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NONPROFIT HOSPITALS' COMMUNITY BENEFITS SHOULD  
ACTUALLY BENEFIT THE COMMUNITY: HOW IRS  
REFORMS CAN IMPROVE THE PROVISION OF COMMUNITY  
BENEFITS

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## ABSTRACT

*Policymakers and health care leaders have frequently questioned and critiqued whether nonprofit hospitals' provision of community benefits is worth their favored tax status. While legislation and regulations have recently been enacted to address such concerns, the tax exemption standards continue to fail to promote the goals articulated in the Patient Protection and Affordable Care Act of 2010 (ACA) of reforming and improve health care delivery systems in the United States for all people. To better effectuate the purposes of the ACA, this article suggests that the Internal Revenue Service adopt minimum community benefit spending requirements that vary depending on the form of community benefit and the goals meant to be achieved by the benefit. By enacting such minimum requirements, society would be better able to ensure that the principles underlying the initial grant of tax exempt status to nonprofit hospitals are realized and better aligned with the forward-looking goals articulated in the ACA.*

## INTRODUCTION

Comparatively, the United States health care system is the most expensive in the world.<sup>1</sup> The United States government consistently spends more on health care as a percentage of gross domestic product than the governments of other large, developed nations.<sup>2</sup> The enactment of the Patient Protection and Affordable Care Act of 2010 (“ACA”) was broadly aimed at reforming and improving health care delivery systems in the United States.<sup>3</sup> Yet, analyses reveal that the United States still outspends and underperforms in relation to other countries, consistently coming in last or near last on aspects of health care such as access, efficiency, and equity.<sup>4</sup>

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<sup>1</sup> Karen Davis et al., Commonwealth Fund, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally* 3, 7 (2014).

<sup>2</sup> Joseph Bankman et al., *Federal Income Taxation* 7–8 (18th ed. 2017).

<sup>3</sup> See Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, *Public Health Reports*, 126 *Pub. Health Rep.* 130, 130 (2011) (explaining that “through a series of extensions of, and revisions to, the multiple laws that together comprise the federal legal framework for the U.S. health-care system, the Act establishes the basic legal protections that until now have been absent: a near-universal guarantee of access to affordable health insurance coverage, from birth through retirement.”).

<sup>4</sup> Davis et al., *supra* note 1, at 7.

A paradigm shift to how underutilized and unconventional actors and delivery models can play a larger role in improving health care in the United States is much needed. One example can be found in community benefit services provided by nonprofit hospitals. Although nonprofit hospitals are required to provide community benefits in order to retain a favored tax status,<sup>5</sup> studies frequently show that these hospitals do not go far enough in fulfilling their obligation.<sup>6</sup> In response to such concern, recent legislative changes have been aimed at increasing accountability and oversight of nonprofit hospitals' community benefit spending.<sup>7</sup> But these legislative changes still do not go far enough. Instead, this article argues that the current reporting system for nonprofit hospitals perpetuates a system in which the underlying justifications for granting nonprofit hospitals tax exemptions are not realized. To decrease shortfalls, the Internal Revenue Service ("IRS") should implement minimum community benefit spending requirements that vary depending on the form of community benefit and current and forward-looking health care goals and policies.

Part I explains legislative requirements and underpinning tax policies at play in granting tax exemptions to nonprofit hospitals. Part I further describes concerns surrounding how nonprofit hospitals' community benefit programs currently operate and details recent legislative changes aimed at increasing the value of community benefit services. Part II analyzes current statistical reports on nonprofit hospitals' community benefit expenditures and argues that the predominant justifications for granting tax exemptions to nonprofit hospitals are not actualized under the current tax structure. Part III reviews how state-level minimum community benefit requirements provide a baseline framework for the implementation of minimum requirements at the federal level. Additionally, Part III lays out specific suggestions for developing and implementing a new federal system. In conclusion, this article argues that developing new federal minimum community benefit requirements would ensure that underlying justifications for granting tax exemptions to nonprofit hospitals are realized and community benefit services are more aligned with current and forward-looking health care policies and goals.

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<sup>5</sup> See Rev. Rul. 69-545, 1969-2 C.B. 117, 1969 IRB LEXIS 176.

<sup>6</sup> See *Community Benefit Spending Not Well Defined or Reported, Investigation Shows*, LOWN Inst., <https://lowninstitute.org/news/blog/little-accountability-for-community-benefit-programs-new-analysis-shows/> (last visited Apr. 8, 2019); see *infra* Part II.

<sup>7</sup> Daniel B. Rubin et al., *Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice*, 36 Ann. Rev. Pub. Health 545, 549 (2015).

## I. BACKGROUND

“Approximately 60% of hospitals in the United States are [categorized as] nonprofit hospitals”,<sup>8</sup> and almost all of them are exempt from paying federal, state, and local taxes on income, property, and sales.<sup>9</sup> At the federal level, nonprofit hospitals are eligible to receive such favored tax status provided they are operated exclusively for a charitable purpose and are not operated, directly or indirectly, for the benefit of private interests.<sup>10</sup> In determining whether hospitals are operating exclusively for a charitable purpose, the IRS in a 1969 revenue ruling adopted a standard which focuses the analysis on whether a hospital’s operational purposes are beneficial to the community as a whole.<sup>11</sup>

Favored tax status for nonprofit hospitals, which grants tax benefits and exemptions, acknowledges and rewards nonprofit hospitals for the community benefits they provide.<sup>12</sup> Lost tax revenues are purportedly justified by nonprofit hospitals’ use of tax savings to provide services which the government would otherwise have to provide.<sup>13</sup> In effect, the government and nonprofit hospitals are in a *quid pro quo* relationship<sup>14</sup> wherein a shifting of the burden of providing services from federal, state, and local governments to nonprofit hospitals is exchanged for tax benefits and exemptions. Nonprofit hospitals’ favored tax status has alternatively been rationalized as a reward for their fundamental charitable character.<sup>15</sup>

The IRS has never specified an exact level of community benefit necessary for nonprofit hospitals to provide in order to qualify for tax-exempt

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<sup>8</sup> Bradley Herring et al., *Comparing the Value of Nonprofit Hospitals’ Tax Exemption to Their Community Benefits*, 55 J. Health Care Org., Provision, & Financing 1 (2017).

<sup>9</sup> Julia James, *Nonprofit Hospitals’ Community Benefit Requirements: Under the Affordable Care Act, Many Nonprofit Hospitals Must Meet New Requirements to Retain Their Tax-Exempt Status*, Health Aff. (Feb. 25, 2016), <https://www.healthaffairs.org/doi/10.1377/hpb20160225.954803/full/.y>.

<sup>10</sup> 1969 IRB LEXIS 176.

<sup>11</sup> *Id.* (stating that “the promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole”).

<sup>12</sup> James, *supra* note 9.

<sup>13</sup> See Cong. Budget Office, *Nonprofit Hospitals & The Provision of Community Benefits* 4 (2006).

<sup>14</sup> Rubin et al., *supra* note 7, at 548.

<sup>15</sup> *Id.*

status<sup>16</sup> and until recently, nonprofit hospitals were allowed broad discretion in determining which of their activities or services constituted community benefits.<sup>17</sup> Consequently, there have been substantial variations in defining and measuring the value of community benefits provided by nonprofit hospitals.<sup>18</sup>

Public opinion of nonprofit hospitals is divergent. Much of the controversy centers on determining the boundaries of what exactly constitutes a “community benefit,” and *how much* of hospital resources and costs should be put toward providing community benefits<sup>19</sup> to justify the growing dollar amount of lost tax revenues for federal, state, and local governments. Reports highlight that nonprofit hospitals may be advantaged by tax savings more than they are disadvantaged by the costs of providing community benefits, and critics argue that nonprofit hospitals are not providing adequate levels of community benefits to outweigh lost tax revenues.<sup>20</sup>

Much of the research on nonprofit hospitals’ community benefit expenditures focuses on Charity Care<sup>21</sup> activities and programs, as most nonprofit

<sup>16</sup> Cong. Budget Office, *supra* note 13.

