Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?

Lisa Kinney Helvin

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Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?

Lisa Kinney Helvin*

INTRODUCTION .............................................................................................................423

I. LAWSUITS AGAINST NOT-FOR-PROFIT HOSPITALS ...........................................433

II. STATUTORY AND REGULATORY REQUIREMENTS FOR FEDERAL TAX EXEMPTION UNDER § 501(C)(3) AND SUBSEQUENT IRS REVENUE RULINGS .............................................................................................440

A. Statutory Obligations and Regulatory Interpretations of the “Charitable Purpose” Requirement ........................................................................................................440

B. Evolution of the “Promotion of Health” Standard Through Regulatory Adjudications and Internal Enforcement Directives ..........443

C. Regulatory and Congressional Efforts To Establish a New Statutory Standard .............................................................................................................446

III. IMPOSING A HEIGHTENED CHARITY CARE REQUIREMENT: LESSONS FROM THE STATES .........................................................................................451

A. State-Level Reforms ..............................................................................................452

B. State Efforts Achieve Limited Success .................................................................454

* Law clerk to the Honorable Diana Gribbon Motz, United States Court of Appeals for the Fourth Circuit; J.D. 2007, University of Virginia School of Law. I would like to thank Professor Julia D. Mahoney for her encouragement and guidance on this Note. I appreciate, as well, the helpful suggestions of the editors of the Yale Journal of Health Policy, Law, and Ethics. Rachel Osterman, in particular, provided incredibly insightful comments that greatly improved the quality of this piece. Finally, I owe a tremendous amount of gratitude to my husband, Steve, for his unassailable patience and support.
IV. VOLUNTARY CHANGES AND PROPOSALS FOR LEGISLATIVE REFORM..457

A. Voluntary Reforms to Charity Care Policies and Billing Practices ..........................................................................................................................457

B. Improving Transparency in Hospital Billing and Collections Policies and Standardizing Community Benefit Reporting.................................................460

CONCLUSION ..................................................................................................................467
INTRODUCTION

In 2004, the Robert Wood Johnson Foundation reported that 44 million individuals in the United States lacked health insurance, and the annual cost of uncompensated care for those individuals was $40.7 billion.1 When individuals lacking coverage for only part of the year were also included, total medical expenditures among all uninsured patients approached $125 billion.2 In August 2007, the Census Bureau reported even more alarming figures: The number of U.S. residents without health insurance rose by 2.2 million, to a total of 47 million, for 2006.3 According to the report, uninsured Americans represented 15.8% of the population.4

Given the growth in the number of uninsured Americans, it is unsurprising that health care providers across the country have noted a significant increase in demand for medical services from individuals lacking coverage.5 Many health care providers are struggling to keep up with this growing demand, particularly as state and federal funding has not kept pace with the increase in the number of uninsured patients seeking care.6 As a result of this lack of funding, hospitals nationwide shoulder an enormous burden in caring for the nation's uninsured; in fact, hospitals in 2001 covered over 60% of the costs for uncompensated care

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2. Id.
4. Id.
5. One report observes that “safety net providers across local communities are seeing increased demand for services” from individuals who are ineligible for public programs, a group that includes undocumented immigrants, legal immigrants who have not been U.S. residents long enough to qualify for public programs, and members of the “underinsured” middle class. Debra A. Draper & Paul B. Ginsburg, Ctr. for Studying Health Sys. Change, Health Care Cost and Access Challenges Persist: Initial Findings from HSC's 2007 Site Visits 5-6 (2007), available at http://www.hschange.org/CONTENT/947/947.pdf; see also Cara S. Lesser et al., Ctr. for Studying Health Sys. Change, Initial Findings from HSC's 2005 Site Visits: Stage Set for Growing Health Care Cost and Access Problems 3 (2005), available at http://www.hschange.org/CONTENT/776/776.pdf (finding that providers are “struggling to keep up with growing demand” for safety net primary care services accessed by uninsured patients).
incurred annually in the United States.\footnote{7}

This burden borne by health care providers carries with it serious consequences for the uninsured. Private and public insurance payors are able to negotiate large volume discounts with hospitals and set payment rates. However, hospitals have historically billed uninsured ("self-pay") patients full, undiscounted rates for medical care.\footnote{8} Following health care reforms in the mid-1980s that dramatically reduced reimbursement rates from both private and government payors—and thus significantly increased pressure on hospital margins—hospitals began to aggressively seek payment from these patients for services rendered.\footnote{9} A series of articles in the \textit{Wall Street Journal} in the early 2000s, and industry studies commissioned shortly thereafter, described hospitals’ “relentless pursuit” of payment from self-pay patients.\footnote{10} The reports depicted the

