TOCQUEVILLE OR AUSTERITY? HEALTH CARE AND THE SOCIAL COMPACT

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Aboard the *Arbella* in 1630, John Winthrop composed "A Modell of Christian Charity," outlining a social compact by which the Puritan settlers in the New World might "be all knit more nearly together in the Bond of brotherly affection." Almost four centuries later, America's democratic society still rests on a tacit social compact enjoining us to seek to balance and maximize individual liberty, personal responsibility, and the public good. These essays by Robert Atkinson and William Dennis invite us to reconsider the function of government and the impact of modern tax policy on our long-lived social commitment to justice and mercy.

Atkinson and Dennis both take a narrow, but very important, focus on the role of tax policy on philanthropy. They reach the same conclusion: each would eliminate tax subsidization of philanthropy through exemptions (and probably through deductions), even perhaps the tax subsidization of all "nonprofit" organizations. Yet they differ greatly in their rationales for this conclusion and in their positive suggestions for how to better realize the American social compact. In place of the current system of tax subsidization of charity, Atkinson proposes a more progressive tax system that increases taxation and government management to provide the "public good." Dennis promotes a more market-based approach to both philanthropy and the identification and funding of the "public good." Both conclusions have noble and virtuous grounding, yet each author raises, but does not answer, questions that lie at the very heart of the social compact.

The "academic" questions the authors present include whether to end tax subsidization of Tocquevillean philanthropy and whether to continue government protection of family-funded perpetuities (such as those established by Carnegie, Ford, and Rockefeller in the early 20th century or those of Gates, Buffet, Broad, Soros, and Koch today). These questions can and should be evaluated through the volumes of more than 100 years of tax data and the history of a charitable tradition

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in Christian cultures extending over two millennia. Perhaps looking at the historical record can help shape a serious, much-needed, and more broadly political debate on the role of government in realizing the social compact. Politics and social influence prevent strictly data-driven conclusions, but volumes of data are available to assess the comparative efficiency of private and public expenditures required by the social compact, and the historical record should inform our reflections on the present recommendations to eliminate federal subsidies for charitable activities.

I would like to explore the questions raised by Atkinson and Dennis by examining in detail health care provision in the United States.

The Fog of Accounting for Health Care Provision

Currently, the United States spends $3.0 trillion on health care each year; that constitutes 17 percent of total GDP and is heading toward $4 trillion (20 percent of GDP). The difficulty of comprehending the complex mix of government funding (direct and indirect), charitable donations, and private payments that fuels American health care clouds honest, transparent debate on the subject.

It is not easy to determine exactly what government spends on health care provision. In addition to direct federal government payments for health care, which comprises almost 25 percent of the federal budget,[1] the Internal Revenue Code currently provides for more than $1 trillion per year in "tax expenditures" (Congressional Research Service). A "tax expenditure" occurs when the government doesn't collect tax revenue otherwise due under the applicable federal, state, or local tax laws and regulations because another law either provides a deduction for defined expenses of the taxpayer (e.g., the charitable deduction) or an exemption from taxation of certain property or transactions as a result of the status of the taxpayer (such as property or sales tax exemptions). The Congressional Research Service and Joint Committee on Taxation have identified more than 250 categories of federal tax expenditures, with the ten largest representing more than $700 billion in "foregone" tax revenue to the federal government (CRS 2010 at 6).

To get at the whole story about government's role in funding health care, we have to dig deeper to understand the impact of tax expenditures. For 2010, the deduction for charitable contributions by individual taxpayers was only the ninth largest tax expenditure, at $36.8 billion (CRS 2010 at 6).[2] The largest tax expenditure of all, the exclusion of the cost of health insurance from taxable

compensation, was $106 billion in 2010, and the exclusion of Medicare benefits from taxation was 8th, at $54.6 billion in 2010 (CRS 2010 at 6).[3] In addition to subsidizing health care by foregoing almost $200 billion annually in federal tax revenue from individual and corporate taxpayers, the federal government also foregoes approximately $32-35 billion per year by exempting interest received by taxpayers from tax-exempt bonds from federal income taxation, the bond proceeds of which benefit many nonprofit health care and educational institutions (CRS 2010 at 781 and 951). Government also provides direct capital investment reimbursement through Medicare and Medicaid payments, HUD, USDA, FNMA, and other GSE subsidized debt for nonprofit hospitals, nursing homes, and senior housing. Indeed, the vast majority of hospital beds in the United States were built with Hill-Burton Act subsidies to nonprofit hospital organizations. Further, these are only the ***federal*** tax expenditures; state and local governments forego tens of billions of dollars in property and sales tax revenue from churches and nonprofit health care and educational institutions.