<sup>17</sup> James, *supra* note 9.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> See Alex Kacik, *Are ‘Community Benefit Programs’ Enough to Let Nonprofit Hospitals Off the Hook For Taxes?*, Crain’s Chi. Bus. (Dec. 3, 2018), <https://www.chicagobusiness.com/health-care/are-community-benefit-programs-enough-let-nonprofit-hospitals-hook-taxes> (“Even with this most liberal interpretation, I was a little surprised that as many as a quarter of not-for-profit hospitals are deemed as not doing enough to justify their tax exemptions.”).

<sup>21</sup> Charity care is defined as subsidized or free care for patients who meet hospital-established criteria pursuant to a financial assistance policy (“FAP”). Charity Care is heavily referenced throughout this article, as the majority of research and nonprofit hospitals’ efforts have historically been exerted towards such. Periodically, Charity Care may be used to refer narrowly to a hospital’s FAP. Additionally, Charity Care should be distinguished from Subsidized Health Services which include clinical services provided at a financial loss after subtracting costs of Charity Care, bad debt and shortfalls in government payments or reimbursements. The key distinction is that Charity Care is offered pursuant to an official hospital policy or decision, while Subsidized Health Services encompass revenue losses as a result of someone *other than the hospital* failing to fully pay for services. Marco A. Villagrana et al., Cong. Research Serv., *Hospital Charity Care and Related Reporting Requirements Under Medicare and the Internal Revenue Code 1* (2018), <https://fas.org/sgp/crs/misc/IF10918.pdf>; *What Qualifies As a Subsidized Service*, Cath. Health Ass’n, <https://www.chausa.org/communitybenefit/what-counts-q-a-listing/subsidized-health-services/what-qualifies-as-a-subsidized-service> (last visited Feb. 23, 2019).

hospitals exert the majority of their efforts toward such programs.<sup>22</sup> For example, according to a 2016 study, seven of the ten most profitable hospitals in the United States were nonprofit hospitals, collecting more than \$160 million in revenue from patient care services.<sup>23</sup> In the same study, an analysis of those top seven hospitals compared each hospital's level of Charity Care with their revenues, revealing that the hospitals reviewed experienced increased revenue while simultaneously reducing Charity Care spending.<sup>24</sup> The report found that in 2015 the nonprofit hospitals reviewed collected more than \$33.9 billion in total operating revenue—a \$29.4 billion increase from 2013.<sup>25</sup> At the same time, the hospitals' combined direct Charity Care spending decreased from \$414 million in 2013 to \$272 million in 2015.<sup>26</sup> Statistically, the hospitals' combined revenue increased by approximately 15% between 2013 and 2015. Yet, during that time, direct Charity Care spending decreased by 35%.<sup>27</sup> Comparatively, the value of tax breaks for nonprofit hospitals nearly doubled between 2002 and 2011,<sup>28</sup> and continues to steadily grow. While the total exemptions received by nonprofit hospitals at the federal, state, and local levels were valued at \$12.6 billion in 2002, they grew to \$24.6 billion in 2011.<sup>29</sup>

In light of analyses and comparisons of nonprofit hospitals' levels of community benefits, revenues, and cost savings from tax exemptions, concerns arise as to whether exempting nonprofit hospitals from taxes in exchange for the provision of community benefits is actually worth it. Further, questions remain as to whether the taxing systems for nonprofit hospitals is

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<sup>22</sup> James, *supra* note 9.

<sup>23</sup> John Commins, *7 of 10 Most Profitable Hospitals Are NFPs*, HealthLeaders (May 4, 2016), <https://www.healthleadersmedia.com/finance/7-10-most-profitable-hospitals-are-nfps>.

<sup>24</sup> Kelly Gooch, *Nonprofit Hospitals Record Greater Revenue, Less Charity Care Spending Under ACA: 7 Findings*, Becker's Hosp. Rev. (July 17, 2017), <https://www.beckershospitalreview.com/finance/nonprofit-hospitals-see-greater-revenue-less-charity-care-spending-under-aca-7-findings.html>.

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> Sara Rosenbaum, *Value of Tax Breaks for Nonprofit Hospitals Doubled Over Decade*, Philanthropy News Dig. (June 22, 2015), <https://philanthropynewsdigest.org/news/value-of-tax-breaks-for-nonprofit-hospitals-doubled-over-decade>.

<sup>29</sup> *Id.*

achieving what it was designed for<sup>30</sup> or, at a minimum, is producing the ends that nonprofit hospitals' favored tax status is theoretically justified by.

#### A. Recent Legislative Attempts to Address Concern Surrounding the Value of Nonprofit Hospitals' Community Benefit Services

Congressional scrutiny of nonprofit hospitals' operations culminated in the inclusion of new community benefit requirements within the ACA, with noncompliance resulting in potential liability for a \$50,000 penalty.<sup>31</sup> The ACA provisions require nonprofit hospitals to establish a written financial assistance policy ("FAP")<sup>32</sup> and make reasonable efforts to determine whether individuals are eligible for assistance under their FAPs before engaging in extraordinary collection actions.<sup>33</sup> In addition, the ACA mandates that nonprofit hospitals submit a copy of their Charity Care policy and details regarding billing and debt collection practices to the government.<sup>34</sup> Most importantly, the ACA directs nonprofit hospitals to perform a community health needs assessment ("CHNA") at least once every three years and include a statement in their filings about how the hospital assesses community needs.<sup>35</sup> The requirements specify that the CHNAs should address financial and other barriers to care as well as actions needed to better prevent illnesses, ensure adequate nutrition, and address social, behavioral, and environmental factors influencing communities' health and emergency preparedness.<sup>36</sup> In response, nonprofit hospitals must develop implementation strategies to address the community health needs discovered through the assessment.<sup>37</sup>

In an effort to further respond to concern surrounding the value of tax exemptions for nonprofit hospitals, the IRS developed new community benefit reporting requirements for nonprofit hospitals. After enactment of

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<sup>30</sup> Commins, *supra* note 23.

<sup>31</sup> Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,956 (Dec. 31, 2014) (to be codified at 26 C.F.R. pt. 1); James, *supra* note 9.

<sup>32</sup> Additional Requirements for Charitable Hospitals, 79 Fed. Reg. at 78,998 (defining a financial assistance policy as a written policy related to care for emergency medical conditions).

<sup>33</sup> *Id.* at 78,956.

<sup>34</sup> *Id.* at 78,954.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* at 78,963.

<sup>37</sup> *Id.* at 78,954.

the ACA and following a five-year implementation process, the IRS issued a final regulation in December 2014 attempting to clarify the ACA requirements for nonprofit hospitals.<sup>38</sup> The IRS also updated nonprofit hospitals' Form 990 Schedule H ("Schedule H") reporting form, specifying seven community benefit measurement spending categories.<sup>39</sup> Under the new Schedule H, Community Benefit spending categories include Charity Care, Unreimbursed Costs for providing services to patients insured by means-tested government programs—such as Medicare and Medicaid—Subsidized Health Services, Community Health Improvement Services and Community-Benefit Operations, Research, Health-Professions Education, and Financial and In-Kind Contributions to community groups.<sup>40</sup> The IRS further recognizes "Community Building" activities as a permissible form of Community Health Improvement Activities.<sup>41</sup> In reporting Community Building expenditures as Community Health Improvement Activities, nonprofit hospitals must additionally include within their filings a description of how their Community Building activities promote the health of the communities they serve.<sup>42</sup>

## II. THE INADEQUACY OF THE CURRENT REPORTING SYSTEM

Despite recent laws and regulations, the federal government's system for holding nonprofit hospitals accountable to their obligation to provide community benefits remains fundamentally flawed. The requirements imposed by the ACA and subsequent IRS regulations do not adequately alleviate concerns regarding the value of community benefit services, and the underlying policy justifications for granting nonprofit hospitals favored tax status are unsupported. Instead, a more assertive approach is needed to ensure nonprofit hospitals are providing sufficient levels of community benefits to justify foregone tax revenues. The IRS should implement a requirement that nonprofit hospitals provide specified minimum levels of community benefits in order to receive tax exemptions. In doing so, state-level requirements for granting nonprofit hospitals tax exemptions—which are at times more

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<sup>38</sup> *Id.*; James, *supra* note 9.

<sup>39</sup> Dep't of the Treasury, Internal Revenue Serv., Instructions for Schedule H (Form 990) 2, 16–20 (2018).