\footnote{7. Hadley & Holahan, supra note 1, at 3.}
\footnote{8. A study of Chicago-area hospitals, for example, found that each hospital charged its uninsured patients up to twice the rates the hospitals accepted from insurance plans. Beverly Cohen, The Controversy Over Hospital Charges to the Uninsured—No Villains, No Heroes, 51 \textit{Vill. L. Rev.} 95, 104 (2006) (citing Hosp. Accountability Project, Serv. Employees Int’l Union, Why the Working Poor Pay More: A Report on the Discriminatory Pricing of Health Care 1 (2003), available at http://www.hospitalmonitor.org/pdf/working_more.pdf). However, recent proposals from various provider associations would change this practice so that self-pay patients are charged at rates that reflect actual costs, not charges, or are billed at amounts that mirror rates the hospitals receive from private or government payors. See infra notes 210-217 and accompanying text.}
\footnote{9. See John D. Colombo, Federal and State Tax Exemption Policy. Medical Debt and Healthcare for the Poor, 51 \textit{St. Louis U. L.J.} 433, 440 n.52 (2007) [hereinafter Colombo, Exemption Policy] (describing reductions in reimbursement that occurred as the federal government shifted from cost-based reimbursement to the Prospective Payment System in the early 1980s, and as corporate transformations and competitive demands rendered hospitals less capable of subsidizing indigent care).}
dire consequences of medical debt for the uninsured, and painted an extremely negative and distasteful picture of the hospitals' actions; investigators "conclusively established" that health care providers "did not tell the uninsured about charity care, did not offer charity care, did not discount bills to the uninsured and aggressively pursued payment."11

In June 2004, in an effort to capitalize on the public concern generated by these reports, a consortium of plaintiffs' lawyers led by Mississippi-based Richard Scruggs filed a series of class-action lawsuits against not-for-profit hospitals and health systems in federal courts.12 The plaintiffs' principal allegation was that the health care providers violated their charitable obligations as tax-exempt organizations by aggressively billing and collecting from uninsured patients. At one point, seventy-six cases were pending in federal courts against not-for-profit hospitals.13 Cases were filed in more than forty states, and more than 600 hospitals were named as defendants.14 Within just a few months, however, over half of the lawsuits were either dismissed by the courts or withdrawn by the plaintiffs' lawyers themselves in response to initial adverse rulings. Ultimately, nearly every case was dismissed on the pleadings.15


11. Cohen, supra note 8, at 103; see also Melissa B. Jacoby & Elizabeth Warren, Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress, 100 Nw. U. L. Rev. 535, 539 (2006) (describing the Wall Street Journal articles and serious financial distress incurred by uninsured patients). The Commonwealth Fund issued a comprehensive report in 2003 describing some of the effects of medical debt on consumers. CAROL PRYOR ET AL., COMMONWEALTH FUND, UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT (2003), available at http://www.accessproject.org/downloads/unintended.pdf. The report noted, for example, that in a survey of clients at a Florida consumer credit counseling agency, 40% of those seeking help restructuring debt did so due to medical bills. Id. at 2. The report also cited another study finding that "nearly half of personal bankruptcies result from health problems or large medical bills." Id. at 3 (citing Melissa B. Jacoby et al., Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts, 76 N.Y.U. L. Rev. 375 (2001)). Low-income and uninsured consumers with medical debts reported that their debt posed "a substantial obstacle to achieving self-sufficiency because of a reduced ability to access credit, save money, or pay for the daily necessities of life." Id.

12. Richard Scruggs earned a national reputation as a plaintiffs' attorney for the role he played in litigation efforts against the tobacco industry. More recently, he pleaded guilty to a charge of conspiracy to bribe a Mississippi state judge to gain a favorable ruling in a lawsuit concerning the allocation of legal fees from Hurricane Katrina-related litigation. See Jonathan D. Glater, Guilty Plea by Lawyer to Bribery, N.Y. TIMES, Mar. 15, 2008, at C1.


Although the widespread rejection of the plaintiffs' theories made it evident that the federal judiciary cannot supply the relief sought by uninsured patients, the cases generated important questions regarding how uninsured patients can obtain—and hold hospitals accountable for providing—necessary and affordable medical care. The litigation also raised larger questions about whether not-for-profit hospitals provide sufficient amounts of charity care to warrant continued tax exemptions, or whether they should be held to a higher standard.16

This recent and intense focus on hospital tax exemption may seem sudden and unexpected.17 But, though it is an issue that has only recently grabbed national attention, it is one that has plagued the not-for-profit sector for more than two decades. States, in particular, have struggled with how to determine whether hospitals are providing a sufficient amount of free and discounted care to adequately serve their communities and warrant continued local tax exemptions.18 Now, given the recent attention to the issue, state lawmakers are


17. Many industry experts attribute the most recent surge in interest to the 2003 Wall Street Journal articles criticizing hospital practices, as well as the industry studies and headline-grabbing lawsuits that followed. See, e.g., Cohen, supra note 8, at 105.

