & S. RAPPAPORT, *supra* note 104, at 189 (tax exempt bonds are also issued by states, municipal hospitals, counties, or cities). In some states, there is one issuing authority for the entire state. In others, there are local hospital authorities. *Id. See, e.g.*, DORMITORY AUTHORITY OF THE STATE OF NEW YORK REVENUE BONDS, THE SOCIETY OF THE NEW YORK HOSPITAL ISSUE, SERIES A, OFFICIAL STATEMENT (Dec. 15, 1981) (example of issuing authority).

115. R. LAMB & S. RAPPAPORT, *supra* note 104, at 189-90. The security for a hospital bond issue is a revenue pledge. *Id.* at 190.

116. *Id.* at 189. In addition to any legal obligations incurred by a state regarding payment of hospital authority debts, a moral obligation may exist. Moral obligation bonds are supported only by a state's moral obligation to supplement a project's revenues if the revenues are insufficient to fulfill financing commitments. *See* Greenberg, *Municipal Securities: Some Basic Principles and Practices*, 9 URB. LAW. 338, 346 (1977) (discussion of moral obligation bonds).

117. R. LAMB & S. RAPPAPORT, *supra* note 104, at 189. A hospital bond issue should have at least a BBB rating to be attractive to investors. Credit rating agencies determine to a large extent whether a hospital will have access to the capital markets. They screen out those institutions with low creditworthiness and an unfavorable or speculative rating (less than BBB) may foreclose access to credit markets. In addition, the rating will help to determine the interest rate which the market will demand. Taddey, *The Importance of Ratings to Health Care Borrowers*, The Daily Bond Buyer, July 28, 1980, Tax Exempt Hosp. Fin. Supp. at 7. The two leading credit rating agencies are Moody's Investors Service, Inc. and Standard & Poor's Corp. Both agencies assign letter grades to obligations ranging from Moody's Aaa to C and Standard & Poor's AAA to D. Fabozzi, *Interest Rates and the Securities Markets*, in HANDBOOK OF FINANCIAL MARKETS 30-31 (F. Fabozzi & F. Zarb eds. 1980).

118. *See* note 106 *supra* (increased use of hospital revenue bonds).

Health Maintenance Organizations have also begun to utilize tax exempt bond financings.[119] Nearly all 240 existing HMOs have expansion plans. In addition, 100 new HMOs are under development.[120] This expansion will increase HMO capital financing requirements. HMO capital analysts are cautious, however, about the quality of HMO investment opportunities due to their recent development and small size.[121]

Health care financings through the 1980's are expected to continue the established trends of declining government support and reduced levels of philanthropy.[122] In addition, reimbursement policies under programs such as Medicare and Medicaid are not expected to emerge as an internal source of capital funds.[123] Debt financing is expected to continue to dominate as a source of capital, with tax exempt financing accounting for seventy to eighty percent of total health care borrowing.[124]

The interest rates which health care institutions must offer to attract capital are expected to remain relatively high due to internal administrative considerations and external market pressures. Internally, hospitals and other health care providers must balance capital structure, liquidity and cash flow. In the past, hospitals have relied upon substantial returns on their investments to maintain constant operating margins in spite of growing problems in the reimbursement funding area. This financial practice discourages investors.[125] Externally, hospitals are faced with the same challenges confronting all participants in the capital markets. High interest rates and investor

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119. Examples of HMOs utilizing tax exempt financing are the Rutgers Community Health Plan in New Brunswick, N.J., Chell, *supra* note 45, at 11, col. 1, and the Group Health Cooperative of Puget Sound, *Analysts Size Up HMOs, New Health Care Alternative*, Bond Buyer, Aug. 30, 1982, at 15, col. 4 [hereinafter cited as *Analysts Size Up HMOs*].

120. Chell, *supra* note 45, at 11, col. 1.

121. *Id.* Lack of past financial records and the small size of most HMOs will probably prevent an HMO from obtaining an investment grade rating for bond issues in the near future. Private placement is an alternative method of financing. *Id. See Analysts Size Up HMOs, supra* note 119, at 15, col. 4 (compared to hospitals, HMOs are perceived as riskier investments lacking real credit stature).

122. Phillips, *Capital Finance—Capital Outlook: Some Encouragement, Much Concern, Many Changes*, HOSPITALS, Apr. 16, 1982, at 70.

123. *Id.* When reimbursement rates do not reflect the true cost of operation, undercapitalization of the institution results. THE CRISIS IN CAPITAL FORMATION, *supra* note 101, at Intro.

124. Phillips, *supra* note 122, at 70.

125. *Id.* at 70-71. Interest on investments subsidizes operating margins. This income is dependent on continued high interest rates. *Id.* at 70. If these rates decline, the subsidy will be reduced.

resistance in 1981 and 1982 resulted in the necessity for offering higher yields.[126] In addition, municipalities are entering the tax exempt market more frequently as a result of reductions in federal and state revenue sharing and larger budget deficits.[127] The higher volume of other municipal securities on the market provides direct competition with tax exempt health care offerings.[128] Increased competition within the health care market will challenge the credit status of existing institutions.[129] Moreover, alternative delivery systems such as HMOs, ambulatory care centers, and surgicenters will crowd the capital market.[130]

In the context of this strenuous competition for capital, the aggregate financing requirements of the health care industry are expanding rapidly.[131] The continued survival of particular health care facilities

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126. In the latter half of 1982, interest rates declined, but long term rates are not expected to fall drastically. *No More "Dr. Death"? But Al Wojnilower Is Still Far From A Raging Bull*, Barron's, Nov. 8, 1982, at 8, col. 1 (interview by editors of Barron's).

127. Federal and state aid to municipalities is affected by budget constraints as well as municipal needs. *See, e.g.*, THE CITY OF NEW YORK GENERAL OBLIGATION BONDS, OFFICIAL STATEMENT 21, 31-34 (Jan. 14, 1983). New York City projects a decline in unrestricted federal and state aid from $832 million in 1983 to $795 million in 1986. *Id.* at 31. Federal and state categorical grants are expected to remain at approximately the same level from 1983-1986. *Id.* at 33. The city also notes that the Reagan Administration has reduced federal support to states and localities. *Id.* at 34. Future budget reductions and the effects of inflation could further increase the amount of funding which localities must raise either through debt or taxes.

128. THE CRISIS IN CAPITAL FORMATION, *supra* note 101, at 4. The process of financing the "reindustrialization" of America crowds the capital markets. The utility industry has estimated its capital needs from 1983 to 1988 at $150 billion. Municipalities have major public works to rebuild. The federal government has become a massive borrower due to its large budget deficits. *Id.* *See* HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 45. To the extent that the capital needs of alternative providers crowd the market and encourage higher interest rates, all issuers suffer. This is unlikely to occur, however, because alternative providers will not be borrowing a large enough aggregate amount to unilaterally affect rates. Total health care volume comprised only 7.8% of the total municipal bond volume in 1980. *Id.*

129. THE CRISIS IN CAPITAL FORMATION, *supra* note 101, at 6. Investors may be uncertain about the ultimate success of their institution in a competitive health care market. Consequently, they are expected to raise credit criteria, making it more difficult to obtain an investment grade rating. *See Analysts Size Up HMOs*, *supra* note 119. The higher financing costs will lead to reliance on the federal government or private placements with insurance companies or venture capital firms. *Id.*

130. *See* notes 119-21 *supra* and accompanying text (HMOs have already begun to utilize the tax exempt market).

131. Fury, *supra* note 106, at 1, col. 1. Investment bankers have projected a need for $150 billion in long term hospital bonds during the 1980's. *Id.* *See* THE CRISIS IN CAPITAL FORMATION, *supra* note 101, at 2. One organization views $150 billion as the requirement for only renovation and replacement. During the entire decade of the 1970's approximately $50 billion of long term hospital bonds were issued. *Id.*

will depend on their ability to compete successfully in the tax exempt capital market.[132]

V. The Market Approach View of the Health Care Industry

Health care has been considered immune to the market forces of supply and demand.[133] Competition theory, also referred to as the Market Approach, does not accept this immunity.[134] Competition theory is not a new economic concept, yet it has only recently been gaining credibility in the health care industry.[135]

Market Approach advocates begin with the assumption that competing providers are more efficient than government regulators in identifying and maintaining the lowest market price for health care services.[136] The Market Approach focuses competitive efforts in two areas: (1) quality of service and (2) price.[137] At its most basic conceptual level, the Market Approach advocates that health care move

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132. *'Haves' to Battle 'Have Nots' For Funds, But Crisis Will Benefit Hospital Industry*, HOSPITALS, Feb. 16, 1982, at 53-54. The result, according to one expert, is that 6,000 of today's 7,000 hospitals will survive. *Id.* at 55. The challenges of raising capital have led to innovative financings. Guncheon, *Capital Finance: Only the Best Laid Plans Bring Capital Success*, HOSPITALS, Apr. 16, 1982, at 72-74. *See* Henry, *Financing Hospital Expansion*, N.Y. Times, Sept. 1, 1982, at D19, col. 1 (use of syndicated partnerships to attract capital). The consequences of failing in the competition for capital or being cut off from government funding are severe, often implying the inability to survive. Yanish, *Proposed FmHA Loan Program Cuts Frighten Small and Rural Hospitals*, MODERN HEALTHCARE, Apr. 1981, at 111. For small hospitals, it is often impossible to obtain an investment grade bond rating, thus closing them out of the tax exempt bond market. *Id.*

See THE CRISIS IN CAPITAL FORMATION, *supra* note 101, at 12. At least one investment banking firm is explicit in its warning: "The bottom line, during the 1980's, is your institutional survival. The key to survival is access to the capital markets in a fiercely competitive environment. The very real crisis is that your access to the capital markets is going to get tougher." *Id.*

133. Pollard, *supra* note 13, at 158. This immunity is said to extend from the precept that medicine is too complex for those not in the health profession to understand. While experimentation in other areas may lead to financial loss or inconvenience, medical care errors are said to lead to irreparable harm, thus justifying an insulation from competition. *Id.* at 158-59.

134. *Id.* Pollard is careful to distinguish between competition among providers and totally uncontrolled exposure to market abuses. *Id.*

135. A. SOMERS, HOSPITAL DEREGULATION: THE DILEMMA OF PUBLIC POLICY 6-15 (1969) (discussion of prospects for competition in the health care industry in the late 1960's and early 1970's).

136. Pollard, *supra* note 13, at 159 (in a competitive setting, prices will be kept low and scarce resources will be efficiently distributed).

137. *Id. See* C. HAVIGHURST, *supra* note 91, at 2. Havighurst has said that the lack of competition in health care has provided insulation for providers from consumer accountability on both price and quality of care. *Id.*

away from government regulation toward two conditions of a competitive market: free market entry and free consumer choice among alternative providers.[138] Changes perceived as necessary to implement these goals include alteration of the insurance system, the use of cost sharing by patients and the restructuring of the supply of medical care to facilitate price competition.[139]

Market oriented policies have been divided into two groups.[140] The first faction emphasizes consumer pressure on providers to control costs by making the consumer pay a higher percentage of health care costs directly out of pocket.[141] The second faction advocates competition between the existing fee for service system and various types of alternative delivery systems.[142] While some alternative delivery systems are already functioning, the entry of new lower cost alternative providers is an essential component of the second faction's competitive plan.[143] The Market Approach does not require society to collectively choose one theory to the exclusion of the other. Rather, a market

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138. Reinhardt, *Table Manners At The Health Care Feast, Financing Health Care: Competition Versus Regulation*, PAPERS AND PROCEEDINGS OF THE SIXTH PRIVATE SECTOR CONFERENCE 24 (March 23-24, 1981). The chief proponent of a strict adherence to these principles is Milton Friedman. *Id.* Commentators advocating a more controlled use of competitive forces are Martin Feldstein and Alain Enthoven. *Id.* at 29-30.

139. Address by Uwe Reinhardt, Emerging Trends In The Economics Of Health Care, Fourth Annual Meeting of the Society for Hospital Planning of the American Hospital Ass'n (May 3, 1982) (Exhibit 13) [hereinafter cited as Reinhardt Address]. Among the proposed changes in the insurance industry are: (1) force consumers to purchase health insurance out of after tax income, (2) require mandatory options on choice of insurance to be offered to employees (with perhaps a voluntary or mandatory Medicaid/Medicare voucher system), and (3) regulate health insurance to encourage insurer pressure on price and utilization patterns recommended by health care providers. *Id.*

140. Blumstein & Sloan, *supra* note 9, at 894. *See id.* at 895-97 (discussion of the questions raised by the two subgroups).

141. Pollard, *supra* note 13, at 160-61 (discussion of increased consumer payments). *See* Blumstein & Sloan, *supra* note 9, at 894-95. Increased direct consumer payments could be accomplished by deductibles or coinsurance with a ceiling on out of pocket payments that varied with household income. This approach involves two assumptions: (1) consumers will learn to choose less costly alternatives because they will be paying more of the cost, and (2) an attitude of conservation of scarce resources will be developed in the health care industry. *Id.*

142. Blumstein & Sloan, *supra* note 9, at 895 (stating need for new market participants). This strategy assumes that consumers will make wise quality and price choices if offered "prepackaged alternatives." *Id. See* C. HAVIGHURST, *supra* note 91, at 111 (HMOs are only one type of alternative delivery system).