<sup>40</sup> *Id.*

<sup>41</sup> Sarah Rosenbaum, Econ. Studies at Brookings, Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement 3 (2018).

<sup>42</sup> *Id.*

stringent that federal requirements<sup>43</sup>—can serve as a baseline framework. In developing new requirements, the IRS would have a unique opportunity to develop standards that bring nonprofit hospitals' community benefit services more in line with current and forward-looking health care policies and goals. Further, the temporary nature of IRS tax regulations allows flexibility in both setting and changing standards for nonprofit hospitals as needed.

#### A. Recent Legislative Changes Perpetuate a System Wherein Nonprofit Hospitals Are Not Providing Community Benefits at Levels Sufficient to “Shift the Burden” in Carrying the Costs of Health Care

The predominant justification for granting tax exemptions to nonprofit hospitals—based on the theoretical *quid pro quo* relationship between the government and nonprofit hospitals<sup>44</sup>—is not actualized under the IRS's current community benefit requirements. It is estimated that in 2018, the federal government spent nearly \$1.1 trillion on health care.<sup>45</sup> Nonprofit hospitals' spending on community benefits does not come close to that amount,<sup>46</sup> and understandably, it may be argued that expecting nonprofit hospitals to spend such a high dollar amount is unreasonable. With studies of the top seven nonprofit hospitals showing operating revenues of \$33.9 billion,<sup>47</sup> these hospitals cannot afford to actually spend what the government would have otherwise spent on providing community benefits. Instead, the predominant concern surrounding nonprofit hospitals' favored tax status centers on a debate as to whether the costs of providing community benefits outweigh the tax savings nonprofit hospitals receive from tax benefits and exemptions.<sup>48</sup>

<sup>43</sup> Emily Katherine Johnson, *State Reporting Requirements and Non-Profit Hospital Community Benefit Spending* 3 (Apr. 30, 2015) (unpublished M.S. thesis, University of Colorado) (on file at Mountain Scholar), [https://mountainscholar.org/bitstream/handle/10968/1121/Johnson\\_ucdenveramc\\_1639M\\_10217.pdf?sequence=1](https://mountainscholar.org/bitstream/handle/10968/1121/Johnson_ucdenveramc_1639M_10217.pdf?sequence=1) (noting that “nine states specify a community benefit requirement beyond the vague federal minimum”).

<sup>44</sup> Rubin et al., *supra* note 7, at 548.

<sup>45</sup> *How Much Does the Federal Government Spend on Health Care?*, Tax Pol'y Ctr., <https://www.taxpolicycenter.org/briefing-book/how-much-does-federal-government-spend-health-care> (last visited Apr. 21, 2019).

<sup>46</sup> Beth Jones Sanborn, *Tax-Exempt Hospitals Spend \$67.4 Billion in Community Benefit, Outweighing Foregone Tax Revenue, Report Says*, *Healthcare Fin.* (Oct. 12, 2017), <https://www.healthcarefinancenews.com/news/tax-exempt-hospitals-spend-674-billion-community-benefit-outweighing-foregone-tax-revenue>.

<sup>47</sup> Gooch, *supra* note 24.

<sup>48</sup> See Kacik, *supra* note 20.

Critics often assert that nonprofit hospitals provide inadequate community benefits, specifically when analyzing the provision of Charity Care.<sup>49</sup> Consequently, recent regulatory action aims to increase the accountability and oversight of tax-exempt nonprofit hospitals' community benefit activities by expanding reporting, developing new exemption requirements, and, in some instances, litigating against nonprofit hospitals.<sup>50</sup> Investigations as to whether recent ACA provisions and IRS regulatory action have successfully increased accountability and oversight of nonprofit hospitals are misleading in their conclusions that current community benefit services justify lost tax revenues.

For example, an October 2017 report commissioned by the American Hospital Association concluded that community benefits from nonprofit hospitals outweigh the federal revenue by an 11:1 ratio.<sup>51</sup> According to the report, foregone tax revenue in 2013—after enactment of the ACA provisions but prior to the IRS final rule—was estimated at six billion dollars, while the nonprofit hospitals studied contributed approximately \$67.4 billion in community health benefits.<sup>52</sup> Of the \$67.4 billion in community benefits, \$34.9 billion was in the form of Charity Care Unreimbursed Costs, and Subsidized Health Services, and \$32.6 billion was reflected in other community benefit activities.<sup>53</sup> Additionally, a study based on 2009 IRS tax filings found that prior to recent regulatory changes, tax-exempt nonprofit hospitals devoted an average of 7.5% of their expenditures to community benefits.<sup>54</sup> “Of these expenditures, more than 85% went toward Charity Care, government payer payment shortfalls (i.e., Unreimbursed Costs), and Subsidized Health Services; and the remaining 15% went toward Community Health Improvement Activities, Health-Professions Education, and Re-

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<sup>49</sup> Rubin et al., *supra* note 7, at 545.

<sup>50</sup> *Id.* at 549; see also Baker Tilly, *Hospital Loses Federal Tax Exemption After Failure to Conduct CHNA*, Insights Blog (Aug. 24, 2017), <https://bakertilly.com/insights/hospital-loses-federal-tax-exemption-after-failure-to-conduct-chna/> (explaining that “the IRS recently revoked the tax-exempt status of a hospital for failing to fully meet all the requirements to complete a community health needs assessment (CHNA), demonstrating that Internal Revenue Code section 501(r) requirements have teeth.”).

<sup>51</sup> Alia Paavola, *AHA Report: Community Benefits from Tax-Exempt Hospitals Outweigh Tax Revenue Foregone by an 11-1 Ratio*, Becker's Hosp. Rep. (Oct. 13, 2017), <https://www.beckershospitalreview.com/finance/aha-report-community-benefits-from-tax-exempt-hospitals-outweigh-tax-revenue-foregone-by-an-11-1-ratio.html>.

<sup>52</sup> *Id.*

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

<sup>54</sup> Rubin et al., *supra* note 7, at 548.

search.<sup>55</sup> Following the 2014 regulation, IRS studies revealed that in 2015 nonprofit hospitals reported total community benefit costs at 13.3% of their total hospital expenses, half of which resulted from expenditures for financial assistance for patients and absorbing losses from Medicaid and other means-tested government program underpayments.<sup>56</sup> Studies have also compared the provision of community benefits between nonprofit hospitals and for-profit hospitals, concluding that on average, nonprofit hospitals appear to spend more on Charity Care as a percentage of their operating budgets.<sup>57</sup>

Despite seemingly optimistic trends in community benefits provided by nonprofit hospitals following the IRS regulation, much of the research provides only a partial picture of nonprofit hospitals' community benefits.<sup>58</sup> Conclusions drawn regarding the adequacy of nonprofit hospitals' community benefit operations depends largely on how broadly-defined "community benefit" is, as well as how the value of such is calculated,<sup>59</sup> and disagreement remains regarding what should count as a community benefit.<sup>60</sup>

The validity and practical impact of reports on nonprofit hospitals' expenditures on community benefits are called in to question when one takes a closer look at how nonprofit hospitals actually operate. For example, IRS studies on 2015 numbers highlight that most of the community benefits nonprofit hospitals report are in the form of financial assistance for patients.<sup>61</sup> However, nonprofit hospitals price their services similar to for-profit hospitals.<sup>62</sup> For non-negotiated rates, uninsured patients' prices are typically inflated much higher than the prices that privately or government-insured patients are required to pay.<sup>63</sup> Consequently, nonprofit hospitals often overstate their provision of Charity Care and Subsidized Health Services by calculating price reductions on inflated costs as revenue loss.<sup>64</sup> For

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<sup>55</sup> *Id.*

<sup>56</sup> Am. Hosp. Ass'n, Results from 2015 Tax-Exempt Hospitals' Schedule H Community Benefit Reports 1 (2018), <https://www.aha.org/system/files/2018-10/2018-schedule-h-community-benefit-reports.pdf>.

<sup>57</sup> Rubin et al., *supra* note 7, at 548.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.* at 549.

<sup>60</sup> *Id.* at 548.

<sup>61</sup> See Am. Hosp. Ass'n, *supra* note 56, at 3.

<sup>62</sup> Niran Al-Agba, *The Fairy Tale of a Non-Profit Hospital*, Health Care Blog (Apr. 25, 2017), <http://thehealthcareblog.com/blog/2017/04/25/the-fairy-tale-of-a-non-profit-hospital/>.