18. States paid little attention to hospital exemption standards until the 1980s, when federal reimbursement rates were cut dramatically, driving hospitals to make significant cuts to the amounts of free and discounted care they provided. Colombo, Exemption Policy, supra note 9, at 440. When this occurred in Utah, for example, the state revoked tax exempt status for a number of hospitals on the ground that they provided too little charitable care, a determination the state supreme court ultimately upheld. Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985); see also Colombo, Exemption Policy, supra note 9, at 441. Similar events occurred in Pennsylvania when the state supreme court denied a health care facility a sales tax exemption because it failed to provide sufficient charitable care. Utilization Project v. Commonwealth, 487 A.2d 1306, 1310 (Pa. 1985); see also Colombo, Exemption Policy, supra note 9, at 442. This trend continued through the early 1990s, with a number of states passing mandatory community benefit standards or voluntary disclosure requirements. See Colombo, Exemption Policy, supra note 9, at 442-43; Alice A. Noble et al., Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives, 26 J.L. MED. & ETHICS 116, 123-28 (1998); see also infra notes 145-146 and accompanying text. Following these efforts, states appeared to shift focus and paid relatively little attention to the issue of community benefit until the highly publicized cases of aggressive hospital billing and collections resumed center stage in the early 2000s. See supra notes 10-11 and...
not alone. Federal officials, too, have taken up the fight and begun to push for more rigorous federal tax exemption standards. Members of both the House and Senate have discussed the need to provide some mechanism for holding not-for-profit hospitals accountable. Lawmakers want to ensure that hospitals are offering community benefits that are commensurate with their federal tax exemptions. As a result, legislators from both houses have initiated research efforts to help inform proposals for legislative reforms.19

This Note will argue, first, that a litigation strategy alone will not drive the changes in hospital billing and collections practices that uninsured patients seek. Nor can litigation affect any large-scale reforms to hospital community benefit standards. Lawsuits may successfully draw attention to hospital billing and collections policies, and, more generally, the issue of hospital charity care. Lawsuits may also drive changes in provider practices. But judges are constrained by the policy choices embedded in existing exemption statutes and regulations. As the recent lawsuits demonstrate, § 501(c)(3) of the Internal Revenue Code simply does not supply federal courts with the tools to hold not-for-profit hospitals accountable for caring for uninsured patients when the complaining parties are third-party patients.20

In fact, even if the Internal Revenue Service (IRS), the federal agency responsible for monitoring hospital exemption, were to conduct more frequent audits of not-for-profit hospitals and file suit to enforce its exemption criteria, the agency itself would be bound by its existing regulations. The IRS could not hold hospitals to a standard other than the one established by current policy rulings, which provide that hospitals have no obligation to provide a minimum amount of

accompanying text.

19. In May 2005, Representative Bill Thomas, a Republican from California and then-Chairman of the House Ways and Means Committee, convened a hearing on the tax-exempt hospital sector. See John M. Quirk, Turning Back the Clock on the Health Care Organization Standard for Federal Tax Exemption, 43 WILLAMETTE L. REV. 69, 85-88 (2007). Representative Thomas commissioned a report from the Congressional Budget Office on the community benefit provided by not-for-profit hospitals; that report was released in December 2006. CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS (2006), available at http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf. In May 2005, Senate Finance Committee member and then-Chairman Charles Grassley sent letters to not-for-profit hospitals demanding that they justify their federal tax exemptions. See Quirk, supra, at 88-89. For more information on federal legislative efforts, see Cohen, supra note 8, at 114-16; Colombo, Exemption Policy, supra note 9, at 437 n.28, 448-49; Jacoby & Warren, supra note 11, at 539; and Quirk, supra, at 98-99.