It is thus clear that government subsidies and direct expenditures far exceed philanthropic contributions to health care provision. The Giving USA Foundation and its research partner, the Center for Philanthropy at Indiana University, estimated that charitable contributions from individuals, corporations, bequests, and foundations in 2009 totaled $303 billion (CRS 2010 at 762). Even assuming that a portion of the donations to religious organizations (approximately one-third of all giving) went to provision of health care by faith-based entities, charitable provision comprises only a small portion of overall health care spending.

With the federal and state governments providing more than $1.1 trillion in Medicare and Medicaid compensation, and tax subsidies for the private insurance markets, we must consider whether charitable donations, or more material, federal tax-exemption of nonprofit organizations, are required to protect and further the social compact embodied in health care provision. Another way to frame this question is to consider whether the nonprofit status of a health care entity allows it to fulfill the social compact promise better or differently than a commercial hospital or health care organization. Would health care be provisioned less, or worse, without nonprofit providers?

What Distinguishes a Nonprofit Health Care Entity?

Some of the largest publicly traded companies in the United States—-to be clear, taxable, for-profit companies—are hospitals or other health care

organizations.[3] Some of the largest nonprofit corporations in the United States are also hospitals and health care organizations. On what criteria do we distinguish the two or find one preferable to the other?

Nonprofit health care entities do not have to meet an objective mathematical standard to qualify for tax exemption. To qualify for the federal tax exemption, a health care organization must commit to provide "community benefit." Historically, that specifically meant and generally still requires a commitment to treat all who present for care, regardless of their ability to pay (IRS Revenue Ruling 69-545, 1969-2 C.B. 117). But that does not mean the nonprofit hospital must provide free care; it merely requires a commitment to care for all, without socioeconomic discrimination, and to have documented charity care policies that provide discounts or free care, based on a patient's ability to pay.

Many states (but still a small minority) have specific, objective, charity care requirements. Texas, perhaps the best example, requires nonprofit hospitals to document and prove that they provide at least 5 percent of net patient revenue in Community Benefit each year. "Community Benefit" includes "pure" charity care and the unreimbursed cost of treating Medicare and Medicaid patients, and must equal at least 4 percent of net patient revenue (Texas Health and Safety Code, Section 311.045.). Dollars invested in community education, medical education, and research can be included in the remaining 1 percent. Unfortunately, even with objective standards and requirements, it is difficult to account for the true "public benefit" of Texas nonprofit hospitals, because hospitals are allowed to self-define income thresholds for qualification for free or reduced-cost services, making it difficult to apply a uniform definition of "charity care," in contrast to, say, "bad debt." Hospitals and charities are not incented or given legal or political credit for having poor business practices; thus it is important to measure "bad debt" as amounts hospitals didn't collect for their services from patients with insurance or the resources to pay compared to "charity care" as most purely defined.

Unlike Texas and other states, Congress has not adopted objective legal standards to justify a health care organization's tax exemption. Upon evaluating this question, the American Hospital Association and other lobbying groups urged Congress to require more reporting of Community Benefit provided by tax-exempt health care organizations. This led the IRS to adopt and require tax-exempt health care organizations to file Form 990 Schedule H reporting their Community Benefits. This policy and requirement for disclosure is an evolution of the policy and laws adopted by Texas and other states. It remains questionable whether

meeting the minimal threshold of community benefit as defined by legislatures makes provision of health care by tax-exempt entities more efficient or more efficacious than provision of health care by taxable entities.

Likewise, mandatory data collection and transparency may help politicians and tax-exempt organizations "justify" the concept of the various tax-exempt health care "tax expenditures," but does it establish or prove greater access to health care services than if there were no "tax exemptions" at all? There is little evidence assimilated to validate whether the subsidies through tax exemption of health care entities actually do much to expand access.

Is Tax Exemption Necessary for Charitable Health Care Provision?

We might shed further light on the supposed necessity of tax-exemption for health care provision by looking at the history of charitable provision of health care. Perhaps the greatest philanthropists in health care and education in the history of the world are William and Catherine Callaghan, a childless couple from Dublin, Ireland. In 1822, upon Mr. Callaghan's death, he left his entire fortune, about £25,000 at the time, to a young orphaned girl who had lived with the Callaghans for twenty years before their death. This young lady, orphaned at age five, was named Catherine McAuley. She used her inheritance to start the Sisters of Mercy, an organization dedicated to the health, education, and general welfare of women and children.