143. Reinhardt Address, *supra* note 139, at Exhibit 13. Reinhardt has identified the restructuring of the supply of health care to facilitate competition as one of the "Five Pillars of the 'Pro Competitive' Strategy." *Id.*

system will dictate which combination is most appropriate.[144] Regardless of which method dominates, three steps must be implemented to curb cost increases: (1) improve competition, (2) initiate cost awareness and (3) reform health care financing as a long range solution.[145]

Advocates of the Market Approach emphasize that increased competition is not synonymous with the total elimination of government participation in health care.[146] Yet even among Market Approach advocates, differences arise concerning specific types of governmental participation.[147] Two commentators have proposed a redefinition of the government role which would orient regulation toward establishing access to truthful information about market alternatives, preventing entrenched provider groups from restricting competitive efforts and assuring that the poor and very sick are adequately considered in the competitive environment.[148] According to this view, the government would neither regulate nor review an individual provider's charges or utilization patterns. It would not set area-wide expenditure ceilings or monitor investments in facilities and services.[149] Such a controlled government role would promote a market-oriented health delivery system while preserving recent gains in consumer protection and universal access to health care.[150]

Professor Schramm has proposed a wider government role through his model act for a state-based approach to hospital cost containment. He visualizes a commission created specifically to stimulate competition using different methods for each sector of the industry.[151] The commission would have authority to plan hospital investment, license hospitals and limit statewide capital expenditure. This single commission would control entry to and exit from the industry and coordinate the regulation of all health institutions.[152]

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144. Blumstein & Sloan, *supra* note 9, at 897. *See* C. HAVIGHURST, *supra* note 91, at 14-15. Havighurst has recognized that in a free society there will be a wide variety of economic and philosophical ideas regarding the delivery of and payment for health care. Rather than imposing a single set of values on the entire system, a Market Approach will allow for the accomodation of different ideas and the development of alternative providers to serve each constituency.

145. Schramm, *supra* note 2, at 641 (financing reform is a component of Schramm's model pro-competition statute).

146. *See* notes 148-52 *infra* and accompanying text (discussion of alternative implementation proposals).

147. *See* notes 148-52 *infra* and accompanying text (various government roles discussed).

148. Blumstein & Sloan, *supra* note 9, at 925 (description of proposed redefinition of the government role).

149. *Id.* (discussion of limits of government role).

150. *Id.* at 924-25.

151. Schramm, *supra* note 2, at 649 (discussion of the model commission).

152. *Id.* at 647-49 (discussion of the specific powers created by the model statute).

By introducing active competition into the health care sector, proponents of the Market Approach hope to achieve substantial improvements in health delivery. Competition will increase the quality of care offered while stimulating greater efficiency in the delivery of that care. The Approach provides incentives for innovative cost containment practices and maximizes the value added for each dollar expended.[153]

A. Criticism of the Market Approach

Criticism of the Market Approach focuses on consumer inability to understand health care, fears of reduced quality and a perceived lack of safeguards for those without buying power.[154] The proponents of the Market Approach address each of these questions. They argue that consumers are able to comprehend health care issues.[155] Consumer interest and study of health care is likely to grow quickly once consumers realize that their purchasing power can affect the outcome of debates within a competitive health care sector.[156] Commentators supporting this procompetition theory also state that the quality of health care may improve, rather than deteriorate, once informed consumers begin comparing providers. This is particularly true if consumers, operating through employer or union groups, can apply their collective bargaining power.[157] These proponents also claim that they will not abandon their societal commitments to groups with little purchasing power.[158]

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153. C. HAVIGHURST, *supra* note 91, at 14. The transition from regulation to competition holds great promise, yet a quick reversal of all controls is not considered reasonable. Instead, Havighurst argues for a system of "competition-sensitive regulation" which could be oriented toward gradual deregulation. *Id.* at 14-15. *See* notes 154-58 *infra* and accompanying text (discussion of criticism of the Market Approach).

154. Pollard, *supra* note 13, at 158-59 (discussion of concerns about effects of Market Approach).

155. *Id.* at 161. It is certain that consumer knowledge will develop gradually. The transition from passive recipient to active participant will not be simple when making a decision regarding an individual provider. In addition, fraud and improper advertising would require careful enforcement of existing laws. *Id.*

156. *Id.* The basic change in the marketplace from provider monopoly to consumer control is seen as adequate incentive to encourage consumers to obtain the knowledge they need. *Id.*

157. Reinhardt Address, *supra* note 139, at Exhibit 13. Reinhardt has identified the importance of *mandatory* multiple choice insurance options for employees as an essential component of a competitive strategy. *Id.* In addition, he encourages the insurance industry to apply greater pressure on providers to influence prices. *Id. See* Pollard, *supra* note 13, at 161. At this time, however, collective bargaining by employers or unions can actually be a hindrance to consumer choice in health care because the employer or union selects a single plan for all the participants. *Id.*

158. Pollard, *supra* note 13, at 159. Groups which would continue to benefit from government intervention in some form are the poor, the aged and the helpless. *Id.*

Other critics of the Market Approach challenge the savings claims of alternative delivery systems and question the adequacy of services offered by new providers for seriously ill patients.[159] These questions are largely unanswered, although limited experience with alternative systems indicates a successful resolution of these issues.[160]

Finally, certain critics object to applying market principles to health care. They are concerned that social needs will be shortchanged and that the Market Approach will cause havoc in health care delivery.[161] However, this ideology no longer prevails. Concerns for efficiency and affordability have been necessitated by decades of persistent inflation in a sector which now accounts for ten percent of the Gross National Product. The Market Approach proposal is a manifestation of these concerns.[162]

B. Judicial and Statutory Support of the Market Approach

The Market Approach is based on expanding the influence of competition in health care, thereby reducing price while maintaining or improving quality.[163] In order to make competition effective, two conditions must be met. First, innovative participants in the health care market must enjoy more accessible market entry opportunities.[164] Second, the consumer must be given the incentive to cause providers to tailor their services to meet consumer demand.[165] Recent court decisions have supported both of these goals.[166]

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159. Blumstein & Sloan, *supra* note 9, at 895-96. These critics argue that savings from alternative providers may be the result of "preferred case selection" whereby healthy people would tend to select an HMO or other alternative provider for their health care. *Id.* Others state that the health status of persons choosing traditional and alternative health providers does not differ. *Id.* at 895 n.217.

160. Pollard, *supra* note 13, at 160-61 (alternative providers have accounted for true savings).

161. Battistella & Eastaugh, *Hospital Cost Containment*, in REGULATING HEALTH CARE, THE STRUGGLE FOR CONTROL 204 (A. Levin ed. 1980). This argument states that societal and community needs are best met by formal planning rather than market forces reflecting individual self interest. *Id.*

162. *See* note 13 *supra* and accompanying text.

163. Borsody, *The Antitrust Laws and the Health Industry*, 12 AKRON L. REV. 417, 462-63 (1979) (policies supporting the proliferation of HMOs have these goals).

164. *See* notes 142-43 *supra* and accompanying text (market entry as a component of the Market Approach).

165. Blumstein & Sloan, *supra* note 9, at 895. Both factions of Market Approach advocates agree that consumer power must be increased. They differ over the method by which to achieve this result. *Id. See generally* notes 140-45 *supra* (discussion of the two factions of the Market Approach).

166. *See* discussion at notes 171-220 *infra* (antitrust) & 221-29 *infra* (consent and commercial free speech).

The principal procompetitive economic policy statement is found in the antitrust laws.[167] Antitrust analysis of the health care industry has been a popular topic among commentators.[168] This section will discuss recent antitrust decisions which may provide support for competitive efforts which are opposed by entrenched provider interests.[169] Finally, the principal cases in the area of informed consent and freedom of commercial speech will be examined. These doctrines afford consumers the opportunity to gain access to personal medical information and health care advertising. Their impact on Market Approach theories is significant.[170]

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167. Three statutes constitute the antitrust laws. They are the Sherman Antitrust Act, 15 U.S.C. §§ 1-7 (1976), Clayton Act, 15 U.S.C. §§ 12-27 (1976), and Federal Trade Commission Act, 15 U.S.C. §§ 41-58 (1976). The antitrust laws represent the view that market competition is a proper technique of social control. P. AREEDA, ANTITRUST ANALYSIS 5 (1981).

168. A complete antitrust analysis of the health care industry is beyond the scope of this Comment. For a more complete discussion *see* Borsody, *supra* note 163; Boubjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981) (discussion and comparison of the regulatory and competitive approaches); Leibenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927 (1981) (antitrust analysis and its relation to procompetitive theories); Richard, *Federal Antitrust Law and the* Royal Drug *Pharmacy Agreement: Implications for Formulating National Health Policy*, 34 OKLA. L. REV. 233 (1981) (discussion of the context and implications of the *Royal Drug* decision); Shapiro, *Cost Containment in the Health Care Field and the Antitrust Laws*, 7 AM. J. L. & MED. 425 (1982) (discussion of recent case law developments); *Symposium on the Antitrust Laws and the Health Services Industry*, 1978 DUKE L.J. 302 (comprehensive treatment of antitrust and health care); Note, *Antitrust and Health Care-Psychologists Entitled to Blue Shield Reimbursement*, 57 WASH. L. REV. 617 (1982) (cited for discussion of historical development of antitrust application to health care); Note, *Antitrust Exemption Denied for Health Planning Regulations*, 23 URB. L. ANN. 325 (1982) (emphasis on *National Gerimedical* decision); Note, *Antitrust-Implied Repeal of the Antitrust Laws by the National Health Planning Act*, 56 TUL. L. REV. 749 (1982) (cited for the discussion of development of antitrust analysis of the health care industry); Note, *Health Law-The Conflict with Antitrust Law-National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City*, 18 WAKE FOREST L. REV. 591 (1982) (emphasis on background and impact of *National Gerimedical* decision); Note, *Health Maintenance Organizations and the McCarran-Ferguson Act*, 7 AM. J. L. & MED. 437 (1982) (cited for discussion of potential antitrust liability of HMOs).

169. Antitrust laws are designed to discourage anticompetitive conduct, encourage competition and maintain the structure of the marketplace to facilitate the market process. Blumstein & Sloan, *supra* note 9, at 908. *See* P. AREEDA, *supra* note 167, at 1-135 (discussion of the economic and legislative context for antitrust analysis). Principal cases will be highlighted in this section. For referral to a complete discussion of the topic see note 168 *supra*.

170. *See* notes 221-29 *infra* and accompanying text (discussion of judicial decisions supporting increased consumer access to personal medical data and health care advertising).

1. Antitrust Developments

The health care industry has supported the idea that it should be exempt from the procompetitive influence of antitrust law. Prior to 1975, this argument was largely successful[171] due to the judicial acceptance of specific defenses such as the interstate commerce defense and the learned professions exemption.[172] The state action exemption[173] and the business of insurance exemption[174] have also been used to forestall antitrust scrutiny.[175]

The interstate commerce defense provided that health services were local transactions and did not affect interstate commerce, thus preventing application of the Sherman Act.[176] In 1976, the Supreme Court in *Hospital Building Co. v. Trustees of Rex Hospital*[177] exam-

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171. Note, *Antitrust-Implied Repeal of the Antitrust Laws by the National Health Planning Act*, *supra* note 168, at 750; Note, *Antitrust and Health Care-Psychologists Entitled to Blue Shield Reimbursement*, *supra* note 168, at 621.

172. Borsody, *supra* note 163, at 423.

173. *Id.* at 435. The theory of the state action exemption is that antitrust laws are not needed in areas where substitute regulation is present. *Id.* *See id.* at 435-40 (discussion of the state action exemption).

The principal cases discussed are Parker v. Brown, 317 U.S. 341 (1943) (regulation of state industry is a local concern in absence of congressional legislation prohibiting or regulating transactions affected by the state program), and Cantor v. Detroit Edison Co., 428 U.S. 579 (1976) (federal interest need not inevitably be subordinated to the state's).

174. Borsody, *supra* note 163, at 440. The theory of the exemption is that the business of insurance is exempt from the antitrust laws to the extent that state regulation controls. *Id.* *See id.* at 440-47 (discussion of the business of insurance exemption). For a discussion of the principal case, Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979) (pharmacy agreements between Blue Shield and pharmacy for purpose of providing drugs at cost to Blue Shield policyholders were not the business of insurance), see Richard, *supra* note 168.

175. *See* Note, *Antitrust Exemption Denied for Health Planning Regulations*, *supra* note 168, at 325 n.5. Exemptions are based on the concept that Congress can decide that regulation is preferable to competition in specific instances.

This section will discuss only the interstate commerce defense and the learned professions exemption. *See* note 173 *supra* (state action exemption). *See also* note 174 *supra* (business of insurance exemption).

While the interstate commerce defense and the learned profession exemption have been active judicial issues, they do not constitute the full range of health care antitrust inquiry. *See* Richard, *supra* note 168, at 242-43 (shared purchasing agreements and exclusive contracts are potential antitrust problems for health providers). *See also* American Medical Ass'n, 94 F.T.C. 701 (1979) (agreements not to advertise declared unlawful).

176. St. Bernard Gen. Hosp., Inc. v. Hospital Serv. Ass'n of New Orleans, Inc., 510 F.2d 1121 (5th Cir. 1975). The district court held that as a matter of law, "the rendition of hospital services is a purely local activity." The plaintiff could not show that restraint of this local activity substantially affected interstate commerce. *Id.* at 1123-24. The circuit court reversed. *Id.* at 1126.