20. See, e.g., Kolari v. N.Y.-Presbyterian Hosp., 382 F. Supp. 2d 562, 565-66 (S.D.N.Y. 2005) ("Plaintiffs here have lost their way; they need to consult a map or a compass or a Constitution because plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch.").
charity care. Because current IRS regulations do not permit administrative enforcement actions premised on requirements that exceed existing policy rulings, the IRS would have to either explicitly revoke or overrule those regulations before it could enforce a new regulatory standard. The IRS could, for example, implement a minimum charity care requirement via formal notice-and-comment rulemaking, although it could also evade the notice-and-comment process by, for example, simply changing its reporting requirements for not-for-profit hospitals, and thereby avoid altering the substantive standard. Alternatively, Congress could pass legislation to either amend the tax exemption criteria under § 501(c)(3) or direct the IRS to change its enforcement criteria.


22. Under existing IRS regulations, exempt hospitals must provide a “community benefit,” but that term has never been read to explicitly require a minimum charity care requirement. Nonetheless, the IRS has focused primarily on charity care as a major component of exemption determinations, and no IRS ruling or court case in the past decade-and-a-half has approved exemption for a health care provider that lacked a substantial charity care program. See John D. Colombo, The Failure of Community Benefit, 15 HEALTH MATRIX 29 (2005) [hereinafter Colombo, Failure of Community Benefit]. But the IRS would not be permitted to argue in an enforcement action that the text of its most recent ruling on this issue, a 1969 Revenue Ruling that explicitly abandoned a minimum charity care requirement, no longer applies. Reply Brief for the Appellant, St. David’s Health Care Sys. v. United States, 349 F.3d 232 (5th Cir. 2003) (Nos. 02-50959, 02-51312), 2003 WL 23411835, at *15-19 (asserting that the lack of a charity care program was wholly dispositive of an organization’s exemption status and that a hospital’s collection efforts bore on the factual question whether the care provided was charitable); see also St. David’s Health Care Sys., 349 F.3d 232 (rejecting the Service’s position). In short, principles of fair notice constrain the IRS’s ability to enforce a definition of “community benefit” that incorporates a minimum charity care requirement as a dispositive factor.


24. The IRS has recently done just that. In December 2007, the IRS released a revised Form 990 and sixteen new associated schedules. All hospitals and medical providers must complete Schedule H, which, in its revised form, includes questions regarding the community benefits provided by tax-exempt hospitals. Hospitals will, however, have a year to submit the information contained in Schedule H, as they are only required to provide identifying information beginning in tax year 2008. See Press Release, Internal Revenue Serv., IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold To Provide Transition Relief (Dec. 20, 2007), http://www.irs.gov/newsroom/article/0,,id=176722,00.html [hereinafter IRS Releases Final 2008 Form 990]. See generally Internal Revenue Serv., Form 990 Redesign Discussion Draft, June 14, 2007, http://www.irs.gov/charities/article/0,,id=171216,00.html [hereinafter Form 990 Redesign].

25. Of course, one might argue that simply empowering the IRS to increase its enforcement
CARING FOR THE UNINSURED

Even if one were to turn to a legislative approach to modify the federal tax-exemption standards for not-for-profit hospitals, the relatively limited success achieved by analogous state legislation counsels the need for a cautious approach. State efforts indicate, for example, that minimum community benefit laws may be insufficient to significantly improve access to affordable care for the uninsured, particularly if those laws lack precise definitions for how providers should measure and account for charity care.\textsuperscript{26} If hospitals are permitted to include bad debt expenditures in their charity care reports, for example, then improper revenue collection practices or inflated charges could make a hospital appear as though it were providing high levels of charity care. Alternatively, inconsistent and poorly managed billing procedures may make it difficult for hospitals to effectively distinguish between charity care and bad debt, rendering reported figures relatively useless. Furthermore, when it comes to federal legislation, lawmakers appear unlikely to support more rigorous standards than those imposed by most states.\textsuperscript{27} Hospital industry experts have questioned how activity is insufficient, as hospitals have already curbed their most objectionable practices following the flood of negative publicity about their billing and collections policies. See Andrea B. Staiti et al., Ctr. For Studying Health Sys. Change, Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients 1 (2005), available at http://www.hschange.org/CONTENT/788/788.pdf (describing providers' efforts nationwide to implement new charitable care policies). That is, given the extent of voluntary reforms, heightened enforcement of existing exemption criteria might have little effect on the day-to-day activities of most health care institutions or on the aggregate amount of charity care provided to local communities. That said, the notion that questionable hospital billing and collections practices can be cured, and that hospitals will continue to meet their obligations to both indigent patients and taxpayers to provide discounted or free care, is certainly a questionable one. See infra note 203 and accompanying text.