The Sisters of Mercy was formed without any tax incentive and grew until 1913 without tax-deductible charitable contributions. Since the introduction of the federal charity tax deduction and tax-exemption, they have utilized and maximized philanthropy and tax-exemption to continue their growth. Today, Sisters of Mercy ministries are worldwide, and they include six of the largest health care systems in the United States. Combined, the health care systems sponsored by the Sisters of Mercy own billions of dollars of assets, earn billions of dollars of revenue, and treat millions of people annually, with faith-based health care services, regardless of the patient's ability to pay or faith background (see www.sistersofmercy.org).

There are countless other examples of successful health care philanthropy predating tax-exemption. Colonel C. C. Slaughter, an iconic cattle baron, at the urging of the pastor of the first Baptist Church of Dallas, Texas, provided the land and funding for a Baptist-sponsored sanatorium, medical school, and nursing school in downtown Dallas. That sanatorium is now Baylor University Medical

Center, the flagship hospital of the Baylor Health Care System, a multibillion-dollar health care system that provides hundreds of millions of dollars of community benefit each year. The medical school, now located in Houston, known as the Baylor College of Medicine, is generally recognized as one of the best and most important medical education and research organizations in the world. The Baylor University Nursing School continues to train nurses near its original location.

Tax policy had no impact on the creation of the Sisters of Mercy or Baylor Medical, nor on their indisputable success for decades. Tax policy, over time, certainly has had an impact on their growth and prosperity, specifically through the ability to issue tax-exempt debt and benefit from direct government subsidies for indigent care. Nevertheless, we certainly should question, as Bill Dennis suggests, whether these entities would, even today, have "net taxable income" after deducting all of their charity care and calculable community benefits over their long histories. Perhaps the greatest subsidy each has enjoyed is a "tax expenditure" equal to the amount of state property tax exemption received annually, as each organization owns millions of square feet of expensive real estate in high-property-tax jurisdictions. Interestingly, however, we might note that this tax expenditure comes at the direct cost of public education, as schools across the United States are financed primarily through property taxes.

In any case, we should consider whether, in the end, these charitable entities are markedly different in operation from those of their for-profit, taxable competitors. Is the cost of their services to payers and those that can pay any lower than among taxable, commercial entities? No. Do they hold to the business principle of "No Margin, No Mission?" Absolutely. Do they provide tremendous Community Benefit? Yes, and Baylor, based in Texas, has to document and prove it every year. But does this mean that commercial hospitals do not provide similar contributions to the provision of the public good?

Comparing Market, Philanthropic, and Government Provision

Atkinson and Dennis raise provocative arguments and models for eliminating government subsidies for philanthropy and tax-exempt benefits for charitable entities. Here I have tried to raise questions, not answers, about the potential implications of such a change in tax policy. The data and history prove, if nothing more, that path dependence must be considered and the issues are complicated.

Dennis' "Thought Experiment" has appeal, and as documented above, provision of health care has and can be supported by a market in which both

commercially and philanthropically motivated entities operate side by side. Could market forces and more efficient payment systems in the market address the broader "requirements" of the Social Compact, allowing us to substantially reduce or eliminate indirect tax expenditures? The U.S. health care market, including its "nonprofit" players, today has so much private capital that it is debatable whether it is necessary to subsidize hospitals and large physician organizations (Mayo, for example, is a nonprofit, tax-exempt physician organization that owns hospitals) to provide access to health care services for the vast majority of the U.S. population.

The elimination of tax-exemption for health care entities would not mean the end of government's role in health care. It is not tax policy alone that defines and enacts societal obligations. There are always at-risk individuals and populations that may need help accessing care, and it may be that government "management" of this access through taxing and paying for care is desirable. The law that requires all Medicare providers to screen and treat all patients, including specifically women in active labor, who present to a hospital seeking emergency medical care (known as "EMTALA"), is a requirement for participating in the Medicare program and is not a requirement for tax-exemption—it applies equally to for-profit taxable hospitals and nonprofit hospitals such as those owned and operated by the Sisters of Mercy. Could such non-fiscal legislation combined with market forces be sufficient to address the basic needs of the at-risk population (emergency care). Dennis' thought experiment asks us to consider just such questions.