177. 425 U.S. 738 (1976).

ined an antitrust allegation and found that the hospital's operations did have a substantial effect on interstate commerce.[178] Hospital Building Company, a for-profit corporation, operated Mary Elizabeth Hospital, a forty-nine bed facility offering general medical and surgical services to the public. Hospital Building alleged that three trustees of Rex Hospital, a private tax exempt hospital, conspired to block the relocation and expansion of Mary Elizabeth Hospital[179] for the purpose of monopolizing paid medical and surgical services in Raleigh, North Carolina.[180] Hospital Building alleged that numerous areas of interstate commerce were affected,[181] and the Supreme Court agreed that a cause of action under the Sherman Act had been stated.[182]

Since *Hospital Building* it has been suggested that the era of modern communication, mobile population and complex governmental and financial interactions have made the interstate commerce defense ineffective.[183] The defense has been sustained only in a narrow class of cases involving suits by single medical practitioners against institutional defendants.[184]

The second major antitrust defense to suffer a significant setback is the learned professions exemption. The leading case establishing this exemption for the medical profession was the 1952 Supreme Court decision in *United States v. Oregon State Medical Society*.[185] The government charged that the defendant societies, corporation and

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178. *Id.* at 739-40. The Supreme Court decision reversed two lower courts. The district court and the Fourth Circuit had found that the provision of hospital services was a local activity and the complaint did not allege a substantial effect on interstate commerce. *Id.* at 739.

179. *Id.* at 740. This conspiracy was alleged to have included delaying the state authorization for expansion, instituting frivolous litigation and instigating the publication of adverse information about the expansion. *Id.* at 741.

180. *Id.*

181. *Id.* These allegations included claims that 80% of the medicines and supplies bought by the hospital came from out of state sellers, a substantial number of patients were from out of state, insurance revenue was largely from out of state sources, the hospital paid a management fee to its parent company (a Delaware corporation based in Georgia), and finance plans totaling $4 million involved out of state lenders. *Id.* at 741.

182. *Id.* at 747.

183. Borsody, *supra* note 163, at 428.

184. *Id.* at 425-28 (discussion of this class of cases). *See* Wolf v. Jane Phillips Episcopal-Memorial Medical Center, 513 F.2d 684, 687 (10th Cir. 1975) (individual practice of medicine is intrastate activity).

185. 343 U.S. 326 (1952). This case was cited as the leading case in Borsody, *supra* note 5, at 429. An earlier case, Federal Trade Comm'n v. Raladam Co., 283 U.S. 643, 653 (1931), had stated that the medical profession was not a trade and therefore not subject to trade regulation.

doctors had conspired to restrain and monopolize the provision of prepaid medical care in Oregon and restrain competition among doctor-sponsored pre-paid medical plans within the state.[186] In addressing this charge, the District Court of Oregon stated that "[t]he sale of medical services . . . is not trade or commerce within the meaning of Section 1 of the Sherman Antitrust Law. . . ." The Supreme Court agreed.[187] The Court justified this exemption by citing ethical considerations of the doctor-patient relationship which are outside the realm of normal business activity regulated by the Sherman Act.[188]

In 1975 the Supreme Court in *Goldfarb v. Virginia State Bar*[189] rejected the argument that learned professions should be excluded from antitrust regulation.[190] In *Goldfarb*, a couple sought a lawyer to perform a title search in connection with the purchase of a home.[191] They were unable to locate any attorney who would perform the service for less than the minimum fee schedule published by the Fairfax County Bar Association.[192] The couple brought a class action alleging price fixing in violation of section 1 of the Sherman Act.[193] The Supreme Court found that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act."[194] The Court cited *American Medical Association v. United States*,[195] an antitrust case involving medical practitioners, as support for the proposition that sales of services have specifically been included in the scope of section 1 of the Sherman Act.[196] In addition, the Court stated that the public service characterization of professional practice does not justify a section 1 exemption.[197]

186. 343 U.S. at 330.

187. *Id.* at 338 (citing the district court at 95 F. Supp. 103, 118 (D. Ore. 1950)).

188. *Id.* at 336. The Court may also have been influenced by the apparent reform of the defendant medical society. Note, *Antitrust and Health Care-Psychologists Entitled to Blue Shield Reimbursement, supra* note 168, at 621 n.32 (discussion of both views on this "reforming" factor).

189. 421 U.S. 773 (1975).

190. *Id.* at 787.

191. Only members of the Virginia State Bar were authorized to perform the service. *Id.* at 775.

192. *Id.* at 776. The fee schedule was a list of recommended minimum prices for common legal services. The State Bar had published reports and ethical opinions supporting the use of fee schedules. *Id.* at 776-77.

193. *Id.* at 778.

194. *Id.* at 787.

195. 317 U.S. 519 (1943) (the AMA adopted "rules of ethics" which violated the Sherman Act by discouraging physicians from participating in or consulting with Group Health Association).

196. 421 U.S. at 787.

197. *Id.* This position was qualified, however, by a footnote which stated that professions may not always be interchangeable with businesses for purposes of the Sherman Act. The Court stated: "It would be unrealistic to . . . automatically . . .

After *Goldfarb*, the Supreme Court in 1978 found that a professional engineers' association's canon of ethics violated the Sherman Act.[198] The canon had been adopted for the purpose of minimizing the risk that competition would produce inferior engineering work and endanger the public safety.[199] The Supreme Court decided that this consideration did not allow the engineers to refrain from discussing project fees until after jobs were accepted.[200]

While the Supreme Court did cite *American Medical Association* as an illustration that professional services are not immune from antitrust examination, the Court has not ruled specifically on the medical learned professions exemption. Lower courts, however, have held that the *Goldfarb* restriction on the learned professions defense does apply to medicine. The Fourth, Fifth and Ninth Circuits have held that the medical status of physicians and dentists does not remove them from the scope of the antitrust laws.[201] In other circuits, plaintiffs have successfully alleged antitrust causes of action against medical practitioners. In these cases, the defendants did not attempt to use the learned professions exemption.[202] Moreover, recent successful medical antitrust defenses have not relied on a learned professions theory.[203]

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apply to the professions antitrust concepts which originated in other areas." *Id.* at 788 n.17.

198. National Soc'y of Professional Engr's v. United States, 435 U.S. 679 (1978).

199. *Id.* at 681.

200. *Id.* at 682-83.

201. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (conspiracy found where psychologists were forced to bill Blue Shield only through physicians); Ballard v. Blue Shield of S.W. Va., Inc., 543 F.2d 1075 (4th Cir. 1976) (denial of insurance coverage to chiropractors stated facts within federal court jurisdiction of the Sherman Act; professional status of physicians offered no defense); Hyde v. Jefferson Parish Hosp. Dist. No. 2, 686 F.2d 286 (5th Cir. 1982) (exclusive contract between hospital and professional medical association for anesthesia services was an illegal tying arrangement); Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530, 552-53 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (center with abortion clinic brought federal and state antitrust action against physician); Boddicker v. Arizona State Dental Ass'n, 549 F.2d 626, 630-32 (9th Cir. 1977) (learned professions exemption does not apply to dentists where an association required membership in national dental association as condition precedent to membership in local dental association).

202. Barry v. St. Paul Fire & Marine Ins. Co., 555 F.2d 3 (1st Cir. 1977) (antitrust cause of action was stated where suit charged that four insurance companies conspired to reduce malpractice coverage available to Rhode Island doctors through the medium of a boycott); American Medical Ass'n v. Federal Trade Comm'n, 638 F.2d 443 (2d Cir. 1980) (A.M.A. violated the F.T.C. Act when it took coordinated action to restrain advertising and solicitation); Bogus v. American Speech Hearing Ass'n, 582 F.2d 277 (3d Cir. 1978) (speech pathologist stated cause of action under Sherman Act where plaintiff challenged tying arrangement whereby association membership was a prerequisite to applying for, receiving and retaining a certificate of clinical

A difficulty with health care antitrust analysis is that it is a double-edged sword. It restricts anticompetitive conduct on the part of associations and competing providers and assists in establishing new providers.[204] However, it may also defeat some potential cost containment strategies.

In *Arizona v. Maricopa County Medical Society*,[205] members of a medical society and an insurance company constructed and published a maximum fee schedule.[206] The Supreme Court found the schedules to be price fixing and a violation of the Sherman Act.[207] In applying the per se rule against price fixing, the Court thus restricted the cost containment efforts of the insurer,[208] notwithstanding the public benefit of reducing health care expenditures.[209]

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competence); Williams v. St. Joseph's Hosp., 629 F.2d 448 (7th Cir. 1980) (cause of action under the federal antitrust laws was stated where plaintiff alleged that doctors in and around Joliet, Illinois were engaged in a conspiracy to refuse to treat any person or family member of any person who had instituted a malpractice suit against any doctor in the area); Crane v. Intermountain Health Care, Inc., 637 F.2d 715 (10th Cir. 1980) (pathologist stated claim for relief under the Sherman Act where he alleged that defendant and others had conspired to limit competition and fix prices in practice of pathology).

203. Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982) (substantial foreclosure of competition in relevent market not shown where exclusive contract for hospital anesthesia services was challenged); Federal Prescription Serv., Inc. v. American Pharmaceutical Ass'n, 663 F.2d 253 (D.C. Cir. 1981) (lobbying efforts of pharmacists and national associations of retail druggists were not a conspiracy to harm mail order pharmacy and did not violate antitrust laws).

204. Health Maintenance Organizations have been the victim of anticompetitive efforts aimed at restricting their development. In 1943 the American Medical Association conspired to discourage physicians from utilizing Group Health Association, an organization engaging in a group medical practice. American Medical Ass'n v. United States, 317 U.S. 519 (1943). *See* Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487, 493-99. HMOs have also faced charges of promoting unethical medicine, refusals to deal with HMO physicians and negative statements about HMOs by state and county medical societies. *Id. See also* Group Health Coop. v. King County Medical Soc'y, 39 Wash. 2d 586, 237 P.2d 737 (1951) (exclusion of HMO physicians from county medical society and hospitals and refusals to deal with HMO physicians).

205. 102 S. Ct. 2466 (1982).

206. *Id.* at 2470-71.

207. *Id.* at 2475. The Court noted: "We have not wavered in our enforcement of the per se rule against price fixing." *Id.* Maximum fees are as improper as minimum fees because the maximum fee quickly evolves into an actual uniform minimum fee. *Id.* at 2474-75.

208. The Court emphasized that some price fixing arrangements appear to be reasonable, but the aim and result of every price fixing agreement is to eliminate one form of competition. *Id.* at 2473. Therefore, the error in *Maricopa* was the *method* of cost containment, not the concept of reducing costs.

209. The dissent emphasized the public benefit of the *Maricopa* plan. *Id.* at 2480-85 (Powell, J. dissenting). The dissent noted that the *Maricopa* plan is a new method of providing medical services which does not involve coercion and seems to be in the

Further limitations were imposed on the cost containment efforts of insurers in *National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City.*[210] The Supreme Court held that a plan of health regulations promulgated by Blue Cross and designed to control the distribution of new hospital construction was not immune from antitrust scrutiny.[211] In *National Gerimedical,* a private hospital was denied a Certificate of Need from a local planning agency.[212] Based on this denial, Blue Cross refused to include the new facility in its 100% reimbursement program.[213] As a result of being excluded from the program, National Gerimedical would receive only eighty percent reimbursement.[214] The Court decided to bar Blue Cross from enforcing the policy of the National Health Planning and Resources Development Act of 1974.[215] This decision may actually thwart congressional intent to limit unneeded expansion.[216] The *National Gerimedical* and *Maricopa* decisions are two restrictions on the use of insurance

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public interest. *Id.* at 2480. Since the medical society "serves as an effective cost containment mechanism that has saved patients and insurers millions of dollars [it arguably does not violate the Sherman Act, which is] a law designed to *benefit* consumers." *Id.* at 2481 (emphasis in original). The dissent argued that in the absence of a complete factual record, the Court should not condemn a novel practice which may have substantial consumer benefits. *Id.* at 2485. *But see id.* at 2472-75 (discussion of the application of the per se rule against price fixing to this case).

210. 452 U.S. 378 (1981).

211. *Id.* at 393. The Court held that this immunity fails regardless of the proper motive of Blue Cross in seeking to implement the congressional legislative intent to avoid duplication of hospital services. *Id.* at 391.

212. *Id.* at 380-81. The Certificate of Need process is part of a statutory plan to prevent unneeded capital expenditures in health facilities. *Id.* at 383-88. *See* notes 90-93 *supra* (discussion of CON programs).