\textsuperscript{26} A review of various state-level approaches, for example, found that in states requiring hospitals to report annual charitable care levels, the hospital reports often are not read by state regulators due to a lack of funding for audit and enforcement activities. Noble et al., supra note 18, at 130-32; see also Kevin M. Wood, Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make Any Difference?, 20 Rev. Litig. 709, 723-36 (2001). In fact, legislators in Texas passed a 1995 revision to the state's charity care statute, explicitly permitting hospitals to include bad debt in their charity care reports. Wood, supra, at 735-36; see also Tex. Health & Safety Code Ann. §§ 311.041 to 048 (Vernon 2008); Tex. Tax Code Ann. § 11.1801 (Vernon 2008).

\textsuperscript{27} Legislators have in the past proven to be highly responsive to industry interest groups, such as the American Hospital Association (AHA), thus making it hard to imagine that they would support more drastic measures, including mandatory minimum care requirements with steep penalties for noncompliance. For example, the IRS proposed a revised version of Schedule H (an attachment to the Form 990 submitted by exempt entities) that would have required hospitals to provide detailed reports on how they comply with the community benefit standard. That proposal evoked a "strong display of congressional concern." Matthew Malamud, Most House Members...
politically feasible some of the more drastic reforms, including a minimum charity care requirement, might be, given the difficult policy questions such reforms would generate, including which revenues will be used to cover the increased costs of indigent care, how to address geographic variations in how much care is needed and how much care is available, and how to ensure that uninsured patients receive adequate preventative health services. Some academics have wondered whether Congress has the necessary incentives to pass laws that would require hospitals to provide significantly greater amounts of uncompensated care given the extent to which hospitals are dependent on federal funds to survive.

Want Full-Value Reporting for Tax-Exempt Hospitals, AHA NEWS, Nov. 12, 2007, at 1; see also Letter from Stephanie Tubbs Jones and Jon Porter, Members of the House of Representatives, to Steven T. Miller, Comm'r, Tax Exempt & Gov't Entities Div., Internal Revenue Serv. (Nov. 7, 2007), http://www.aha.org/aha/letter/2007/071108-let-tubbsj-porter-irs.pdf [hereinafter Letter from Representatives Tubbs Jones and Porter]. Lawmakers urged the IRS to reduce hospitals' reporting obligations and delay the filing deadline under the new Schedule H to tax year 2010. That House members supported the AHA's position on this issue is unsurprising given the organization's lobbying efforts. See Letter from Rick Pollack, Executive Vice President, Am. Hosp. Ass'n, to Members of House of Representatives (Oct. 10, 2007), http://www.aha.org/aha/letter/2007/071010-let-rp-house.pdf [hereinafter Letter from Rick Pollack] (advocating that members of Congress sign a letter urging the IRS to modify its Form 990 and Schedule H); see also Matthew DoBias, Grassley Hears, But Will He Listen? Community-Benefit Draft Needs Work, Execs Say, MODERN HEALTHCARE, Nov. 5, 2007, at 9 (noting the AHA's lobbying efforts). The AHA is a powerful organization, and lawmakers may be particularly attuned to its advocacy efforts given the importance of health care issues to many voters and given that each member will have at least one hospital in his or her district. Moreover, the opposition to the AHA is relatively weak and poorly organized. See Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways & Means, 109th Cong. (2005) [hereinafter Hearing on the Tax-Exempt Hospital Sector] (reflecting few submissions to the record in favor of imposing a more stringent charity care standard); David L. Nie, Nonprofit Hospital Billing of Uninsured Patients: Consumer-Based Class Actions Move to State Courts, 4 IND. HEALTH L. REV. 173, 190-92 (2007) (describing some of the advocacy groups working on behalf of uninsured patients). But see Serv. Employees Int'l Union, Hospital Accountability Project, http://www.hospitalmonitor.org/about.htm (last visited May 1, 2008) (a "research and advocacy initiative" intended to "hold nonprofit, charitable hospitals accountable to their mission of placing the needs of patients, communities, and workers ahead of financial objectives" and providing links to other, similar advocacy organizations). 28. Hearing on the Tax-Exempt Hospital Sector, supra note 27, at 91 (statement of John D. Colombo, Professor, Univ. of Ill. Coll. of Law).