Turning to Atkinson's argument for replacing federal tax subsidies of philanthropy with a more progressive tax system, we are asked to consider a path leading to more direct government funding of health care. Direct government subsidies of health care through programs such as Medicare now have a long history, but it remains debatable that direct government funding and provision of health care services, in and of itself, has provided a high-quality, low-cost, efficient model to address the needs of society's at-risk population. It is difficult to contemplate federal and state budgets and expenditures well in excess of $1.25 trillion (at least half of the U.S. GDP dedicated to health care products and services) and not question whether there isn't already enough tax revenue and government spending in the system to honor the Social Compact, and to wonder instead whether these funds are being spent most efficiently and with the objective of maximizing access to care.

The question is not whether Atkinson and Dennis are on to something in questioning the necessity of preferential tax treatment for charitable entities; I

would submit that ***the*** question is to clarify the role of government, which should hinge in part on an evaluation of the efficiency and efficacy of government-funded care and better delineation of where the market can fairly honor the Social Compact and where we may in fact need either "incented" philanthropy or "coerced" progressive taxation to achieve the greater public benefit of a population with broad access to the best medical care in the world.

The Interesting Case of Medical Research

Medical research funding provides a concise case study for delineating where incented philanthropy or taxation may be desirable to supplement market activity. Free-market (i.e., private) investment for basic, bench, early-stage medical research and clinical trials is all but nonexistent today. Due in large part to an inefficient, slow, and very expensive regulatory approval process combined with allies in the plaintiff's bar and a broken U.S. tort system, there is no financial return for private investment in early stage research. Indirect government subsidy through incented philanthropy and/or direct government subsidy from taxation are currently the only fuel for early stage medical research. Fortunately, Gates, Buffet, Broad, and Koch all take advantage of current U.S. tax policy and give generously to medical research, but even their large foundations do not supply sufficient fuel for this effort. Is there a danger in relying upon a few enlightened (or perhaps only tax-avoiding) donors to fund lifesaving and economically stimulating research? Should we trust only donors, who typically focus on very specific medical research of specific personal interest, to fund and thus "manage" medical research? The history of eugenics research in the United States certainly provides a cautionary tale about the selection process in medical research, and this cautionary tale applies to both private and publicly funded research. Is there a need for a broader public process for supporting critical research on unpopular causes or rare "orphaned" diseases?

Conclusion

Can a decentralized philanthropy help us address such challenges? Isn't that the question both Atkinson and Dennis are asking? What is the balance among market, philanthropic, and government action in a free society? Can markets provide for all public goods without support of philanthropy? Can voluntary beneficence help us realize our social compact without financial incentives? Where the market will not fund and philanthropy does not provide, can we reach

a broad public consensus about what we should support with indirect or direct government spending? What aspects of health, education, and welfare should we leave to philanthropists such as McAuley and Slaughter, motivated by God or their own human existence, and not tax policy, and where should society as a whole enforce broad funding participation, albeit in a manner that is most efficient and most necessary?

These questions are not only important philosophically, but must be considered anew in today's fiscal environment. Health care and Social Security spending, to meet the political "promises" made over the past one-hundred years, will rapidly consume U.S. federal, state, and local budgets, leaving little left over for other government functions such as infrastructure renewal, education, and national defense. We live in a world of abundance, but our resources remain limited and choices are always necessary. Honest, data-driven analysis is needed now more than ever in our public discourse. As we proceed to make hard decisions, we should not abandon our political principles, but we should bear in mind that Americans have proven time and again our mutual commitment to promote the general welfare, and that American philanthropy has always been a substantial contributor to our economic wealth, liberty, and public good, even before it was incented through tax policy. The choice before us may be to reclaim Tocqueville's republic or to prepare for European-style austerity.

NOTES

[1] U.S. federal appropriations for the Department of Health and Human Services for FY 2012 were $860 billion, out of total appropriations of $3.5 trillion. For comparison, the total for the Department of Defense was $688 billion.

[2] The Congressional Research Service assigns philanthropic subsidies to three categories classified by the recipient of the tax-deductible charitable donation: educational institutions ($5.1 billion), health care organizations ($2.5 billion), and all other charities ($29.2 billion) (CRS 2010 at 665, 759, and 785).

[3] The Kaiser Foundation estimates the federal tax expenditure was $225 billion in 2008. Levitt, "A Primer on Tax Subsidies for Health Care," Kaiser Foundation, Kaiser.edu, April 2009.

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