213. 452 U.S. at 381. Blue Cross policy was to exclude a new hospital if it could not show it was meeting "a clearly evident need for health care in a defined service area." *Id.* at 381. Blue Cross relied on a local "health systems agency" set up according to the National Health Planning and Resources Development Act of 1974 to make this determination. *Id.*

214. *Id.* at 380. In addition, the reduced payments are made directly to the subscriber rather than to the hospital. *Id.*

215. 452 U.S. at 388-91. Blue Cross claimed implied antitrust immunity because its policy promoted congressional intent. The Court stated that Congress did not intend the private company to enforce limitations on unneeded hospital expansion. *Id.* at 391. The Court also emphasized that Congress expected health systems agency planning to be implemented through persuasion and cooperation rather than through compulsion. *Id.*

216. *See* Note, *Health Law-The Conflict with Antitrust Law-National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City, supra* note 168, at 607. Observers have noted that the construction of hospital beds in Missouri has become uncontrollable. As many as 1,000 current beds may be unnecessary by 1987. In addition, the threat of antitrust liability has restricted Blue Cross's ability to assist in cost containment through the Certificate of Need Program. *Id.*

companies as enforcement mechanisms for cost containment. This is a setback for the Market Approach because insurance companies possess substantial purchasing power and thus could assist in implementing a competitive approach.[217]

Some alternative providers such as Health Maintenance Organizations, which have borne the burden of anticompetitive practices in the past,[218] may find themselves to be potential violators of the antitrust laws in the future. As HMOs grow in size and market power, their antitrust exposure increases. In addition, aggressive business practices by a small alternative provider could be viewed as an effort to reduce competition once that provider has become a major market force.[219] Moreover, if national health organizations acquire local HMOs, the potential concentration of market share may lead to charges of a tendency to monopolize the HMO segment of the health care market.[220]

2. Consent and Commercial Free Speech

Judicial support of the Market Approach can also be found outside the boundaries of antitrust analysis. Developments in the doctrines of informed consent and commercial speech have increased consumer access to information. Such access is essential if consumers are to have a stronger voice in determining the quality and price of a provider's services.[221]

The doctrine of informed consent has traditionally relied upon the judgment of the doctor to decide what information should be provided to the patient.[222] In 1972, however, the District of Columbia Circuit Court rejected the traditional professionally controlled standard and substituted a legal standard.[223] The court determined that

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217. *See* notes 156-57 *supra* and accompanying text (discussion of consumer power through group purchasing).

218. *See* note 204 *supra* (discussion of anticompetitive practices used against HMOs).

219. *See* Note, *Health Maintenance Organizations and the McCarran-Ferguson Act, supra* note 168, at 442 (discusses possibility of reduced competition between HMOs and private providers or among HMOs themselves).

220. *See id.* at 441-43 (potential violations of the antitrust laws by HMOs).

221. *See* notes 154-58 *supra* (discussing the role of consumers in a competitive health care market).

222. Blumstein & Sloan, *supra* note 9, at 902-08, *citing* J. KING, THE LAW OF MEDICAL MALPRACTICE 136 (1977).

223. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (patient submitted to spinal operation and later suffered significant paralysis). The court determined that the law, and not the individual doctors, would control the standard. The *Canterbury* approach represents important support for the Market Approach. Blumstein & Sloan, *supra* note 9, at 907. Pollard has identified this same

true consent is rooted in choice and such choice is not possible without knowledge of the available options and risks.[224] The court determined that the patient is capable of making an intelligent decision provided he is adequately informed and has discussed the situation with his doctor.[225]

Additional judicial support of the consumer's right to information was set forth in *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*[226] The Supreme Court held that consumers have a first amendment right to receive commercial speech in the form of advertising.[227] A Virginia statute made the advertising of prescription drug prices unprofessional conduct for the state's liscensed pharmacists.[228] The Court held that commercial speech is not wholly outside the constitutional protections because both the individual and society have a strong interest in the free flow of commercial information.[229]

While some judicial decisions such as *Maricopa County* and *National Gerimedical* limit the permissible activities in cost containment efforts, the courts have provided significant support to the competitive theory underlying the Market Approach. Direct support is evident in antitrust decisions such as *Hospital Building* and *Goldfarb*. Recent developments in the doctrines of informed consent and commercial speech have increased consumer awareness and support for the Market Approach theory. The Market Approach will need additional judicial support in the future if its cost containment efforts are to be implemented.

VI. Current Treatment of Tax Exempt Health Care Financing Under the Internal Revenue Code

There are no specific Internal Revenue Code provisions granting tax exempt status to financings of health care facilities in general or

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trend toward placing responsibility for health care expenditures with the consumers. Pollard, *supra* note 13, at 159.

224. 464 F.2d at 780.

225. *Id.* at 782. The court went on to note that, "it must be the exceptional patient who cannot comprehend such an explanation at least in a rough way." *Id.* at 782 n.27.

226. 425 U.S. 748 (1976).

227. *Id.* at 756. *See* Bates v. State Bar of Ariz., 433 U.S. 350 (1977). In the context of prohibitions on attorney advertising, the Court further stated that any justification which is based on the benefits of public ignorance is questionable. *Id.*

228. 425 U.S. at 749-50.

229. *Id.* at 761-65. Justice Rehnquist dissented, arguing that in considering a balance between free speech and public welfare, the interests of public welfare were strong in this case. *Id.* at 788-89. The dissent noted that consumers could obtain the

hospitals in particular. The interest on bonds issued for the benefit of health care facilities will be taxable unless certain exemption criteria can be met.[230] These criteria are significantly more favorable for health care facilities which qualify as exempt persons under section 501(c)(3)[231] than for those facilities which cannot qualify as exempt persons.[232] This section will discuss the provisions of the Internal Revenue Code which determine the tax status of interest on bonds issued for use by health care facilities.[233] In addition, this section will examine current standards of the charitable exemption.[234]

A. Financing Provisions

Section 103(a) states that interest on the obligations of certain governmental units including political subdivisions of those units will be exempt from federal income taxation.[235] Treasury Regulation section

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information by phone or in person, so the statute was not a restriction of the right to receive the information. *Id.* at 782 n.*.

230. The general rule is that income is subject to taxation unless there is an applicable exemption. *See* notes 254-56 *infra* and accompanying text (exemptions from the tax laws are narrowly construed).

231. I.R.C. § 501(c)(3) (1976). The section states:

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

Section 501(a) (1976) reads: "An organization described in subsection (c) . . . shall be exempt from taxation under this subtitle unless such exemption is denied under section 502 or 503." Section 502 states that for-profit "feeder organizations" will not be exempt merely because the profits are payable to an exempt organization. I.R.C. § 502(a) (1976). Section 503 states that exempt organizations cannot participate in certain "prohibited transactions." I.R.C. § 503(a)(1) (1976).

232. For a discussion of the use of bond financing by both exempt and non-exempt health care facilities, see notes 235-53 *infra* and accompanying text.

233. *See* notes 235-53 *infra* and accompanying text.

234. *See* notes 254-99 *infra* and accompanying text.

235. I.R.C. § 103(a) (1976). The section states:

> SEC. 103. INTEREST ON CERTAIN GOVERNMENTAL OBLIGATIONS.
>
> (a) General rule.—Gross income does not include interest on—

1.103-1(b) states that obligations issued by authorities empowered to issue such obligations are included in the scope of section 103(a).[236] Therefore, state or local hospital authorities[237] can issue tax exempt obligations.

Section 103(b) discusses "Industrial Development Bonds" which are taxable obligations under section 103(b)(1).[238] Section 103(b)(2) defines the characteristics of an industrial development bond[239] and states that any person who is an exempt person under section 103(b)(3) can avoid taxable status for their bonds.[240] Section 103(b)(3) states that an organization described in section 501(c)(3)[241] can use bond proceeds without those bonds being considered industrial development bonds.[242] Therefore, by avoiding the taxable status which accompanies the designation as an industrial development bond, the section 501(c)(3) organization can benefit from tax exempt bonds

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(1) the obligations of a State, a Territory, or a possession of the United States, or any political subdivision of any of the foregoing, or of the District of Columbia . . . .

236. Treas. Reg. § 1.103-1(b) (1972).

237. For a discussion of hospital authorities, see notes 114-15 *supra* and accompanying text.

238. I.R.C. § 103(b)(1) (1976). The section states:

(b) Industrial Development Bonds.—

(1)Subsection (a)(1) or (2) not to apply.—Except as otherwise provided in this subsection, any industrial development bond shall be treated as an obligation not described in subsection (a)(1) or (2).

239. I.R.C. § 103(b)(2) (1976). The section states:

(2) Industrial development bond.—For purposes of this section, the term 'industrial development bond' means any obligation—

(A) which is issued as part of an issue all or a major portion of the proceeds of which are to be used directly or indirectly in any trade or business carried on by any person who is not an exempt person (within the meaning of paragraph (3)), and

(B) the payment of the principal or interest on which (under the terms of such obligation or any underlying arrangement) is, in whole or in major part—

(i) secured by any interest in property used or to be used in a trade or business or in payments in respect of such property, or

(ii) to be derived from payments in respect of property, or borrowed money, used or to be used in a trade or business.

240. *Id.* § 103(b)(2)(A).

241. *See* note 231 *supra*.

242. I.R.C. § 103(b)(3) (1976). The section states:

(3) Exempt person.—For purposes of paragraph (2)(A), the term 'exempt person' means

(A) a governmental unit, or

(B) an organization described in section 501(c)(3) and exempt from tax under section 501(a) (but only with respect to a trade or business carried on by such organization which is not an unrelated trade or business, determined by applying section 513(a) to such organization).

issued by a hospital authority "on behalf of" a qualified governmental unit.[243]

Hospitals which cannot qualify as section 501(c)(3) organizations are confronted with a narrow tax exempt financing option. The obligations of these organizations will fit the definition of industrial development bonds as set forth in section 103(b)(2).[244] Therefore, under section 103(b)(1) the interest on these obligations will be taxable.[245] The tax exempt financing advantage offered by hospital authority financing will not be available to these non-section 501(c)(3) organizations.[246] The remaining option for these non-exempt organizations is to qualify their financing as an exemption from the industrial development bond category.[247] Section 103(b)(4) lists certain exempt activities which do not include hospitals and health care facilities.[248] An additional exemption possibility is the small issue exemption under section 103(b)(6).[249] This section allows an exemption for up to $1 million of

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243. Rev. Rul. 63-20, 1963-1 C. B. 24 expands on the I.R.S. position set forth in Treas. Reg. § 1.103-1, *supra* note 236, by stating five requirements which must be satisfied before a nonprofit corporation (hospital authority) will be able to issue obligations "on behalf of" a state or political subdivision. They are:

> (1) the corporation must engage in activities which are essentially public in nature; (2) the corporation must be one which is not organized for profit (except to the extent of retiring indebtedness); (3) the corporate income must not inure to any private person; (4) the state or a political subdivision thereof must have a beneficial interest in the corporation while the indebtedness remains outstanding and it must obtain full legal title to the property of the corporation with respect to which the indebtedness was incurred upon the retirement of such indebtedness; and (5) the corporation must have been approved by the state or a political subdivision thereof, either of which must also have approved the specific obligations issued by the corporation.

Hospitals and health care organizations which have attained § 501 (c)(3) status will not violate these requirements.

244. *See* note 239 *supra*.

245. *See* note 238 *supra*.

246. *See* R. LAMB & S. RAPPAPORT, *supra* note 104, at 187-88. The authors note, "the private, full-profit hospitals are only allowed to issue up to $10 million in tax-exempt bonds to finance capital additions." *Id.* at 187. The other three types of hospitals, federal government hospitals, state and municipal hospitals and not-for-profit hospitals, can finance their capital needs through either federal taxes or tax-exempt revenue bonds. *Id.* at 187-88. *See* Rev. Rul. 63-20, *supra* note 243 (for-profit health care facilities could not satisfy the five requirements necessary to utilize a hospital authority).

247. *See* notes 248-49 *infra* (discussion of these exemptions).

248. I.R.C. § 103(b)(4) (1976, Supp. II 1978, Supp. III 1979, Supp. IV 1980, Supp. V 1981 & West Supp. 1982). This section includes exemptions for qualified rental properties, sports facilities, convention facilities, airports, docks, waste disposal facilities, pollution control facilities, etc. Hospitals or health care facilities are not included in the list.

249. I.R.C. § 103(b)(6)(A) (1976). The section states:

> (6) Exemption for certain small issues.—

bonds for use by a restricted class which may include qualifying hospitals.[250] The ceiling can be increased to $10 million in certain cases.[251] The limitations on raising the ceiling are connected to methods of computing the value of the bond issue. For the purposes of section 103(b)(6), bond issues for three years on each side of the subject bond issue are aggregated in reaching the $10 million maximum.[252]

While the $1 million and $10 million provisions of section 103(b)(6) have been utilized by hospitals, the capital needs of the health care industry require a larger source of financing.[253] Tax exempt hospital revenue bonds issued by a state or local authority for the benefit of a hospital are only availiable to organizations which qualify as section 501(c)(3) exempt organizations. Health organizations which operate for profit do not have this option because they do not qualify as a religious, charitable, scientific, or educational organization under section 501(c)(3).

B. Exemption Provisions

The Supreme Court has stated clearly that exemptions from the tax laws are to be narrowly construed by the courts. In *HCSC Laundry v.*

> (A) In general.—Paragraph (1) shall not apply to any obligation issued as part of an issue the aggregate authorized face amount of which is $1,000,000 or less and substantially all of the proceeds of which are to be used (i) for the acquisition, construction, reconstruction, or improvement of land or property of a character subject to the allowance for depreciation, or (ii) to redeem part or all of a prior issue which was issued for purposes described in clause (i) or this clause. . . .

250. Substantially all of the proceeds of the $1 million issue must be used, "(i) for the acquisition, construction, reconstruction, or improvement of land or property of a character subject to the allowance for depreciation, or (ii) to redeem part or all of a prior issue which was issued for purposes described in clause (i) or this clause." I.R.C. § 103(b)(6)(A). *See* note 249 *supra*.