29. Because the federal government funds the Medicare and Medicaid programs, legislators are arguably predisposed to favor efficient hospitals that minimize unreimbursed expenses. Accordingly, the federal government may be unlikely to require higher levels of charity care in exchange for exemptions. Such legislation would almost inevitably generate additional pressure from providers to increase Medicare reimbursement rates to help offset the costs of caring for the uninsured. Jack Burns, Are Nonprofit Hospitals Really Charitable?: Taking the Question to the
But even if lawmakers should exercise caution before imposing drastic reforms, that caution should not preclude progress toward implementing new community benefit reporting requirements. Industry associations themselves support reforms to enforce uniform accounting and reporting standards, and industry leaders and lawmakers alike have applauded these efforts. The IRS, too, has recently made changes to its reporting requirements for exempt hospitals. These reforms, if successful, will provide significant benefits. Most existing community benefit data currently suffer from a severe lack of uniformity both within and across institutions. Lack of consistency in intra-hospital financial reporting may mean that policymakers are unable to compare community benefit information to other hospital financial data. And because definitions for critical reporting terms have changed over time, regulators may also be unable to track hospital performance over time. Moreover, ambiguity in standards can make enforcement difficult. Thus, new reporting requirements that prescribe uniform community benefit standards may both enhance transparency in hospital community benefit reporting and enable more meaningful comparisons across exempt institutions. These results will enable policymakers to effectively assess whether hospitals are meeting their obligations to taxpayers to provide a measurable public good in exchange for tax exemptions and determine whether additional policy responses are necessary.

Part I of this Note reviews the recent lawsuits in which plaintiffs unsuccessfully sought to use the Internal Revenue Code to hold not-for-profit hospitals accountable for providing higher levels of charity care. Part II offers an overview of federal requirements for tax exemption and describes the evolution of IRS policy under the statutory guidelines. In particular, this Part explains why current regulatory tools preclude the IRS from changing its exemption criteria without explicitly revoking or overruling prior rulings. Part III explores why a new community benefit standard—implemented either by the agency directly or via a congressional mandate—might be hampered by many of the same problems.
that have plagued analogous state laws enacted in recent years. Finally, Part IV discusses voluntary reforms hospitals have undertaken to improve transparency in billing and collection practices and also addresses proposals for standardizing community benefit reporting. Ultimately, this Part concludes that lawmakers would be wise to allow recently implemented regulatory changes and industry-driven approaches to take effect before imposing any more drastic and controversial reforms.  

35. A number of scholars have discussed the evolution of not-for-profit hospital exemption criteria, the success of current standards, the recent attention to the plight of uninsured patients seeking affordable medical care, and the potential efficacy of proposed legislative and regulatory changes. Much of the recent academic literature has focused on the increased attention not-for-profit providers have received in recent years, discussing the basis for recent criticism of hospital policies. See, e.g., Leah Snyder Batchis, Can Lawsuits Help the Uninsured Access Affordable Hospital Care?: Potential Theories for Uninsured Patient Plaintiffs, 78 TEMP. L. REV. 493 (2005); Neville M. Bilimoria, Patients Challenge Nonprofit Hospital’s Charitable-Care Practices, 93 ILL. B.J. 134 (2005); Cohen, supra note 8; Jack Hanson, Are We Getting Our Money’s Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals, 17 LOY. CONSUMER L. REV. 395 (2005); Jacoby & Warren, supra note 11; Nie, supra note 27. Other authors have focused on historic and ongoing efforts at the state and federal levels to modify hospital exemption standards, often assessing the merits of the various legislative and regulatory approaches. See, e.g., Gabriel O. Aitsebaomo, The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care To Qualify for Federal Tax Exemption, 26 CAMPBELL L. REV. 75 (2004); Burns, supra note 29; Nancy M. Kane, Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?, 51 ST. LOUIS U. L.J. 459 (2007); Douglas M. Mancino, The Impact of Federal Tax Exemption Standards on Health Care Policy and Delivery, 15 HEALTH MATRIX 5 (2005); Noble et al., supra note 18; Quirk, supra note 19; Helena G. Rubinstein, Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription, 7 HEALTH MATRIX 381 (1997); Wood, supra note 26. Professor John D. Colombo has provided particular insightful commentary on the issue, having written extensively about hospital tax exemption, focusing largely on the history and success of the community benefit standard and whether alternative standards could provide more straightforward and coherent exemption criteria for not-for-profit hospitals. See, e.g., Colombo, Exemption Policy, supra note 9; Colombo, Failure of Community Benefit, supra note 22; John D. Colombo, The Role of Access in Charitable Tax Exemption, 82 WASH. U. L.Q. 343 (2004) [hereinafter Colombo, Role of Access]; John D. Colombo, The Role of Tax Exemption in a Competitive Health Care Market, 31 J. HEALTH POL. POL’Y & L. 623 (2006) [hereinafter Colombo, Competitive Health Care Market]. Thus, in reviewing the media attention to not-for-profit providers and the lawsuits alleging uncharitable billing and collections policies, and in discussing the evolution of the federal exemption criteria, this Note covers ground that has been covered before. Those parts of the story are necessary, however, for understanding the arguments put forth in Parts III and IV. Part III likewise treads on some familiar ground when discussing the success of state-based initiatives, but draws independent conclusions about the potential success of federal reforms based on analysis of the state-level efforts. Finally, Part IV also charts new territory when discussing very recent industry reforms and revisions to regulatory requirements.
I. LAWSUITS AGAINST NOT-FOR-PROFIT HOSPITALS