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

example, “in a patient evaluated with chest pain, the allowable for Medicare is \$3600; however, in an uninsured patient, the hospital may ‘write-off’ an inflated \$25,600 in uncompensated costs.”<sup>65</sup> The potential for nonprofit hospitals’ reports of Charity Care to include discounts or reductions on artificially inflated prices distorts the accuracy and reliability of recent studies.

Similarly, the differences between nonprofit and for-profit hospitals’ provision of community benefits is slight and appears to be even more narrow when the comparison includes “bad debt” as well as Charity Care.<sup>66</sup> For patients who lack adequate health insurance but do not meet a hospital’s Charity Care guidelines, unpaid charges are written off as bad debt.<sup>67</sup> However, in light of the discretion hospitals have to set their own Charity Care guidelines as they see fit, the line between Charity Care and bad debt is often vaguely-defined.<sup>68</sup> In contrast, for-profit hospitals “may have more stringent criteria for patients seeking Charity Care and so have relatively lower Charity Care expenditures.”<sup>69</sup> However, because for-profit hospitals may have less patients qualifying for Charity Care they in turn incur higher unpaid charges—“bad debt”—and ultimately, face comparable costs of treating indigent patients.<sup>70</sup>

Although under the ACA’s provisions, nonprofit hospitals may not use gross charges and must limit charges for emergency or other medically necessary care for FAP-eligible individuals (i.e., patients receiving Charity Care) to no more than the amounts generally billed to insured individuals,<sup>71</sup> there remains a shortfall in how non-negotiated prices are set by nonprofit hospitals. The new ACA provisions still allow nonprofit hospitals to set the charges for FAP-eligible individuals at the amount set for individuals with *private* insurance, which creates situations wherein the price for services is set significantly higher than government insurance prices and the difference is written off as Subsidized Health Services or Charity Care costs. Further, for individuals who are not eligible for a nonprofit hospital’s FAP policy, are not receiving emergency care, and are uninsured, the ACA provisions

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<sup>65</sup> *Id.*

<sup>66</sup> Rubin et al., *supra* note 7, at 548.

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

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

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> Additional Requirements for Charitable Hospitals: Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,954, 79,009 (Dec. 31, 2014) (to be codified at 26 C.F.R. pt. 1).

do not place adequate limits on the prices nonprofit hospitals are allowed to set for rendered services.<sup>72</sup>

Conclusively, it cannot be said with any certainty or reliability that accountability and oversight of nonprofit hospitals has been increased by recent ACA provisions and IRS regulatory action, and uncertainty remains as to whether new laws have led to improvements in the provision of community benefits by nonprofit hospitals. Additionally, there is no way to know whether new laws have resolved concerns that the community benefits hospitals provide do not outweigh foregone tax revenues.

#### B. Analyses of Nonprofit Hospitals' Practices and Community Benefits Activities Call into Question Whether Nonprofit Hospitals Are Operating in a "Fundamentally Charitable" Way

An alternative justification for granting nonprofit hospitals favored tax status is that tax exemptions and benefits are a reward for the hospital's fundamentally charitable character,<sup>73</sup> which begs the question—are nonprofits hospitals operating in a "fundamentally charitable" way? The promotion of health, often at the core of nonprofit hospitals' missions, has been deemed to be a charitable purpose in IRS revenue rulings.<sup>74</sup> According to the IRS, the promotion of health "is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole . . . provided that the class [of individuals whose health is promoted] is not so small that its [overall] relief is not of benefit to the community."<sup>75</sup> Yet, examination of recent trends in nonprofit hospitals' community benefit expenditures reveals that the "class of individuals" whose health is promoted by community benefit services is shrinking.<sup>76</sup> Further, comparing nonprofit hospitals' operations to their for-profit counterparts highlights that nonprofit hospitals' characteristics are frequently no more "fundamentally charitable" than those of for-profits hospitals.<sup>77</sup>

The vast majority of community benefit spending by nonprofit hospitals has been devoted to providing patient care services for free or at a reduced

<sup>72</sup> See Jessica Curtis, Cmty. Catalyst, *What does the Affordable Care Act Say About Hospital Bills?* 5 (2015), <https://www.communitycatalyst.org/resources/publications/document/CC-ACAHospitalBillsReport-F.pdf?1434480883>.

<sup>73</sup> Rubin et al., *supra* note 7, at 548.

<sup>74</sup> Rev. Rul. 69-545, 1969 I.R.B. 176, 1969 IRB LEXIS 176.

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

<sup>76</sup> See Gooch, *supra* note 24.

<sup>77</sup> See Rubin et al., *supra* note 7, at 548.

charge,<sup>78</sup> while only a small fraction has been on community health improvement.<sup>79</sup> However, in recent years nonprofit hospitals' spending on Charity Care, Unreimbursed Care and Subsidized Health Services has declined.<sup>80</sup> Nonprofit hospitals reported a total of \$34.9 billion in expenses for 2013 on Charity Care, Unreimbursed Care, and bad debt costs.<sup>81</sup> In 2014, expenditures fell to \$28.9 billion, a seventeen percent drop.<sup>82</sup>

Despite a decrease in spending on Charity Care, Unreimbursed Care, and Subsidized Health Services, nonprofit hospitals have not increased expenditures on Community Health Improvement Activities. For example, a recent study using data from 2009 to 2012 hospital tax and other governmental filings found that while hospitals spent 6.4% of their community benefit expenses on community health improvement activities in 2009, spending decreased to 5.4% in 2012.<sup>83</sup> While the ACA now requires nonprofit hospitals to conduct CHNAs and address the needs revealed by such,<sup>84</sup> the requirements do not include any specific minimum valuations of community benefits that a hospital must provide to retain tax-exempt status.<sup>85</sup> Without an incentive to shift savings from reducing Charity Care, Unreimbursed Care, and Subsidized Health Services toward community-wide, far-reaching activities and programs, nonprofit hospitals have instead exhibited an increase in expenditures on Health-Professions Education.<sup>86</sup>

Compounding with the shrinking class of individuals receiving some form of benefit under community benefit programs and services, nonprofit hospitals are continuing to operate like for-profit hospitals in significant ways. Similarities between nonprofit hospitals and their for-profit counterparts are present in hospital administration, financial investments, profits,

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<sup>78</sup> See James, *supra* note 9.

<sup>79</sup> *Id.*

<sup>80</sup> See Peter Cunningham et al., Henry J. Kaiser Family Found., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes* 4 (2016), <http://files.kff.org/attachment/issue-brief-understanding-medicare-hospital-payments-and-the-impact-of-recent-policy-changes>.

<sup>81</sup> *Id.* at 1.

<sup>82</sup> *Id.*

<sup>83</sup> Jonathon P. Leider et al., *Establishing a Baseline: Community Benefit Spending by Not-for-Profit Hospitals Prior to Implementation of the Affordable Care Act*, *J. Pub. Health Mgmt. & Prac.* 1, 5 (2016).

<sup>84</sup> See *The ACA Pushed Hospitals to Increase Their Community Benefit Spending—But That Hasn't Happened, Study Finds*, Advisory Board (Jan. 16, 2018), <https://www.advisory.com/daily-briefing/2018/01/16/community-benefit>.

<sup>85</sup> James, *supra* note 9.