251. I.R.C. § 103(b)(6)(D) (1976 & Supp. II 1978). Explanations of the criteria for the $10 million ceiling are found in § 103(b)(6)(E)-(I) (1976, Supp. II 1978, Supp. III 1979, Supp. IV 1980, Supp. V 1981 & West Supp. 1982). *See* Treas. Reg. § 1.103-10 (1977) (discussion of the small issues exemption).

252. I.R.C. § 103(b)(6)(D)(ii) (1976). The section states:

> (ii) in determining the aggregate face amount of such issue, by taking into account not only the amount described in subparagraph (B), but also the aggregate amount of capital expenditures with respect to facilities described in subparagraph (E) paid or incurred during the 6-year period beginning 3 years before the date of such issue and ending 3 years after such date (and financed otherwise than out of the proceeds of outstanding issues to which subparagraph (A) applied), as if the aggregate amount of such capital expenditures constituted the face amount of a prior outstanding issue described in subparagraph (B).

253. *See* note 131 *supra* and accompanying text (discussion of the capital needs of the health care industry).

United States,[254] a hospital service organization was denied an exemption under I.R.C. section 501(c)(3).[255] The Court noted that, "[u]nder our system of taxation . . . every element of gross income of a person, corporate or individual, is subject to tax unless there is a statute or some rule of law that exempts that person or element."[256]

Moreover, courts also have been explicit in limiting the use of tax exemptions to their narrowly defined purpose. In *Kirkpatrick v. United States*,[257] the Tenth Circuit addressed the issue of the use of proceeds of a tax exempt bond issue offered for a hospital. In *Kirkpatrick*, interest on the bonds was held to be taxable because a major portion of the benefit of the bond issue was used in the trade or business of persons who were not exempt persons.[258] The hospital built an office building but a major portion of the building's subtenants were not exempt.[259] The court found that the legislative intent of sections 103, 501 and 513,[260] when considered together, was to assure that exempt organizations could not be used as conduits to enable nonexempt persons to receive benefits arising from the use of bond proceeds in their trade or business.[261]

The Internal Revenue Service has established four requirements which a hospital must fulfill to comply with section 501(c)(3).[262] First, the hospital must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick.[263]

254. 450 U.S. 1 (1981).

255. The exemption was denied under § 501(c)(3) because this cooperative service organization was specifically controlled by another Code section, § 501(e). In addition, the legislative history of § 501(e) was specific in stating that these organizations were not subject to a § 501(c)(3) exemption. 450 U.S. at 6-7.

256. *Id.* at 5.

257. 605 F.2d 1160 (10th Cir. 1979).

258. *Id.* at 1161, 1163. The hospital used tax exempt bonds to lease an office building. The hospital then subleased the offices to nonexempt persons. *Id.* at 1161.

259. *Id.*

260. I.R.C. § 513(a) (1976) (stating general rule for determining what is an unrelated trade or business). This section provides that any trade or business which is not substantially related to the organization's charitable or other exempt purpose is an unrelated trade or business. I.R.C. § 511(a) (Supp. II 1978) imposes a tax on unrelated business income of charitable and other exempt organizations.

261. 605 F.2d at 1162. The Conference Committee Report on what is now I.R.C. § 103(b)(2) stated that an obligation is an industrial development bond and thus taxable if all or a major portion of its proceeds "are to be used to construct facilities to be leased to any person who will in turn lease them to another person who is not an exempt person for use in a trade or business carried on by him . . . ." CONF. REP. No. 1533, 90th Cong., 2d Sess., *reprinted in* 1968 U.S. CODE CONG. & AD. NEWS, 2373, 2381.

262. Rev. Rul. 56-185, 1956-1 C.B. 202, *as modified by* Rev. Rul. 69-545, 1969-2 C.B. 117. *See* note 263 *infra* (discussion of Rev. Rul. 69-545).

263. The mere fact that one maintains a hospital does not ensure that the first requirement will be met. Sometimes more than the diagnosis and cure of disease is

Second, the hospital must be operated for the care of all persons in the community who are able to pay the cost, either directly or through third party reimbursement.[264] Third, the hospital must not restrict the use of its facilities to a particular group of physicians and surgeons to the exclusion of all other qualified doctors.[265] Fourth, the hospital

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necessary for a health facility to qualify as a charitable organization. Sonora Community Hosp. v. Commissioner, 397 F.2d 814 (9th Cir.), *aff'g* 46 T.C. 519, 525-26 (1966) (the community hospital operated to a substantial degree for the benefit of the founding doctors and the amount of free health care rendered was less than one percent of paid care. Charitable contributions may be relatively low but serious questions are raised where the contributions are inconsequential).

In Revenue Ruling 69-545 the I.R.S. set forth certain characteristics for both exempt and non-exempt hospitals. "Hospital A" was declared exempt. Among its characteristics were: (1) a Board of Trustees composed of prominent members of the community, (2) facilities available to all qualified physicians in the area consistent with the size of the facility, (3) leases of medical office space at reasonable rates, (4) referrals of persons who could not pay their expenses to another hospital in the community which serves indigents, and (5) excess funds applied to expand and repair facilities and equipment, amortize debt, improve patient care, and provide medical training, education and research. In contrast, "Hospital B" was refused tax exempt status. Among its characteristics were (1) the Board of Trustees was limited to five doctors, their lawyer and accountant, (2) applications of many qualified doctors in the community for staff privileges had been rejected, (3) admissions were ordinarily limited to those who could pay for the services, (4) the hospital operated a relatively inactive emergency room and encouraged ambulance services to take patients elsewhere, and (5) the rentals paid by Board of Trustee member doctors for office space in the hospital were less than those paid for other office space in the community. Rev. Rul. 69-545, 1969-2 C.B. 117-18.

264. Originally, the charitable hospital had to provide free or below cost service to those unable to pay. Rev. Rul. 56-185. This was modified to state that a hospital could qualify as tax exempt by promoting the health of those in the community who could pay and by providing free emergency service. Rev. Rul. 69-545. This has been called the Community Benefit Approach. Sound Health Ass'n v. Commissioner, 71 T.C. 158, 181 (1978) (Health Maintenance Organization held to serve a public interest. HMO not engaged in a form of insurance and is therefore organized and operated exclusively for charitable purposes. HMO qualifies as a § 501(c)(3) organization).

The Commissioner acquiesced in the Tax Court decision relating to the issue of whether Sound Health Associates, "which provides health care services to its members on a prepaid basis, and to nonmembers on a fee for service basis is exempt from federal income tax under § 501(a) . . . as an organization described in § 501(c)(3) or whether it serves the private interests of its members and therefore is not operated exclusively for charitable purposes." 1981-2 C.B. 4 n.36.

The IRS cautions that acquiescence in a decision means acceptance of the conclusion reached and not necessarily the reasons assigned by the court for its conclusions. 1981-2 C.B. 1. The constitutionality of Rev. Rul. 69-545 has been upheld. Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), *vacated and remanded*, 426 U.S. 26 (1976). Several low income individuals and organizations representing such individuals claimed that Rev. Rul. 69-545 encouraged the denial of services to indigents. The circuit court upheld Rev. Rul. 69-545 on the merits and the Supreme Court found lack of standing.

265. In *Sonora Community Hospital*, this standard was not met. 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968). The hospital was found to be

must not permit any of its earnings to directly or indirectly benefit any private shareholder or individual.[266]

"operated to a substantial degree for the benefit of its founding doctors, who together with their associates were the source of 90% of the patients treated at the hospital, and who through private arrangements with the Ruckers were the beneficiaries of one third of the gross receipts of the X-ray department and clinical laboratory which the Ruckers operated at the hospital." 46 T.C. at 526.

266. It is also clear that an organization does not serve a private interest merely because it pays a reasonable salary to its manager, officers or employees. B.H.W. Anesthesia Found., 72 T.C. 681, 685 (1979). In *B.H.W.*, the court examined a corporation affiliated with the Boston School for Women and Harvard Medical School, both of which were exempt under § 501(c)(3). The members of the Foundation provide all their services to the department of anesthesiology. A large part of the receipts is applied toward the physicians' salaries. *Id.* at 682-83. The court found that the Foundation was not merely the incorporation of the members' private medical practice. *Id.* at 687. Rather, the payments were reasonable salaries within the context of a case where the anesthesiology department of an otherwise exempt hospital had incorporated. The Foundation was found to be continuing to serve the hospital patients and applying its operating revenues toward the purpose and for the benefit of the hospital generally. 72 T.C. at 687. In University of Mass. Medical School Group Practice, 74 T.C. 1299 (1980) the court reached a similar result. Group Practice was created to serve as a component of the University of Massachusetts Medical School and its teaching hospital. *Id.* at 1301. Faculty members of the school participated in a clinical program in which the Group Practice collected fees and deposited them in a trust. The trust paid the salaries and non-cash benefits of the members of the Group Practice, with the salary determined by the trustees of the University of Massachusetts. *Id.* at 1301-03. The court held that the IRS had erred in failing to rule that Group Practice was a § 501(c)(3) organization. Contrary to the IRS interpretation, the main purpose of Group Practice was not to collect fees for services rendered by the doctors and then return the fees to them. *Id.* at 1305. Rather, the court cited *BHW Anesthesia Found.* in determining that the salaries paid were reasonable. *Id.* at 1306. The payment of reasonable salaries does not defeat the exemption of an otherwise exempt organization. *Id.*

The concept of reasonable salaries is distinguished from cases where participants in an organization derived substantial private benefit from their affiliation. In Baltimore Regional Joint Bd. Health & Welfare Fund, 69 T.C. 554 (1978), employees of a fund which operated child day care centers and provided physical examinations were charged lower rates than "public" children. The court held that the Fund was not a § 501(c)(3) organization operated exclusively for charitable purposes because a substantial portion (24%) of its receipts were returned to members in the form of medical benefits. *Id.* at 557-58. Similarly, in Lorain Ave. Clinic, 31 T.C. 141 (1958) the court held that the clinic was not operated for charitable purposes because the doctors associated with the clinic were the only beneficiaries of its operation. In addition, the clinic failed to produce records of the number of patients who received free or below cost medical care. *Id.* at 159-60. *See* Sonora Community Hosp., 46 T.C. 519 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968) (community hospital operated for the benefit of the founding doctor).

The concept of "reasonable" salaries has also been applied in determinations concerning facilities owned by an exempt person and operated by a nonexempt management company, Rev. Proc. 82-14, 1982-1 C.B. 459, or non-exempt person, Rev. Proc. 82-15, 1982-1 C.B. 460. In these cases, the IRS position is that any management contract or contract with a non-exempt person must be based on compensation which is reasonable in relation to the services performed. Further, increases may not be excessive and the IRS suggests using the Consumer Price Index

The I.R.S. discussion of exempt health care financing has focused on hospitals. The I.R.S. has not specifically addressed alternative delivery systems, but the experience of Health Maintenance Organizations is a valuable guide. HMOs were given specific congressional encouragement by the Health Maintenance Organization Act of 1973,[267] yet the I.R.S. maintained a hostile position regarding examinations of tax exempt status and seriously hindered the natural growth of these organizations.[268] In 1978, an HMO named Sound Health

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as a standard for determining increases. Rev. Proc. 82-14, *supra*, Rev. Proc. 82-15, *supra*.

The Tax Court has determined that if the founder of a hospital maintains his private offices at the hospital for his private medical practice, this is not necessarily a violation of the exemption criteria. R.C. Olney, 17 TAX CT. MEM. DEC. (CCH) 982, 23.265(M), T.C. Memo 1958-200 (1958). In *Olney*, a foundation constructed a hospital which it operated for the benefit of any staff members who wished to join while not denying admission to any patient regardless of ability to pay. The hospital was held to be exempt. *Id.* at 992. *But cf.* Lowry Hospital Ass'n, 66 T.C. 850 (1976), where the hospital failed to show that the integration of the founding doctor's medical practice with the operations of the hospital did not inure to the benefit of the founding physician. *Id.* at 860. In *Lowry*, the corporation made loans to the physician. The court found that the loans were not in the corporation's best interests and would not have been made in the absence of the special relationship. *Id.* at 858-59. The transaction was not at arms length. *Id.* However, where the transaction is at arms length, a hospital's exempt status will not be lost where it enters into an agreement with a hospital-based radiologist providing for compensation based on a fixed percentage of the departmental income. Rev. Rul. 69-383, 1969-2 C.B. 113.

A hospital may also charge fees to its doctor staff under certain conditions where the purpose of such fees is to raise money to build a new hospital. The fees may be required, but may not be unreasonable in amount or discriminatory in application. Rev. Rul. 65-269, 1965-2 C.B. 159.

267. 12 U.S.C. § 1721; 42 U.S.C. §§ 201 note, 280c, 300e to 300e-14, 2001 (1976). The Act provided HEW financial support for feasibility studies, planning and development. *See* Bromberg, *Obtaining a 501(c)(3) Exemption for an HMO Should Be Easier Now Despite IRS Objections*, J. TAX'N., Nov. 1979, at 302 (discussion of exemptions for HMOs); *see also* note 45 *supra* and accompanying text (discussion of the definition of a Health Maintenance Organization); notes 119-21 *supra* and accompanying text (discussion of HMOs and their relationship to tax exempt financing).