This Part addresses how uninsured patients, spurred on by aggressive plaintiffs’ attorneys, sought to use the federal tax code to challenge providers’ billing and collection practices. Despite plaintiffs’ best efforts, however, federal district court judges have uniformly rejected the attempt to use § 501(c)(3) of the Internal Revenue Code to hold hospitals accountable for providing minimum amounts of free or discounted care.

Plaintiffs’ lawyers initially moved to consolidate all of the federal cases into a single proceeding, contending that centralization was warranted because the lawsuits all sought to challenge similar billing and collections strategies by not-for-profit hospitals and health systems. The plaintiffs were dealt an early setback in October 2004, however, when the Judicial Panel on Multidistrict Litigation denied their motion. The Panel held that centralization would neither serve the convenience of the parties and witnesses nor further the fair and efficacious conduct of the litigation.

The denial of consolidation was followed by virtually unanimous dismissal of the federal claims by district courts nationwide. The courts that so ruled

36. The plaintiffs’ attorneys may have sought to consolidate out of a desire to increase their bargaining leverage in prospective settlement negotiations; litigation in a class-action context is more likely to attract additional plaintiffs to the suit and, because of the consolidated damages amounts, more amenable to settlement than individual suits might be. See Victor E. Schwartz et al., Addressing the “Elephantine Mass” of Asbestos Cases: Consolidation Versus Inactive Dockets (Pleural Registries) and Case Management Plans that Defer Claims Filed by the Non-Sick, 31 PEPP. L. REV. 271, 298 (2003) (noting that consolidation can invite new case filings); Peyton Sturges, Multidistrict Judicial Panel Rejects Motion To Consolidate, Transfer Charity Care Cases, 13 BNA HEALTH L. REP. 1533 (2004), available at http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-667KU7?OpenDocument. Viewing their motivations in a more generous light, it is also possible that the plaintiffs’ attorneys merely sought to obtain the benefits of scale that consolidation can provide.

37. In re Not-For-Profit Hosps./Uninsured Patients Litig., 341 F. Supp. 2d 1354, 1356 (J.P.M.L. 2004) (denying centralization of actions, which may be permitted at the district court’s discretion pursuant to 28 U.S.C. § 1407(a) (2000)).

38. Id.; see also Cohen, supra note 8, at 128. The Panel held that, “notwithstanding the numerosity of actions, movants have failed to persuade us that these actions share sufficient common questions of fact to warrant 1407 transfer.” In re Not-For-Profit Hosps., 341 F. Supp. 2d at 1356.

39. The one exception to this pattern is a lawsuit that Scruggs settled. The lawsuit was one of the earliest cases he filed. Press Release, Richard Scruggs, Largest Rural Nonprofit Hospital in America Becomes First To Reach Settlement With Uninsureds (Aug. 5, 2004), http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=109&STORY=/www/story/08-05-
dismissed with prejudice the claims under § 501(c)(3), as well as any allegations under the Fair Debt Collection Practices Act, the Emergency Medical Treatment and Active Labor Act, and 28 U.S.C. § 1983. The courts also typically declined jurisdiction over the various state law claims raised, dismissing them without prejudice so that the plaintiffs would be able to re-plead the claims in state forums if they so chose.

At the core of the plaintiffs’ claims were charges alleging that the defendant
hospitals’ billing and collection practices were inconsistent with their obligations as not-for-profit, tax-exempt organizations. Both the legal and equitable claims reflected a theory that the grant of tax exemption under § 501(c)(3) created a contractual relationship between the health care provider and the federal government. The complaints typically alleged: 1) third-party breach of contract between hospitals and the federal government; 2) third-party beneficiary claims for breach of the same alleged contract; 3) breach of duty of good faith and fair dealing, based on the alleged contract; 4) breach of charitable trust for failure to provide affordable medical care to the uninsured in exchange for federal, state, and local tax exemption; and 5) unjust enrichment and constructive trust, also based on the theory that the hospitals owed a duty to provide affordable medical care to the uninsured in exchange for federal, state, and local tax exemptions. In short, through these claims, addressed in turn below, the plaintiffs sought to hold not-for-profit health care providers liable for delivering insufficient levels of charity care and failing to adequately accommodate uninsured patients.