<sup>86</sup> See Kacik, *supra* note 20.

and pricing in response to financial hardships.<sup>87</sup> For example, like for-profit hospitals, nonprofit hospitals bring in significant profits from portfolio building. An *Axios* report on eighty-four of the nation's largest nonprofit hospitals found that in 2016, the hospitals reviewed brought in more than twenty-one billion dollars through investments in stocks, bonds, mergers and acquisitions, credit default swaps, and accounting gains.<sup>88</sup> When factored in, these profits more than doubled overall profits from \$14.4 billion to \$35.7 billion, amounting to a 6.7% profit margin.<sup>89</sup>

Similarities between nonprofit and for-profit hospitals further arise when comparing the revenues and profits of overall hospitals systems as well as individuals working within the hospital.<sup>90</sup> Many individuals mistakenly believe that all nonprofit hospitals lose money or at best, breakeven.<sup>91</sup> While a 2013 study in *Health Affairs* did show that a majority of the 3,000 United States hospitals studied lost money, such loss occurred when considering *only* patient care services.<sup>92</sup> The study failed to consider "potential profits from other activities such as education, licensing technology, renting space, investments, parking, selling T-shirts and plush toys, and providing wonderful hospital food."<sup>93</sup> Additionally, salaries may be considered in calculating "costs," and thus, losing money does not necessarily equate to individuals within the hospital not making money.<sup>94</sup> Generally, nonprofit hospitals can be quite profitable,<sup>95</sup> and contrary to public perception not all nonprofit hospitals are bleeding money. In fact, a substantial number of nonprofit hospitals have ample resources to support additional activities,

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<sup>87</sup> See Meg Bryant, *Nonprofit Hospitals Reap Billions on Wall Street: Report*, HealthCare Dive (Dec. 8, 2017), <https://www.healthcaredive.com/news/nonprofit-hospitals-reap-billions-on-wall-street-report/512579/>.

<sup>88</sup> *See id.*

<sup>89</sup> *Id.*

<sup>90</sup> See Sachin Waikar, *What Happens to Healthcare Costs When Nonprofit Hospitals Take a Financial Hit?*, Kellogg Insight (Aug. 3, 2017), <https://insight.kellogg.northwestern.edu/article/what-happens-to-healthcare-costs-when-nonprofit-hospitals-take-a-financial-hit>.

<sup>91</sup> Bruce Y. Lee, *Very Profitable Nonprofit Hospitals...But Where Are The Profits Going?*, Forbes (May 8, 2016), <https://www.forbes.com/sites/brucelee/2016/05/08/very-profitable-nonprofit-hospitals-but-where-are-the-profits-going/#60f5b60b36b2>.

<sup>92</sup> *Id.* (citing Ge Bai & Gerard F. Anderson, *A More Detailed Understanding of Factors Associated with Hospital Profitability*, 35 Health Aff. 889, 889 (2016)).

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

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

programs, or other community benefit services.<sup>96</sup> Furthermore, nonprofit hospitals are often scrutinized “for high C-suite salaries and, at times, significant revenues.”<sup>97</sup>

Nonprofit hospitals’ response to financial shocks reiterates similarities between nonprofit and for-profit hospitals’ operations. Unlike for-profit hospitals, nonprofit hospitals—in theory—do not charge exorbitant prices for their services because part of their mission is to benefit society, regardless of monetary gain.<sup>98</sup> Consequently, financial shocks can be compensated for in nonprofit hospitals’ operating budgets by temporary increases in prices.<sup>99</sup> Alternatively, failure to raise prices following a financial shock is a sign that a nonprofit hospital was already charging excessive prices.<sup>100</sup> Illustratively, a study of nonprofit hospitals’ pricing responses to financial shock—focusing on price and service shifts after the 2008 financial crisis—found “only limited evidence that nonprofit hospitals raised prices in the wake of the recession.”<sup>101</sup> The hospitals that *did* raise prices did not raise them by much and tended to be larger nonprofit hospitals with greater pricing power.<sup>102</sup> This suggests that like their for-profit counterparts, large nonprofit hospitals were already charging excessive or near-excessive prices. Further, smaller nonprofit hospitals with less pricing power—also like their for-profit counterparts—were more likely to reduce services that were less profitable or to simply go out of business.<sup>103</sup>

Finally, nonprofit hospitals are spending similar amounts on community benefits as their for-profit counterparts.<sup>104</sup> For example, a study from the University of California San Francisco showed that the average proportion of total operating expenses nonprofit hospitals spent on Charity Care was 1.9% compared to 1.4% for for-profit hospitals.<sup>105</sup> In light of the failure of

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<sup>96</sup> *Id.*

<sup>97</sup> *See* Bryant, *supra* note 87.

<sup>98</sup> *See* Waikar, *supra* note 90.

<sup>99</sup> *See id.* (explaining that, because nonprofit hospitals do not try to maximize their profits, they may have to absorb financial shock by raising prices).

<sup>100</sup> *See id.* (noting that for-profit hospitals maximize profits even in times of plenty and thus do not need to increase costs in less plentiful periods).

<sup>101</sup> *Id.*

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

<sup>103</sup> *Id.*

<sup>104</sup> Rick Cohen, *Nonprofit Hospitals No Better than For-Profits on Charity Care*, Nonprofit Q. (Aug. 4, 2015), <https://nonprofitquarterly.org/2015/08/07/nonprofit-hospitals-no-better-than-for-profits-on-charity-care/>.

<sup>105</sup> *Id.*

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nonprofit hospitals' costs of community benefit services to outweigh foregone tax revenues, the contrastingly *uncharitable* nature of nonprofit hospitals, and the glaring similarities between nonprofit hospitals and for-profit hospitals; it is evident that the underlying rationales for granting favored tax status to nonprofit hospitals are unjustified.

### III. A MINIMUM STANDARD FOR NONPROFIT HOSPITALS' PROVISION OF COMMUNITY BENEFITS

As a supplement to recent regulations outlining specific categories of community benefits, the IRS should implement a schedule of minimum expenditure levels that nonprofit hospitals are required to spend on providing community benefits. Legislation imposing minimum community benefit requirements has already been adopted in a handful of states.<sup>106</sup> However, failure to enact minimum requirements at the federal level has largely been the result of concerns about potential effects on nonprofit hospitals' operating expenses and ability to offer certain services,<sup>107</sup> as well as questions surrounding how best to structure and implement such requirements. In developing and structuring a minimum community benefit requirement, this comment argues that the IRS can build on state-level minimum requirement systems, specified categories of community benefits outlined in IRS regulations, and health care policies and goals within the ACA to build a system which better holds nonprofit hospitals accountable for their duty to provide community benefits and assists in achieving forward-looking health care goals.

#### A. A Baseline Framework: Current State-Level Legislation Imposing Minimum Community Benefits Requirements

State legislation has often mirrored federal standards for nonprofit hospitals, automatically granting favored tax status to hospitals deemed by the IRS to be in compliance with the federal requirements.<sup>108</sup> However, some states have imposed additional requirements on hospitals. Of the states that

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<sup>106</sup> *Hospital Community Benefits Comparison Table for Six New England States*, Nat'l Acad. for St. Health Pol'y, [https://nashp.org/wp-content/uploads/2018/05/Hospital-community-benefits-chart-final-5\\_3\\_2018.pdf](https://nashp.org/wp-content/uploads/2018/05/Hospital-community-benefits-chart-final-5_3_2018.pdf) (last visited Feb. 24, 2019) (noting the details of community benefit requirements in six states).

<sup>107</sup> See Kacik, *supra* note 20 (explaining that "an absolute measure would not consider the hospital's patient mix and financial situation . . . [and] could even cause some high-performing hospitals to give less").

<sup>108</sup> Rubin et al., *supra* note 7, at 547.

deviate from federal standards and requirements, two trends have emerged.<sup>109</sup> The broader trend reflects an “increasing prevalence of [additionally] mandated disclosures by [nonprofit] hospitals of their community benefit activities to government agencies and...to the public at large.”<sup>110</sup> More than half of all states require nonprofit hospitals to make such disclosures.<sup>111</sup> Less commonly, a handful of states have established minimum standards for nonprofit hospitals’ retention of tax exemptions.<sup>112</sup> According to a 2015 *Hilltop Institute* updated survey, Illinois, Utah, Pennsylvania, Nevada, and Texas have imposed minimum community benefit standards.<sup>113</sup> Additionally, while Virginia legislation does not impose minimum requirements, nonprofit hospitals must obtain a Certificate of Public Need before they are permitted to operate.<sup>114</sup> “The Commissioner of the State Board of Health is authorized to condition approval of applications for certificates of public need on an applicant’s agreement to provide an acceptable level of reduced-rate care to indigents, to provide care to persons with special needs, or to facilitate primary care services in designated medically underserved areas within its service area.”<sup>115</sup> Thus, agreed conditions of approval could theoretically include quantifiable amounts of community benefit expenditures.<sup>116</sup>

Two of the states whose legislation imposes minimum community benefit requirements use a system focused on property tax costs. For example, Illinois amended its property tax code to impose minimum community benefit standards in 2012.<sup>117</sup> Under Illinois’s legislation, nonprofit hospitals may only receive an exemption from property and sales taxes where costs of providing Charity Care or other health care services and activities to low-income or underserved individuals is equivalent to what the hospital otherwise would be required to pay in property taxes.<sup>118</sup> Utah similarly bases its

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

<sup>110</sup> *Id.* at 548.