268. Bromberg, *supra* note 267, at 302. The IRS had granted § 501(c)(4) (1976) exemptions (organizations operated exclusively for the promotion of social welfare) to HMOs but its unpublished general position for 30 years had been to deny a § 501(c)(3) exemption. This is particularly damaging to health care organizations because it deprives them of potential support from private foundations, corporations and individual donors. Such donations are typically made under I.R.C. § 170(a)(1) (1976) (deductions for charitable contributions and gifts). Contributions to § 501(c)(3) organizations are deductible; contributions to § 501(c)(4) organizations are not deductible. *Id.*

In spite of this general position, as many as 10% of the HMOs received § 501(c)(3) exemptions anyway, probably because of (1) a distinct orientation toward providing services to indigents through the use of federal funds or (2) close association with a university health, education and research program. *Id.*

Association challenged an I.R.S. denial of section 501(c)(3) status.[269] The Tax Court held for the HMO.[270] Significantly, the court applied the hospital standards of the section 501(c)(3) qualification to determine if the HMO should receive section 501(c)(3) status. The court stated, "[h]aving determined without difficulty that the rendering of medical care is a charitable activity, it is reasonable to conclude that the tests applied to determine the status of a hospital are relevant to a determination of the status of an HMO. Clearly, both types of organizations must qualify as charitable under 501(c)(3) on the basis of the health care services that they provide."[271] The same could be said of any other type of alternative delivery system.[272]

If an alternative delivery system is examined under the hospital criteria, it must attain a "charitable" designation to qualify for exempt status. This will be difficult because the I.R.S. has applied the charitable exemption criteria strictly. In *Federation Pharmacy Services*[273] the petitioner was a nonprofit corporation which operated a pharmacy for the purpose of selling drugs at a discounted cost to elderly and handicapped persons.[274] The Tax Court held that the Federation failed to show that it was operated exclusively for charita-

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269. 71 T.C. 158 (1978).

270. *Id.* at 191. *See* note 264 *supra* (Commissioner acquiesced to the decision in 1981). Hospitals have utilized tax exempt bonds to build facilities which offer services similiar to those offered by HMOs. *See, e.g.*, Lttr. Rul. 8208200, Nov. 30, 1981 (bonds to provide facilities for hospital-sponsored, direct service health care on a prepaid basis). Private letter rulings may not be cited as precedent. I.R.C. § 6110(j)(3) (1976).

271. 71 T.C. at 178-79.

272. Courts had previously analogized nursing homes to hospitals when confronted with the issue of their tax exempt charitable status. Evangelical Lutheran Good Samaritan Soc'y v. County of Gage, 181 Neb. 831, 836, 151 N.W.2d 446, 449 (1967) (property used for nursing home exempt from taxation because the home is operated by a nonprofit corporation which does qualify as a charitable institution).

The question of what is a health care institution has also been the subject of debate. In North Suburban Blood Center v. NLRB, 661 F.2d 632 (7th Cir. 1981), the Board claimed that the blood bank was not a health care institution and thus was not subject to provisions of the National Labor Relations Act which minimized disruption of patient care services. The court found that although blood banks need not automatically be classified as health care institutions, *id.* at 635, this blood bank was such an institution because it was integrally related to the hospitals it served. *Id.* at 637.

273. 625 F.2d 804 (8th Cir. 1980).

274. *Id.* at 805. The record failed to describe the exact criteria for obtaining a card which would allow purchases of the drugs at a discount. However, Federation did identify its goal of selling its drugs at a 5% discount from the lowest price found in an area survey to be conducted periodically. All customers, however, would be required to pay for their drugs. Significantly, no guarantees of sales below cost or distribution of free drugs to indigent persons were made. *Id.* at 806.

ble purposes because it was created to sell drugs and thus competed with profit-making enterprises.[275] The court stated the danger of providing too wide a health exemption: "Virtually everything we buy has an effect, directly or indirectly, on our health. We do not believe that the law requires that any organization whose purpose is to benefit health, however remotely, is automatically entitled, without more, to the desired exemption."[276] A vigorous dissent argued that the "courts have defined 'charity' to be something more than mere alms-giving or the relief of poverty and disease, and have given it a significance broad enough to include practical enterprises for the good of humanity operated at a moderate cost to those who receive the benefits."[277] The dissent argued that the drugs were used in the prevention of disease and illness and promoted health generally.[278] In the absence of commercial purpose, these were said to be adequate grounds for tax exemption.[279]

The District of Columbia Circuit affirmed the Tax Court denial of the exemption.[280] The court found that Federation made no accommodation for those unable to pay for their drugs and was therefore in competition with for-profit pharmacies in the area.[281] The organiza-

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275. 72 T.C. 687, 691-92 (1979). The Tax Court stressed that the Federation's exclusive purpose for existence was to sell drugs, which is an activity normally carried on as a profitmaking enterprise. *Id.*

276. *Id.* at 692. The original burden is on the taxpayer to prove that he falls within the intent of the statute and in *Federation*, the court was not satisfied this had been accomplished. *Id.* at 691. The dissent responded that the prescription drugs were specifically applied to the mitigation of disease and illness: "If the sale of those drugs does not *directly* and *immediately* promote health, nothings does." *Id.* at 695 (emphasis in original).

277. *Id.* at 695 (Tietjens, J., dissenting) (citing Young Men's Christian Ass'n v. Lancaster County, 106 Neb. 105, 111, 182 N.W. 593, 595 (1921)). In *YMCA* the court examined a petition for exempt status where the institution had not managed to run at a profit for the preceding year. The court noted, "[r]eason and authority are opposed to the proposition that an institution otherwise charitable will be deprived of that character by the mere fact that charges for facilities and services are made to individual members. . . ." 106 Neb. 105, 111, 182 N.W. 593, 595. *Accord* Evangelical Lutheran Good Samaritan Soc'y v. County of Gage, 181 Neb. 831, 836, 151 N.W.2d 446, 449 (1967). The County challenged the charitable status of a nursing home. The court analogized the nursing home to a hospital. Further, the court noted that with the introduction of modern social programs and the decline of private gifts, provision of free services is not the best standard for determining the status of charitable organizations. *Id.*

278. 72 T.C. at 697 (Tietjens, J., dissenting).

279. *Id.* *See* note 264 *supra* (Rev. Rul. 69-545 relaxed previous standards for determining charitable status).

280. 625 F.2d at 809.

281. *Id.*

tion's provision of a discount for senior citizens belonging to the Federation was insufficient to earn a charitable status.[282]

The Fifth Circuit recently made a strict distinction regarding the exempt status of hospital pharmacy sales. In *Hi Plains Hospital v. United States*,[283] the court found that pharmacy sales to non-hospitalized patients of doctors on the institution's staff did not generate taxable income. The number of such transactions was limited and the court said that such sales were necessary to attract doctors to the hospital to enable it to fulfill a charitable purpose.[284] Sales by the hospital pharmacy to the public, however, were taxable income despite the fact that during most of the hospital's existence, its area of service was not served by any other pharmacy.[285] The lower court applied a restrictive analysis to Hi Plains' argument that its pharmacy sales to the public were exempt, finding that the exemption would operate only if the benefits "relate to the hospital."[286] The Fifth Circuit remanded the case back to the lower court to determine if the sales were minor and occasional and therefore exempt.[287] This limited sales requirement, however, would preclude the hospital pharmacy from offering any substantial community benefit to the public while maintaining exempt status. Providing the benefit would be an exempt activity only if it related directly to the operation of the hospital.

The Tax Court also has utilized a strict interpretation of "charitable" activity in evaluating health service companies. Those companies which include non-exempt organizations among their clients and which compete with other commercial firms carry a heavy burden when attempting to attain exempt status. In *B.S.W. Group, Inc.*,[288] an organization was formed to provide consulting and research serv-

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282. *Id.* at 806. *See* Medical Diagnostic Ass'n v. Commissioner, 42 B.T.A. 610, 615-16 (1940) (medical laboratory providing services to physicians at cost with intent that the physicians charge lower fees to indigent patients held not charitable).

283. 670 F.2d 528 (5th Cir. 1982).

284. *Id.* at 531-33.

285. *Id.* at 533. Generally, sales to nonpatients will generate unrelated trade or business income because they are not related to the hospital. *Id. See generally* Lttr. Rul. 8135016 (undated) (hospital testing of laboratory specimens taken at private doctor's offices subject to patient/nonpatient distinction). An exception can be made where the testing results in important contributions to the hospital's exempt purpose. *See generally* Lttr. Rul. 8124006 (undated) (discussion of factors to be weighed, including the needs of the community and hospital, degree of private benefit served and level of competition with commercial laboratories). Private letter rulings may not be cited as precedent. I.R.C. § 6110(j)(3) (1976).

286. 670 F.2d at 533.

287. *Id.*

288. 70 T.C. 352 (1978).

ices to exempt and non-exempt clients.[289] The non-exempt clients were, however, nonprofit organizations.[290] Although the general policy was to provide consulting services at or near cost, the fees provided for a modest profit.[291] The Tax Court focused on the issue of whether the organization was operated exclusively for an exempt purpose under section 501(c)(3)[292] and determined that it was not.[293] The court noted that furnishing managerial services at cost is not an exempt activity because it lacks any indication of donative intent.[294] Providing the same services to exempt organizations at substantially below cost, however, would have been a basis for an exemption.[295] In *B.S.W.*, the court also declared that it would have been "sympathetic" to B.S.W.'s exemption request if the corporation had acted only to further exclusively exempt purposes.[296] B.S.W., however, had acted as a conduit linking individual researchers with both exempt and non-exempt client organizations.[297] The court was concerned by the fact that commercial firms did not participate in this field of consulting, but this did not alter the court's conclusion.[298] The fact that such businesses are normally carried on for profit placed a burden on this petitioner to show otherwise.[299]

Under current I.R.S. and court determinations, for-profit alternative delivery systems cannot meet the qualification standards for exempt status. The hospital tax exemption criteria which *Sound Health* applies to HMOs and impliedly to other alternative delivery systems will not accommodate many types of new health care providers. *Federation Pharmacy* narrowed the exemption criteria further by finding that a health care provider who offers lower cost services will not qualify as a charitable organization even if significant discounts are widespread in the community. *B.S.W.* illustrates that even a modest profit will be fatal to an exemption application. These rulings severely limit the range of tax exempt health care activities.

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289. *Id.* at 354-55.
290. *Id.*
291. *Id.* at 355.
292. *Id.* at 353.
293. *Id.* at 360-61.
294. *Id.* at 356, *quoting* Rev. Rul. 72-369, 1972 C.B. 245. The I.R.S. stated that such provision of services for a fee is a trade or business ordinarily carried on for profit. Providing the services solely for exempt organizations does not overcome the fact that the transaction lacks the donative intent needed to qualify as charitable. Rev. Rul. 72-369, *supra.*
295. 70 T.C. at 356, *citing* Rev. Rul. 71-529, 1971-2 C.B. 234.
296. 70 T.C. at 359.
297. *Id.* This is not inherently charitable, educational or scientific activity. *Id.*
298. *Id.* at 361.
299. *Id.* at 358.

VII. Tax Exempt Financing as a Component of the Market Approach

The argument for broader tax exempt financing of health care facilities is made against established criticism.[300] Nevertheless, it is a

300. Whether tax exempt financing should be available for *any* health care facilities is a different question from whether only *some types* of providers should be eligible for its use. This footnote will raise the issues relating to tax exempt financing to benefit health care facilities generally.

Tax exempt financing has been criticized as an economically inefficient subsidy and a misallocation of public funds. Each of these criticisms will be discussed.

Tax exempt financing has been described as economically inefficient because the federal government essentially foregoes tax revenues in exchange for private lenders demanding lower interest rates from the health providers. *See* Gabinet, *The Municipal Bond Interest Exception: Comments On A Running Battle*, 24 CASE W. RES. L. REV. 64, 66 (1972) (referring to this exchange as a subsidy); *see also* D. COHODES & B. KINKEAD, HOSPITAL CAPITAL FORMATION IN THE 1980'S—IS THERE A CRISIS? 198-99 (August 1982) (the Senate Budget Committee estimated that each $1 of interest savings to institutions using tax exempt hospital bonds cost the government $1.33 in lost tax revenue).

To the extent that tax exempt financing may contribute to unnecessary construction and renovation of health facilities, it is economically inefficient. *See* Harris, Eizenstat, Kahn, McIntyre, Press & Schultze, Memorandum to the President, April 24, 1980, *reprinted in* 126 CONG. REC. H4383-84 (daily ed. May 30, 1980) (an estimated 130,000 excess beds contribute to $4 billion in unnecessary payments). Members of the Carter Administration recommended a reduction in tax exempt financing to reduce unneeded health facility expansion. *Id.* (proposing legislation to subject tax exempt bond financings to more strenuous review). The Reagan Administration has also considered restrictions on tax exempt revenue bonds for hospitals. *See* D. COHODES & B. KINKEAD, *supra*, at 197-98 (discussion of the proposed Reagan restrictions).

Opponents of tax exempt financing for health care also argue that the health care industry will not respond to market conditions even if they can be created. *See* Pollard, *supra* note 13, at 159 (this argument states that (1) medicine is too complex for consumers to understand, (2) patients are too sick to evaluate alternatives and performance and (3) in the health care industry, increased supply will stimulate demand rather than reduce price).

In addition to noting economic inefficiencies created by tax exempt financing, critics argue that it provides an improper benefit to private individuals. *See* note 21 *supra* (discussion of tax benefits to investor of the exemption). *See also* Kochan, Bond Market Comment, Merrill Lynch Pierce Fenner & Smith, Vol. 5 No. 50, Dec. 17, 1982, at 4 (in 1982, individuals purchased an estimated 90% of new municipal bond issues).