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

<sup>112</sup> *Id.* at 547.

<sup>113</sup> Hilltop Inst., Community Benefit State Law Profiles: State Community Benefit Requirements and Tax Exemptions for Nonprofit Hospitals (2015), <https://www.hilltopinstitute.org/wp-content/uploads/publications/CommunityBenefitStateLawProfiles-January2015.pdf>.

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

<sup>115</sup> Va. Code § 32.1-102.2(c) (2018); 12 Va. Admin. Code §§ 5-220-270(A), 5-220-420(A) (2019); *id.*

<sup>116</sup> Hilltop Inst., *supra* note 113.

<sup>117</sup> *Id.* (citing 35 Ill. Comp. Stat. 200/15-86(c) (2012)).

<sup>118</sup> 35 Ill. Comp. Stat. 5/223(a) (2019).

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minimum requirements on property tax costs, requiring nonprofit hospitals' annual community benefit contributions to exceed its annual property tax liability.<sup>119</sup>

Other states have based minimum community benefit standards as a requirement for tax exemptions on percentages of nonprofit hospitals' costs, revenues, or in some instances, both. For example, Pennsylvania's Institutions of Purely Public Charity Act requires nonprofit hospitals to donate a substantial portion of services to community benefits, benefit a substantial and indefinite class of persons receiving Charity Care, and further, to relieve the government of some of the burden of providing health care.<sup>120</sup> In determining whether a nonprofit hospital's community benefits make up a "substantial portion" of its services, one of seven measurement standards may be chosen by nonprofit hospitals—six of which specifically set minimum rates relating to goods or services and one of which requires fundraising on behalf of another nonprofit institution.<sup>121</sup>

Pennsylvania's legislation grants property tax exemptions to nonprofit hospitals treating uninsured and insured patients without regard to ability to pay where uncompensated care costs are equal to at least seventy-five percent of the hospital's net operating income, but not less than three percent of total operating expenses.<sup>122</sup> Additionally, nonprofit hospitals treating patients pursuant to a schedule of fees based on ability to pay may be eligible for property tax exemptions.<sup>123</sup> Such exemptions are granted where at least twenty percent of patients are treated for free or at a below-cost charge, at least ten percent of patients receive at least a ten percent cost reduction, and no patients are charged a fee greater than or equal to the cost of care.<sup>124</sup> Alternative ways nonprofit hospitals are eligible for property tax exemptions under Pennsylvania's legislation include:

- (1) providing wholly gratuitous care to at least five percent of patients receiving similar care from the hospital;<sup>125</sup>
- (2) providing financial assistance or uncompensated care to at least twenty percent of patients receiving similar care, if at least ten per-

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<sup>119</sup> Hilltop Inst., *supra* note 113.

<sup>120</sup> *Id.* (citing Hosp. Utilization Project v. Commonwealth, 487 A.2d 1306 (Pa. 1985)).

<sup>121</sup> 10 Pa. Cons. Stat. § 375(d)(1)–(2) (2018).

<sup>122</sup> *Id.* at § 375(d)(1)(i)(c).

<sup>123</sup> *Id.* at § 375(d)(1)(ii).

<sup>124</sup> *Id.* at § 375(d)(1)(ii)(B)–(D).

<sup>125</sup> *Id.* at § 375(d)(1)(iii).

cent either paid no fees or paid fees at ninety percent or less than the cost of care;<sup>126</sup>

- (3) providing uncompensated care which in the aggregate equals at least five percent of the hospital's cost of providing the goods or services;<sup>127</sup> or
- (4) treating government-insured patients at no charge or a reduced charge, if the hospital receives seventy-five percent or more of its gross operating revenue from government payments and the aggregate amount of government payments does not exceed ninety-five percent of the costs of providing such care to government-insured patients.<sup>128</sup>

In comparison, Nevada requires both nonprofit and for-profit hospitals to annually provide Charity Care in an amount that represents at least 0.6% of the hospital's net revenue for the preceding fiscal year.<sup>129</sup> Where a hospital does not meet the 0.6% standard, the shortfall is deducted from any payments otherwise owed to the hospital.<sup>130</sup>

Texas legislation, whose standards are widely regarded as the most aggressive and detailed,<sup>131</sup> requires that nonprofit hospitals either (1) provide Charity Care and Unreimbursed Services equal to four percent of net patient revenue, (2) provide Charity Care and community benefits overall equaling five percent of the hospital's net patient revenue, with Charity Care and Unreimbursed Services still accounting for at least four percent of that number, or (3) provide Charity Care and Unreimbursed Services at one-hundred percent of the value of the hospital's state tax exemption.<sup>132</sup> Alternatively, nonprofit hospitals may qualify for tax exemptions where Charity Care and unreimbursed care equals a level that is "reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system."<sup>133</sup>

State-level legislation imposing minimum community benefit requirements highlights the potential benefits of imposing more stringent federal

<sup>126</sup> *Id.* at § 375(d)(1)(iv).

<sup>127</sup> *Id.* at § 375(d)(1)(v).

<sup>128</sup> *Id.* at § 375(d)(1)(vi)(A).

<sup>129</sup> Nev. Rev. Stat. § 439B.320(1) (2019).

<sup>130</sup> *Id.* at § 439B.320(3) (2019); Hilltop Inst., *supra* note 113.

<sup>131</sup> Rubin et al., *supra* note 7, at 547.

<sup>132</sup> Tex. Tax Code § 11.1801(a)(2)-(4) (2019).

<sup>133</sup> *Id.* at § 11.1801(a)(1).

requirements and serves as a framework for developing and implementing federal minimums. A thesis assessing the impact of state-level regulations on nonprofit hospital community benefit behavior—predominantly focusing on the provision of uncompensated care—found in 2016 that states’ implementation of additional community benefit requirements increased nonprofit hospitals’ provision of Charity Care.<sup>134</sup> The presence of state reporting requirements was associated with a 12.4% increase in the total expenses nonprofit hospitals dedicated to community benefits.<sup>135</sup> Further, evidence based on a study of nonprofit hospitals in Indiana revealed that relatively strict reporting requirements, such as specific levels or minimums, resulted in larger volumes of Charity Care.<sup>136</sup> Overall, “legislation limiting the billing and collections practices of [nonprofit] hospitals appear to have the largest effect, followed by policies specifically regulating community benefit provisions.”<sup>137</sup> In contrast, “policies regarding financial assistance and financial assistance information dissemination...did not appear to produce any changes” in the provision of Charity Care.<sup>138</sup>

The study further indicated that specific language in state legislation may drive increased levels of charity or uncompensated care.<sup>139</sup> For example, Illinois’s regulation partly qualifies community benefits as “health services to low-income or underserved individuals, subsidies of state or local government programs, support for state health care programs for low-income individuals, and other activities.”<sup>140</sup> Additionally, Pennsylvania’s legislation requires nonprofit hospitals to donate or render gratuitously “a substan-

<sup>134</sup> See Angela Chen, *The Provision of Charity Care by Nonprofit Hospitals* 12 (2016) (unpublished B.S. thesis, University of Pennsylvania) (on file with ScholarlyCommons at [https://repository.upenn.edu/joseph\\_wharton\\_scholars/22/](https://repository.upenn.edu/joseph_wharton_scholars/22/)) (citing Elizabeth K. Johnson, *State Reporting Requirements and Non-Profit Hospital Community Benefit Spending* (2012) (unpublished Ph.D. dissertation, University of Colorado)).

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* (citing F.J. Hellinger, *Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements*, 34 *J. Health Pol., Pol’y & L.* 37, 57 (2009)).

<sup>137</sup> *Id.* at 23.

<sup>138</sup> *Id.*

<sup>139</sup> See *id.* at 24 (explaining that unreimbursed patient care may be a result of non-specific language such as “community benefit”).

<sup>140</sup> *Id.* (quoting Bernadette Broccolo et al., *Groundbreaking Legislation On Property Tax and Sales Tax Exemptions For Illinois Hospitals*, Mondaq (June 21, 2012), <http://www.mondaq.com/unitedstates/x/183034/property+taxes/Groundbreaking+Legislation+On+Property+Tax+And+Sales+Tax+Exemptions+For+Illinois+Hospitals>).

tial portion of its services” to benefitting the community.<sup>141</sup> Such language effectively focuses nonprofit hospitals’ choices surrounding what type of community benefits to provide on free or reduced-rate care. Consequently, nonprofit hospitals may have chosen to meet the requirements through increases in Charity Care, Unreimbursed Care, Subsidized Services, or other forms of uncompensated care, as opposed to other categories of community benefits.<sup>142</sup>

While the 2016 study of the impact of state-level legislation focused on measurements of uncompensated care, its results suggest that setting minimum requirements for each category of community benefit outlined by the IRS will increase nonprofit hospitals’ community benefit activities nationwide.<sup>143</sup> Further, lessons of state-level implementation of minimum community benefit requirements serve as guidance in developing federal minimum requirements. For example, as state legislation limiting the billing and collection practices of nonprofit hospitals had the largest effect on nonprofit hospitals’ community benefit activities,<sup>144</sup> the IRS may specify that in setting minimum Charity Care, Subsidized Health Services, or Unreimbursed Services requirements, cost calculations must be based on uninflated prices. Alternatively, costs could be calculated in proportion to the ratio of prices for uninsured or government-insured individuals versus privately insured individuals. Such a provision would solve transparency issues while creating a responsibility to nonprofit hospitals to act more fairly in their billing operations. Conversely, as state FAP policies and regulations had virtually no effect on nonprofit hospitals’ community benefit activities,<sup>145</sup> it would be wise for the IRS to avoid inefficiencies by shifting focus away from discussing FAP requirements at length. Finally, where a focus on any specific category of community benefits—such as Community Health Improvement Activities, for example—is desired, including strong language delineating specific examples of what activities or programs the IRS values would result in specific increases in those areas.

#### B. Recommendations for Developing and Structuring Federal Minimum Community Benefit Requirements

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<sup>141</sup> *Id.* (quoting 10 Pa. Cons. Stat. 375(d)(1) (2018)).

<sup>142</sup> *Id.* at 25.

<sup>143</sup> *Id.* at 12.

<sup>144</sup> *Id.* at 23.

<sup>145</sup> *Id.* (explaining that financial assistance policies did not appear to produce any changes in uncompensated care provision).

IRS implementation of minimum community benefits requirements at the federal level will better hold nonprofit hospitals accountable while effectuating an increase in the level of community benefits provided. In implementing standards, the IRS should require either that a specific percentage of nonprofit hospitals' expenses, or alternatively, that a level of expenses equal to the value of a hospitals' tax savings be devoted toward community benefits. Nonprofit hospitals should be given discretion to choose which measuring method to comply with. Further, the IRS should dictate a schedule of varying percentages of expenditures for each category of community benefits. The categories of community benefit should include the categories previously laid out in Schedule H but should also include "community building" activities as a separate category of its own. The varying levels specified in the schedule should further align with current and forward-looking goals and policies of health care and public health. Because tax codes typically have sunsets and are therefore "temporary," the standards can be adjusted as necessary as time goes on.

The current standards for granting tax exemptions were designed for the health care environment as it existed several generations ago, and thus, are not in-line with current community health needs.<sup>146</sup> However, the imposition of a varying schedule of minimum community benefits requirements at the federal level would modernize the IRS's current approach, better ensure that the burden of providing health care is shifted from the government to nonprofit hospitals, and better align with forward-looking health care needs and policies.

Health care policies and goals inherent in ACA provisions provide a foundational focus for the IRS in developing and implementing minimum community benefit requirements. The most important goal of the ACA is to achieve near-universal coverage by sharing responsibility for the costs of health care between the government, individuals, and employers.<sup>147</sup> Additionally, the ACA aims "to improve the fairness, quality, and affordability of health insurance coverage [and]...improve the value, quality, and efficiency" of healthcare by "reducing wasteful spending and making the health-care system more accountable to a diverse patient population."<sup>148</sup> Further, the ACA emphasizes the necessity of strengthening "primary health-care access", attaining "longer-term changes in the availability of primary and preventive health care", and making "strategic investments in the public's health" by expanding "clinical preventive care and community

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<sup>146</sup> Rubin et al., *supra* note 7, at 546.

<sup>147</sup> Rosenbaum, *supra* note 3.

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

investments.”<sup>149</sup> Overall, the ACA reflects policymakers’ efforts to both re-define the financial relationship between individuals and actors within the healthcare system and to realign the system with long-term changes in healthcare quality, organization and design of healthcare practice, and transparency.<sup>150</sup>

In conjunction with the health care policy goals present in the ACA, the IRS should consider the overarching goals and policies of the health care field as a whole. In recent years, there has been an increasing interest in using the health care system to address social determinants of health beyond the walls of hospitals and doctors’ offices.<sup>151</sup> Nonprofit hospitals are “now expected to focus less on direct patient financial assistance and more on public and population health efforts.”<sup>152</sup> Such growing interest and expectation presents an opportunity for nonprofit hospitals to assume a broader role both within their communities and to engage in efforts to address upstream issues impacting public health.<sup>153</sup>

Current categories of community benefits include Charity Care, Unreimbursed Costs for means-tested government programs, Subsidized Health Services, Community Health Improvement services and Community-Benefit operations, Research, Health-Professions Education, and Financial and In-Kind Contributions to community groups.<sup>154</sup> Currently, Community Building activities are evaluated as a subcategory of Community Health Improvement services, with additional reporting requirements.<sup>155</sup> All of these categories present opportunities to advance big-picture health care policies and goals.

Under IRS regulations, Charity Care is defined as subsidized or free care for persons who meet criteria established by the hospital pursuant to a FAP.<sup>156</sup> Alternatively, Subsidized Health Services include clinical services provided at a financial loss after subtracting costs of Charity Care, bad debt,

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<sup>149</sup> *Id.*

<sup>150</sup> *Id.* at 131–32 (citing Patient Protection and Affordable Care Act, Pub. L. No. 111–148 § 1501 (2010)).

<sup>151</sup> See Rosenbaum, *supra* note 41, at 1.

<sup>152</sup> Leider et al., *supra* note 83, at 2.

<sup>153</sup> See Rosenbaum, *supra* note 41, at 6.

<sup>154</sup> Catholic Health Ass’n of the U.S., IRS Form 990, Schedule H: Community Benefit and Catholic Healthcare Governance Leaders 4 (2008), [https://www.chausa.org/docs/default-source/general-files/form990\\_booklet-pdf.pdf](https://www.chausa.org/docs/default-source/general-files/form990_booklet-pdf.pdf).

<sup>155</sup> Rosenbaum, *supra* note 41.

<sup>156</sup> Villagrana et al., *supra* note 21.

and losses from means-tested government programs.<sup>157</sup> In establishing requirements for nonprofit hospitals' provision of Charity Care and Subsidized Health Services, the most efficient approach would be for the IRS to correlate required minimums with statistical impacts of health disparities in each respective nonprofit hospital's surrounding community. This would more drastically shift the burden of health care costs and more adequately hold nonprofit hospitals accountable for promoting health within their communities. Additionally, this would promote the ACA goals of strengthening primary healthcare access and attaining long-term changes in the availability of primary and preventive health care. For example, a 2006 Congressional Budget Office report found that compared to their for-profit hospital counterparts, nonprofit hospitals on average tended to operate in more rural areas<sup>158</sup> with higher average incomes, lower poverty rates, and lower uninsured rates.<sup>159</sup> In light of such, the IRS may set minimum Charity Care and Subsidized Health Services requirements lower for nonprofit hospitals operating in rural areas than those operating in urban areas or communities with lower average incomes, higher poverty rates, or higher rates of uninsured patients.

Unreimbursed Costs, on the other hand, encompass shortfalls in payments to nonprofit hospitals for government-insured patients when compared to the actual costs of providing services.<sup>160</sup> Medicaid expansion under the ACA indicates the best approach to burden-shifting is for the IRS to set minimum requirements for Unreimbursed Costs which increase over time.<sup>161</sup> With the expansion of Medicaid, the level of matching funds the federal government will grant to states will be reduced from one-hundred percent to ninety percent by 2020.<sup>162</sup> Additionally, "disproportionate share" hospital payments are being reduced under the ACA across all states.<sup>163</sup>

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<sup>157</sup> *What Qualifies as a Subsidized Service*, *supra* note 21.