Supporters of tax exempt financing dispute both the economic inefficiency and improper private benefit criticisms. First, they note that the tax exempt financing process applies market scrutiny to proposed financings. *See* West, *Efficiency of the Securities Markets*, in HANDBOOK OF FINANCIAL MARKETS: SECURITIES, OPTIONS, FUTURES 20-28 (1981) (discussion of operational and pricing efficiency of the market). If a health care bond issuer were an unreasonable risk, market financing would result in reduced demand for the debt instruments. *See* Fabrozzi, *supra* note 117, at 29-31 (discussion of the credit rating agencies and the role of ratings in determining the marketability of bonds).

reasonable option in light of the inability of the current health care system to provide affordable medical services. Tax exempt financing could be utilized to implement a competitive approach to health care delivery by enabling alternative delivery systems to enter the health market.[301]

Health care in the United States is a sophisticated and capital intensive industry. One recent hospital improvement and expansion required the issuance of $228,260,000 of Hospital Improvement Revenue Bonds.[302] Within the health care industry, some providers receive government sponsored assistance in capital financing. Those health providers which can qualify as nonprofit charitable facilities can issue tax exempt revenue bonds through issuing authorities at interest rates significantly lower than taxable bonds.[303] The lower financing cost of

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Second, supporters of tax exempt hospital bonds dispute the charge that the bonds have stimulated unneeded construction and renovation. HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 7-9 (noting the effect of inflation on the measurements of actual bond financings and the declining percentage of hospital bonds as part of the municipal bond market).

Third, the assumption that the health care system will not respond to economic principles of supply and demand has been questioned. *See* Pollard, *supra* note 13, at 167 (stating that if the market mechanism works in other economic sectors, we cannot *assume* that health care is different). *See also* C. HAVIGHURST, *supra* note 91, at 3 (lack of experience with a competitive health care system precludes assumptions about health care's ability to respond to a competitive market).

Finally, while tax exempt bonds do provide a private benefit for the investor, this benefit represents congressional intent to encourage specific types of private activity. The alternative is coercion or programs which tax and then return those revenues in the form of grants. *See* I.R.C. § 501(c) (1976) (discussing 23 types of exempt organizations including nonprofit *cemetery companies and burial corporations*. I.R.C. § 501(c)(13) (1976)). In addition, supporters of tax exempt financing argue that without such financing, many hospitals would be excluded from the capital market, possibly forcing closure. HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 21-24. *See* D. COHODES & B. KINKEAD, *supra*, at 28 (closures have the most impact on the poor and elderly; financial problems account for 27% of all hospital closings).

301. *See* notes 45-52 *supra* and accompanying text (discussion of different types of alternative delivery systems).

302. STATE OF OHIO HOSPITAL IMPROVEMENT REVENUE BONDS (The Cleveland Clinic Project), *supra* note 20. The funds will be used to construct a clinic building, hospital wing, pedestrian link, and parking garage. In addition, the Project includes site work including sewer, water, lighting, and landscaping, as well as acquisition of major movable equipment for the Clinic Building and Hospital Wing. *Id.* at 19. Even relatively small and specialized operations are capital intensive. Clinical laboratories are one example. Such labs do tests that can be routine or sophisticated. Industry participants have noted that market entry was once possible for $200,000 but now a single machine can cost in excess of $300,000. Such conditions and the growing market for clinical laboratories have attracted large corporations with technology and resources. Many small labs cannot compete. Koenig, *supra* note 22.

303. Hospital Financings Through The Use Of Tax Exempt Securities 70 (1982) (Law Journal Seminars Press Publication Number 751). The interest rate for tax

exempt providers discourages those who are not exempt from using taxable financings to enter the market. While a taxable provider may be able to offer an actual medical service for lower cost, this advantage would not be translated into lower fees. Any savings would be significantly or totally neutralized by the taxable provider's higher financing costs.[304] In sum, the nonprofit charitable health care providers have a competitive advantage in the tax laws.[305] The question is whether it is a proper advantage.

If competitive opportunities were available, health care would be an attractive market for for-profit enterprises. Under a Market Approach, alternative providers which balanced the needs of quality and reasonable cost could achieve profits by eliminating inefficiencies as well as by improving procedures and policies.[306] The current health care system has strong inflationary tendencies which could be exploited in a competitive environment.[307] As a result of third party payments, the individual consumer has been separated from his responsibility for his health care consumption decisions. At the same

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exempt bonds has been 60 to 70% that of taxable bonds. *Id. See* notes 234-37 *supra* and accompanying text. (For-profit facilities can utilize small issue industrial development bonds, but these are limited to $1 million or in some cases $10 million).

304. *See* Areeda, *Barriers to Entry*, in P. AREEDA, *supra* note 167, ¶ 117, at 20. Capital requirements can impede market entry when the volume of capital needed to support entry is very high and/or the likelihood of obtaining the needed capital at costs comparable to those of established providers is low.

305. Comment, *Income Taxation—A Pauper A Day Keeps The Taxman Away; Qualification of Hospitals As Charitable Institutions Under Section 501(c)(3) of the I.R.C. of 1954*, 54 N.C.L. REV. 1195, 1214 (1976) (discussing restrictions on commercial activities of charitable organizations).

306. A. SOMERS, *supra* note 135, at 11-13. Profit oriented businesses have observed the rising percentage of health care expenditures in the Gross National Product and have indicated interest in hospitals, health care industry hardware and hospital computer use. *Id.*

The inefficiencies of the health care market are not subject to economic sanctions, but rather rely on government administrative oversight. For example, a September 10, 1982 report from the Senate Special Committee on Aging described how pacemakers costing $500 to $900 were sold to hospitals for $2,000 to $5,000. There were additional kickbacks in some instances. The hospital then increased the price to patients by 50 to 150%. Estimates that 30 to 50% of pacemaker implants are unnecessary are significant because 150,000 persons will receive pacemakers in 1982. The average cost will be $10,000 to $18,000 per operation and after-care period. *Pacemaker Prices Far Outpace Costs*, U.S. NEWS & WORLD REP., Sept. 20, 1982, at 14. Under a Market Approach, this abuse would attract a surge of competitors who could cut the cost drastically and still be profitable.

307. *See* note 4 *supra* (discussion of cost increases in health care and the CPI). *See also* Areeda, *Allocative Efficiency*, in P. AREEDA, *supra* note 167, ¶ 116, at 18-19. In economic terms, the government has granted an exclusive privilege to a distinct class of health care providers. Not suprisingly, costs have risen. *Id.*

time, third party payments through insurance and government programs have paid an increasing health care bill for large segments of society.[308] These payors have had little success in controlling inflated health care expenditures and are moving toward a new competitive approach to health care delivery.[309]

The need for granting tax exempt financing privileges to for-profit health institutions is demonstrated by cases in which nonprofit hospital foundations and systems have tried to purchase investor owned hospital systems. While nonprofit hospitals dominate the industry, for-profit hospitals have had limited success[310] by introducing corporate management techniques and private sector executive talent.[311] Despite these management abilities, for-profit hospitals have been absorbed by expanding nonprofit systems.[312] To the extent that the nonprofit's relative financial strength is a product of their tax exempt status, it is not a fair competitive situation.

A. Development of the Charitable Tax Exemption

Encouraging competitive market forces by targeting tax exempt financings to for-profit delivery systems would entail a break with current tax policy.[313] There is precedent, however, for broadening the charitable exemption as it applies to health care.[314] The I.R.S. originally insisted on provision of free care to all patients before a hospital could qualify as charitable and tax exempt.[315] This position was re-

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308. *See* notes 62-74 *supra* and accompanying text (discussion of the allocation of health care expenditures).

309. *See* notes 133-62 *supra* and accompanying text (discussion of the Market Approach and other pro-competitive theories).

310. *See* Table 53 and Table 58, *supra* note 34. In 1979 there were 867 proprietary short-stay hospitals out of 6,525 facilities in the United States. In the same year, 75 of 560 long-stay hospitals were "propritary." *Id.*

311. Coyne, *Nonprofit Hospital Groups Make A Move On Investor Owned Systems*, MODERN HEALTH CARE, Nov. 1980, at 82.

312. *Id.*

313. *See* notes 224-27 *supra* and accompanying text (introductory discussion of current tax policy).

314. Bromberg, *Financing Health Care And The Effect Of The Tax Law*, LAW & CONTEMP. PROBS. 156, 162-68 (Autumn 1975) (broadening criteria discussed with evaluation of trend); Comment, *supra* note 305, at 1201-06 (traces widening view of charitable status).

315. Davis Hospital, Inc., 4 T.C.M. (CCH) 312 Dec. 14,456(M) (1945). In *Davis*, the I.R.S. took the position that charitable status was lost if the exempt organization charged those able to pay for the services rendered. *Id.* at 315. The Tax Court disagreed, stating that the institution may charge fees to those who can afford them. So long as "admission and treatment are not denied to those unable to pay, an institution is classed as charitable." *Id.* at 315. *See* Commissioner v. Battle Creek, Inc., 126 F.2d 405 (5th Cir. 1942) (I.R.S. denied exemption under Revenue Act of

jected by the courts.[316] Following this setback, the I.R.S. moved toward the Relief of Poverty Approach. This Approach, as set forth in Revenue Ruling 56-185, states that hospitals deserve a tax advantage if they provide free care to indigents[317] by operating "to the extent of their financial ability for those not able to pay for the services rendered and not exclusively for those that are able and expected to pay."[318] While Revenue Ruling 56-185 was consistent with its historical roots, it was an "inadequate criteria" for evolving nonprofit hospitals.[319]

Revenue Ruling 69-545[320] was the I.R.S. response to criticism of Revenue Ruling 56-185. The new ruling adopted the Community Benefit Theory.[321] This broader concept of charity viewed the promotion of health as a charitable purpose in spite of the fact that indigents were no longer guaranteed care in excess of an emergency room.[322]

Revenue Ruling 69-545 was upheld as constitutional by the District of Columbia Circuit Court in *Simon v. Eastern Kentucky Welfare Rights Organization*.[323] The Supreme Court vacated and remanded to the district court after finding that the plaintiffs lacked standing.[324] In

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1934, § 101(6). The Board of Tax Appeals reversed and the circuit court affirmed, holding that charges for those able to pay does not cause forfeiture of exempt status). *See also* Comment, *supra* note 305, at 1201 (discussion of I.R.S. position denying exemption to those who charged for services).

316. 126 F.2d at 406. It was held that charging those able to pay while offering free care to indigents was classified as charitable. *Id.* at 405-06.

317. Bromberg, *supra* note 314, at 162 (discussion of the Relief of Poverty Approach); Comment, *supra* note 305, at 1201 (development of the Relief of Poverty Approach in the context of historical evolution of different theories of exemption).

318. Rev. Rul. 56-185, 1956-1 C.B. 202 (discussing criteria and tests to be met in determining whether a hospital can qualify for exemption from income tax as a public charitable organization).

319. Bromberg, *supra* note 314, at 162-63. Revenue Ruling 56-185 sought to link the historical origin of hospitals as providers of free care to indigents with tax exempt criteria of the Internal Revenue Code. *Id.* at 163. Rev. Rul. 56-185 was, however, an uncertain guide to hospital tax exemptions because it was inconsistent with other provisions of the Code. *See id.* (discussion of contradictions between Rev. Rul. 56-185 and I.R.C. § 501 (c)(3) definition of charitable criteria).

320. Rev. Rul. 69-545, 1969-2 C.B. 117. *See* note 263 *supra* (discussion of Rev. Rul. 69-545).

321. Bromberg, *supra* note 314, at 164. This new standard gave the hospital the option of using the Rev. Rul. 56-185 standard (operate for those unable to pay to the extent the hospital is financially able to do so), or the Rev. Rul. 69-545 standard (benefit the community by treating all those who are able to pay directly or through third party reimbursement as well as operate an emergency room open to all patients).

322. Rev. Rul. 69-545, *supra* note 320. Care exceeding emergency room treatment is required only when the patient can pay for the service in some manner. *Id.*

323. 506 F.2d 1278 (D.C. Cir. 1974).

324. 426 U.S. 26, 45-46 (1976).

Simon, private citizens and welfare organizations claimed that Revenue Ruling 69-545 operated contrary to congressional intent to provide free or reduced rate health services to the poor.[325] The District of Columbia Circuit found that the Ruling operated within a permissible definition of "charitable" and therefore was lawful.[326] The circuit court noted, "the definition of the term charitable has never been static and has broadened in recent years."[327] The court continued with a strong affirmation of the evolving concept of charity:

> While it is true that in the past Congress and the federal courts have conditioned a hospital's charitable status on the level of free or below cost care that it provided for indigents, there is no authority for the conclusion that the determination of 'charitable' status was always to be so limited. Such an inflexible construction fails to recognize the changing economic, social and technological precepts and values of contemporary society. In the field of health care, the changes have been dramatic.[328]

While not all views on the subject have been expansionist,[329] Revenue Ruling 69-545 is an example of a once novel idea developing into a view which has become firmly planted in the conception of fairness in hospital tax exemptions.

Perhaps there is room for further development. For example, certain types of Health Maintenance Organizations may qualify for tax exempt status under an expanded concept of charitable organizations. In *Sound Health Associates*,[330] the Tax Court approved specific aspects of the HMO's operation.[331] The court expressed particular ap-

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325. 506 F.2d. at 1281.

326. *Id.* at 1287. The court noted, "[T]he question involved here . . . is whether the term 'charitable' as used in § 501(c)(3) may be broadly interpreted as was done in Revenue Ruling 69-545 or is to be restricted to its narrow sense of relief of the poor. We cannot conclude . . . that Congress intended the latter construction." *Id.*

327. *Id.* at 1286.

328. *Id.* at 1287-88.

329. The Sixth Circuit took the view that even a ratio of uncompensated services to total revenue of between 4.25 and 7.78%, while higher than many other exempt hospitals, did not provide the basis for an exemption in all cases. Harding Hosp. Inc. v. United States, 505 F.2d 1068, 1077 (6th Cir. 1974). The facts of this case, however, indicate that the hospital only treated as charitable cases those who had been admitted as paying patients and who had exhausted their funds. *Id.* Further, the court found a general failure to operate the hospital for charitable purposes. *Id.*

330. 71 T.C. 158. *See* note 264 *supra* (Commissioner acquiescence to Tax Court decision).

331. 71 T.C. at 184. Favorable aspects included a research program, non-discrimination in selecting physicians for staff privileges and designation of a board of directors made up of prominent members of the community rather than persons associated with the formation or administration of the facility. *Id.*

332. *Id.*

proval of a fund established to receive contributions to subsidize the membership fees of persons who could not afford the monthly payments. This fund was not mandated by Revenue Ruling 69-545 but rather was an initiative by the HMO.[332] Such voluntary innovations would be encouraged if they were rewarded by inclusion within the charitable exemption.

B. A Proposal to Expand Tax Exempt Financing of Health Care Facilities

A for-profit alternative delivery system could meet all the requirements of the current tax exemption except that "no profit inure to the benefit of any private shareholder or individual."[333] In order to justify an exception to this policy for alternative health providers, two principal requirements must be addressed. First, such a policy must have a compelling ideological basis and second, the policy must not be economically wasteful.

The ideological basis of the proposal to allow targeted tax exempt financing for alternative health providers is rooted in the concept of fair and equal competition among all health providers. Such competition does not exist today because new market entrants are forced to compete with established providers who obtained their physical plants with the aid of government assistance.[334] To continue a policy of government sponsored monopoly when a legitimate competitive alternative is availiable is inconsistent with fundamental concepts of economic fairness and efficiency expressed in the antitrust laws.[335] The goal of implementing a competitive market approach in health care provides sufficient ideological basis for considering a limited expansion of tax exempt financing.

To remain consistent with the goal of initiating a competitive health care market, the extension of tax exempt status must be limited

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333. *See* I.R.C. § 501(c)(3).

334. Examples of government assistance include the Hill-Burton Program, *supra* note 6, and the supports available through tax exempt financing. While tax exempt revenue bonds have become the leading financing technique, there are other methods discussed at note 107 *supra*. Even Health Maintenance Organizations have received government encouragement. The Health Maintenance Organization Act of 1973 assisted in the establishment and expansion of HMOs. Pub. L. No. 93-222, 87 Stat. 914 (1973). The 1976 Amendments to the Act eased the requirements for HMOs to receive federal support. Pub. L. No. 94-460, 90 Stat. 1945 (1976). The 1978 Amendments extended the program for an additional three years. Pub. L. No. 95-559, 92 Stat. 2131; Pub. L. No. 96-32, § 2(a)-(c), 93 Stat. 82 (1978). HMOs have also begun to use tax exempt financings. *See* notes 119-21 *supra* and accompanying text.

335. *See* note 167 *supra* (referral to the statutes which comprise the antitrust laws).

and temporary.[336] The assistance must be limited to providers without great financial strength otherwise unable to enter the health care market. In addition, the exemption must apply only to a period reasonably calculated to assist the new provider in becoming firmly rooted in the health care industry. At that point the ideological purpose of equalizing market entry conditions will be fulfilled.[337]

The second requirement which a proposal to expand tax exempt financing must fulfill is that it must not be economically wasteful. Initially, the proposal must reduce costs or it will not become a practical policy alternative.[338] In addition, those not truly in need of capital financing assistance must be discouraged from taking unfair advantage of expanded tax exempt financing availability. Finally, the total cost of the additional tax exempt financing to the taxpayer must be justified. Each of these requirements will be discussed.

First, the encouragement of alternative delivery systems through tax exempt financing does hold promise for cost reduction. Some alternative providers are currently in place. Ambulatory surgical centers, home health providers, hospices for terminally ill persons and birthing rooms are attempting to enter the health care market.[339] Health maintenance organizations have emerged as a significant force in the delivery of health care.[340] HMOs have been able to achieve

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336. Granting limited and temporary assistance to alternative providers is consistent with the notion of gradual deregulation proposed by Market Approach theorists. While the role of government in the health care market varies according to different theories, it would not be eliminated. For example, Martin Feldstein favors a maximum liability risk insurance plan (MLRI) which gives consumers a direct financial stake in efficient delivery of health care. He minimizes the government role. Reinhardt, *supra* note 138, at 29. *See also* note 148 *supra* and accompanying text (Blumstein and Sloan's view of the government role in a competitive market); *see* note 151-52 *supra* and accompanying text (Professor Schramm's state statute conferring wide powers over the health industry to a state commission); Pollard, *supra* note 13, at 158 (discussion of the Market Approach view that total or instant elimination of regulation is not a practical policy).

337. The issue of meeting ongoing capital needs remains. Perhaps, additional equalizing measures will be needed to provide for renovations and improvements. The successful operation of the then "established" alternative providers may reduce the need for continuing assistance. In addition, a provision similiar to I.R.C. § 103(b)(6) (small issues exemption) may be utilized to provide capital access for minor projects.

338. *See* Reinhardt, *supra* note 138, at 31. Reinhardt, in discussing the idea of entrepreneurship in health care, states that the perceived advantages of delegating responsibility from dental or medical to paradental or paramedical personnel is evaluated first on a strict cost savings basis. Without demonstrating that quality delivery can be obtained for lower cost, the issue is predetermined. *Id.*

339. *See* notes 48-51 *supra* for a discussion of these alternative delivery systems.

340. *See* note 47 *supra* for a discussion of the growth of HMOs.

significant cost savings and limited experience[341] with other alternative providers indicates that they can also achieve substantial cost reductions.[342]

The second requirement for expanded tax exempt financing is that abuse of the tax exemption privilege must be prevented. This may be accomplished by limiting the salary or investment return which accrues to an employee, owner or investor during the period when an alternative provider is using tax exempt financing.[343] This concept is evident throughout both I.R.S. policy positions and court decisions. Revenue Procedures 82-14 and 82-15 limit certain hospital employee salaries to "reasonable" levels with provisions for controlled increases.[344] Court decisions have based grants of tax exempt status under section 501(c)(3) on the premise that the granting of a "reasonable" salary did not defeat the tax exempt status of an otherwise exempt organization.[345] If the requirement of a "reasonable" salary limitation is strictly enforced while the tax exempt financing is operative and then totally removed once the organization is no longer utilizing the exemption, abuses of the support will be deterred and an incentive to operate independently will be provided.

Third, a viable proposal to expand tax exempt financing must justify its cost to the taxpayer.[346] Tax exempt financing has been

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341. *See* note 45 *supra* for a discussion of savings achieved by HMOs.

342. *See* notes 48-51 *supra* for a discussion of savings achieved by alternative delivery systems other than HMOs. Experimentation with alternative delivery systems in a Medicare and Medicaid context has also proved successful. Galblum & Trieger, *supra* note 7, at 1. But other decisions within reimbursement programs contribute to the competitive disadvantage of some alternative delivery systems. For example, "emergicenters" have the goal of making primary care services accessible during hours when physicians are not in their offices. For many emergicenter services, the cost is half of the comparable hospital emergency room treatment. Yet the development of such centers is being restricted because third party payors such as Medicare have been slow to recognize emergicenters as legitimate health providers. Michaels & Crouter, *Emergicenters and the Need for a Competitive Regulatory Approach*, 10 LAW, MED. & HEALTH CARE No. 3, at 108 (1982).

343. *See* Tables 53 & 58, *supra* note 34. Hospitals are currently classified as either (1) government-state or federal, (2) "propritary," or (3) nonprofit. *Id.* The use of tax exempt financing and the accompanying regulations for a limited period of time would create a new category of for-profit health providers with temporary nonprofit status during the period the provider was benefiting from the exempt financing.

344. Rev. Proc. 82-14, 1982-1 C.B. 459, Rev. Proc. 82-15, 1982-1 C.B. 460. In these procedures the I.R.S. set forth conditions which, if met, would usually enable a facility to avoid being found to be engaging in a trade or business as defined by § 103(b)(2)(A). *See* Treas. Reg. § 1.103-7(b)(3) (1972) (discussion of the trade or business test).

345. *See* note 266 *supra* (discussion of effect of paying a "reasonable salary").

346. *See* note 300 *supra* (tax exempt financing questioned on the basis of cost).

criticized as an expensive subsidy.[347] It is not possible to know the cost of providing tax exempt financing to alternative providers without elaborate economic calculations based on projections of total financings offered under the program. This is not an insurmountable problem, however,[348] as it is possible to analyze some factors which reduce the actual cost of any tax exempt financing proposal. Under the government programs of Medicare and Medicaid, for example, providers are allowed to include apportionments of their capital costs in bills to patients covered by the government programs.[349] For providers able to utilize the low rates of tax exempt financing, the interest component of capital costs is decreased. This savings is reflected in government reimbursements. Therefore, the cost of tax exempt financing is reduced.[350]

The potential savings to government sponsored programs are relative to the size of the program. Medicare and Medicaid expenditures exceeded $60 billion in 1980.[351] Even a small percentage net saving in that expense would have profound benefits. To the extent that alternative providers can achieve large savings and a significant share of the health care market, the government savings will be greater.[352]

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347. *See* note 300 *supra* (tax exempt financing as a subsidy).

348. *See* HEALTH CARE FINANCING STUDY GROUP, *supra* note 21 (a quantitative assessment of the actual growth in the use of tax exempt financing from 1971-1981 and the various impacts of tax exempt bonds. The study examines the effects of tax exempt financings on hospital costs, hospital financial conditions, hospital construction and the federal budget).

349. Gibson & Waldo, *National Health Expenditures, 1980*, in HEALTH CARE FINANCING REV., Sept. 1981, at 48 (Table 7A), *cited in* HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 30 n.27.

350. HEALTH CARE FINANCING STUDY GROUP, *supra* note 21, at 28. The effects of this lower interest rate are evident when examining the hospital charge increases necessary to pay the higher financing cost of taxable bonds. *Id.* at 19. If the tax exempt hospital issues of 1979-1981 had been taxable issues, the additional interest cost is estimated to have been $149 million in 1979, $189 million in 1980 and $128 million for the first six months of 1981. *Id.* at 28-29. Since Medicare and Medicaid reimburse hospitals for approximately one-third of all expenses, the government realized savings of about $50 million in 1979 and $63 million in 1980 due to the tax exempt status of *new* hospital issues. *Id.* at 30. In addition, in 1980, savings on reimbursement for annual interest charges due to *previously* issued tax exempt bonds exceeded $150 million. *Id.*

351. Medicare expenditures and percent distribution . . . 1967-80 (Table 75), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 212; Medicaid expenditures and percent distribution . . . 1967-80 (Table 76), *reprinted in* HEALTH: UNITED STATES 1981, *supra* note 27, at 213.

352. Lower reimbursement expenses for Medicare and Medicaid programs can be achieved in two ways: (1) reduce the capital finance (interest) component of the provider's fee by using tax exempt financing, *supra* note 350, or (2) utilize those

Expanded availability of tax exempt financing would enable alternative delivery systems to enter the market and compete fairly with nonprofit providers. The for-profit providers have an incentive to improve the existing system to increase market share or profits. Without parity in market entry, they effectively will be excluded. Those that do enter the market in spite of their weak competitive position will have limited possibilities of success and will face constant exposure to takeovers by nonprofit systems.[353] The price for excluding competitive for-profit providers from the health care system is the continuance of a system which experts charge rewards waste and drains the nation's economy.[354]

VIII. Conclusion

In the area of health care cost containment, pragmatic concerns compel action. Health care costs have been rising for decades, but they have assumed new significance as the health care share of the Gross National Product approaches ten percent. Health care inflation also has a ripple effect to the extent that it affects contracts and government program benefits which tie automatic increases in prices, wages or benefits to the Consumer Price Index.

A major political restructuring of the health care system in the United States is unlikely. There are national issues of seemingly greater significance which presently command our attention. Therefore, the solution to the cost containment issue must come from within the general fabric of the current system if it is to be enacted in the near future. Widening the tax exemption for health care financing to stimulate the development of a competitive health delivery system is such an alternative.

Health care regulation has failed to control the surge of health care expenditures. It is time for significant experimentation with the widely supported alternative of the Market Approach. Tax exempt financing is necessary to provide market access for the competitive health care providers who will ultimately reduce health costs.

George A. King

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providers who can charge the lowest price for the medical care component of the fee. If alternative providers are lower priced, they should be used for the provision of Medicare and Medicaid services.

353. *See* Coyne, *supra* note 311, at 82, 86 (discussing nonprofit takeovers of investor owned systems).

354. *See* Stevens, *supra* note 7 (criticism of high medical costs).