<sup>158</sup> Cong. Budget Office, *supra* note 13, at 14.

<sup>159</sup> *Id.*

<sup>160</sup> Dep't of the Treasury, *supra* note 39, at 19.

<sup>161</sup> See Thomas DeLeire et al., Dep't of Health & Human Serv., *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014*, at 4–5 (2014), [https://aspe.hhs.gov/system/files/pdf/77061/ib\\_UncompensatedCare.pdf](https://aspe.hhs.gov/system/files/pdf/77061/ib_UncompensatedCare.pdf).

<sup>162</sup> Laura Snyder & Robin Rudowitz, Henry J. Kaiser Family Found., *Medicaid Financing: How Does it Work and What are the Implications?* 1 (2015), <http://files.kff.org/attachment/issue-brief-medicaid-financing-how-does-it-work-and-what-are-the-implications>.

<sup>163</sup> *Id.* (explaining the reductions of disproportionate share hospital payments and describing such payments as a source of financing available to hospitals serving a large number of Medicaid and low-income uninsured patients).

The cuts began in 2018 and will continue through 2025.<sup>164</sup> Consequently, the federal government will spend more upfront on reimbursing government-insured patient costs.<sup>165</sup> In response, minimum requirements for Unreimbursed Costs should initially be set at a lower rate and increased over time. Further, minimum requirements for Unreimbursed Costs should take into account whether a nonprofit hospital is operating in a state that has decided to expand Medicaid pursuant to the ACA. In states where Medicaid expansion is underway, the federal government will spend more in matching funds initially while down the line state governments will be spending more in payments to hospitals as the population of individuals insured by Medicaid grows.<sup>166</sup>

Alternatively, Community Health Improvement Services and Community-Benefit Operations are defined as “activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health.”<sup>167</sup> Community Health Improvement Services and Community-Benefit Operations typically do not generate inpatient or outpatient revenue.<sup>168</sup> Examples tend to focus on the upstream conditions of health rather than patient services, and usually include hospital participation—through donated professional time, grants, and other efforts—in broader, community-wide efforts to improve health.<sup>169</sup> While the ACA requires nonprofit hospitals to perform CHNAs, it does not require any specific level of responsive action based on CHNA findings, but rather leaves such a determination to the discretion of nonprofit hospitals.<sup>170</sup> In regard to Community Health Improvement Services and Community Benefit Operations, the IRS should impose minimum requirements corresponding to nonprofit hospitals’ CHNA findings. Further, the IRS should delineate specific examples of activities which would qualify, such as job training for underprivileged individuals, free transportation to healthcare or job-related appointments, assistance in child care for individuals who are not able to afford professional child care services, or education of dietary and nutrition-based health impacts. While these are only a few examples, im-

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<sup>164</sup> *Id.* (citing Medicare Access and CHIP Reauthorization Act of 2015, H.R. 2, 114th Cong. (2016) (enacted)).

<sup>165</sup> *Id.*

<sup>166</sup> *Id.* at 6.

<sup>167</sup> Sara Rosenbaum et al., *Modifying Hospital Community Benefit Tax Policy: Easing Regulation, Advancing Population Health*, Health Aff. (Dec. 1, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20161201.057691/full/>.

<sup>168</sup> *Id.*

<sup>169</sup> *See id.*

<sup>170</sup> *See James, supra* note 9.

plementing these suggestions would enable nonprofit hospitals to promote the ACA goals of making the health care system more accountable to a diverse patient population and expanding clinical preventive care and community investments.<sup>171</sup>

While currently, community building activities are deemed a subcategory of community health improvement and benefit activities,<sup>172</sup> the IRS should delineate community building activities as a separate category of overall community benefits. Given analysis of state-level requirements and findings that language can often drive where nonprofit hospitals focus their efforts,<sup>173</sup> creating community building activities as its own separate category can place an emphasis on nonprofit hospitals' need to assist in managing and improving upstream health implications and providing preventive health care services. Under the IRS's current approach, agency guidance does not discuss or define any range or form of evidence that will automatically deem a community building program as an acceptable Community Health Improvement Activity.<sup>174</sup> "This vagueness leaves [nonprofit] hospitals potentially vulnerable to the IRS's rejection of the hospital's justification as not sufficient to classify . . . expenditures as community benefits."<sup>175</sup> Mandating specific minimums for programs that address economic, social, and environmental determinants of health—such as affordable and safe housing, environmental improvements, economic development, community support, or workforce development<sup>176</sup>—would help clarify what kind of community building costs are acceptable, increasing the likelihood that nonprofit hospitals increase their levels of community building operations.

Finally, in-line with goals of increasing focus on preventive health care, the IRS should impose higher minimum requirements for Research, Health-professions Education, and Financial and In-kind Contributions to community groups. Specifically, requirements should focus on nonprofit hospitals increasing programs aimed at addressing forward-looking health issues. Similar to community building activities and community health improve-

<sup>171</sup> Rosenbaum, *supra* note 3.

<sup>172</sup> Rosenbaum et al., *supra* note 167.

<sup>173</sup> Chen, *supra* note 134, at 24–25 (citing Bernadette Broccolo et al., *Groundbreaking Legislation On Property Tax and Sales Tax Exemptions For Illinois Hospitals*, Mondaq (June 21, 2012), <http://www.mondaq.com/unitedstates/x/183034/property+taxes/Groundbreaking+Legislation+On+Property+Tax+And+Sales+Tax+Exemptions+For+Illinois+Hospitals>).

<sup>174</sup> Rosenbaum, *supra* note 41, at 3–4.

<sup>175</sup> *Id.* at 4.

<sup>176</sup> *Id.* at 7.

ment, dictating specific examples of qualifying programs and operations can influence nonprofit hospitals to focus more efforts on these categories.

For example, deeming programs aimed at addressing health impacts of climate change is one way that minimum requirements can shift Research, Health-Professions Education, and Financial and In-Kind Contributions to a more forward-looking approach. Public health leaders and analysts have suggested nonprofit hospitals take actions such as mitigating threats from toxins by expanding alerts in hospital-information and quality-control systems, increasing health literacy by integrating into patient and community decisions the local health impacts of climate change, and sharing data and analyses with community planners and environmentalists for health-impact assessments of parks and trails to decrease obesity.<sup>177</sup> Nonprofit hospitals could also increase professional education on or research into methods of curing or preventing water-borne diseases and illnesses stemming from or exacerbated by poor air quality. Further, as there are health implications arising from increases in the exacerbation of food insecurity as a result of climate change, nonprofit hospitals could focus on creating and maintaining methods for communities to obtain greater access to agricultural food crops<sup>178</sup>—such as food clinics and drives, promotion of urban farming, lessons on growing foods, transportation to grocery stores, or reforestation efforts.

## CONCLUSION

Policymakers and health care leaders have frequently questioned and critiqued whether nonprofit hospitals' provision of community benefits is worth their favored tax status. In light of shortfalls in the value of community benefit services, action is needed to improve the federal government's system of holding nonprofit hospitals' accountable. Due to the failure of recent legislation to address issues in the current federal tax system for nonprofit hospitals, the IRS should implement minimum community benefit requirements at the federal level. Further, these standards should vary based on the category of community benefit being assessed. Developing new requirements would ensure that underlying justifications for granting non-

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<sup>177</sup> Warren G. Lavey, *Underutilized Community Health Needs Assessments: Four Environmental Actions for Hospitals that Improve Community Health*, 27 Health Matrix: J. L.-Med. 229, 229 (2017).

<sup>178</sup> See generally Lindsay F. Wiley, *Adaptation to the Health Consequences of Climate Change as a Potential Influence on Public Health Law and Policy: From Preparedness to Resilience*, 15 Widener L. Rev. 483, 493–96 (2010) (discussing food insecurity issues and suggested responses for nonprofit hospitals).

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profit hospitals tax exemptions are realized and that community benefit services are better aligned with current and forward-looking health care policies and goals.

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