First, regardless of whether there was a contractual relationship under § 501(c)(3)—and a corresponding cause of action to sue to enforce the contract—the courts uniformly held that the plaintiffs lacked standing to sue to enforce the federal tax code. As one court explained, “§ 501(c)(3) does not create a direct right of compensation for indigent or uninsured hospital patients” but “only creates a tax exemption for qualifying entities.” Because plaintiffs were unable to demonstrate a direct right to compensation, they were held to be merely “incidental beneficiaries of the tax exempt status conferred by § 501(c)(3).” Yet, “[i]ncidental beneficiaries of a government contract generally have no standing to enforce the contract.” Therefore, even had the courts recognized both a contractual obligation on not-for-profit providers and an implied cause of action under § 501(c)(3), uninsured patients would not have been granted standing to sue to enforce that obligation.

41. See cases cited supra note 40.
42. Grant v. Trinity Health-Mich., 390 F. Supp. 2d 643, 651 (E.D. Mich. 2005); see also Jellison v. Fla. Hospital Healthcare Sys., Inc., No. 6:04-cv-1021-Orl-28KRS, 2005 U.S. Dist. LEXIS 8036, at *10-11 (M.D. Fla.) (ruling that there is no language in § 501(c)(3) demonstrating that plaintiffs were the intended beneficiaries of the hospital’s tax-exempt status).
43. Grant, 390 F. Supp. at 651.
44. Id.
45. For claims that hospitals have violated their obligations under § 501(c)(3), only the IRS would have standing to enforce a claim that the hospital has violated its statutory obligation. See Allen v. Wright, 468 U.S. 737 (1984) (finding, outside the hospital setting, that only the IRS has standing to enforce the charitable purpose requirements of § 501(c)(3)). The IRS has, at times, invoked this authority. See, e.g., IHC Health Plans, Inc. v. Comm’r, 82 T.C.M. (CCH) 593, 605 (2001) (challenging the tax-exempt status of a corporate subsidiary of Intermountain Health Care in Utah); IHC Group, Inc. v. Comm’r, 82 T.C.M. (CCH) 606, 615 (2001) (same); IHC Care, Inc. v.
Next, the courts typically considered the merits of the plaintiffs’ claims. First, in response to plaintiffs’ contention that § 501(c)(3) creates a binding contract between the federal government and the recipient, the courts generally held that, absent statutory language indicating congressional intent to create a contract, the presumption is that statutes do not create contracts. In some cases, the plaintiffs unsuccessfully attempted to rebut this presumption by analogizing to the federal Hill-Burton Act, 1940s legislation intended to “promote the construction and modernization of hospitals” that has been held to create contracts between the federal government and participating institutions. As one court explained, however, the Hill-Burton Act is “fundamentally different from § 501(c)(3)”; unlike § 501(c)(3), the Hill-Burton Act explicitly required hospitals seeking construction grants to agree to provide medical services to persons unable to pay and expressly conditioned the grant of federal funds on that promise. Moreover, also unlike § 501(c)(3), “the Hill-Burton Act expressly provides for a private right of action to enforce the Act.” Thus, the courts, in no uncertain terms, rejected plaintiffs’ assertion that § 501(c)(3) should also be read to impose a contractual obligation on hospitals. Still not deterred, plaintiffs alleged that even in the absence of an express cause of action, § 501(c)(3) should be read to contain an implied cause of action. The courts also uniformly rejected this claim, however, on the ground that there was no evidence of congressional intent to create an implied cause of action.

46. See supra note 40.
50. See id.
51. See, e.g., id.
52. The District Court for the Northern District of Ohio, for example, explained that: [T]here is no evidence that Congress intended to create a private cause of action. The statute does not describe who may receive the benefits of a 501(c)(3) organization’s activities; rather, it describes the types of organizations that may seek tax exemption. Where the statute focuses “on the person regulated rather than

http://digitalcommons.law.yale.edu/yjhple/vol8/iss2/4
In many cases, plaintiffs also alleged that hospitals' billing and collections practices toward uninsured patients breached a duty of good faith and fair dealing. A duty of good faith and fair dealing, however, exists only where the parties are bound by a contractual relationship. And, because "a contractual relationship between the federal government and a non-profit entity is not created by § 501(c)(3)," the courts that were called upon to make this determination dismissed these claims as well.

In many cases, the courts next had to assess whether the hospitals were liable for breach of charitable trust for their failure to offer discounted rates to the uninsured. The plaintiffs claimed that by accepting federal, state, and local tax exemptions, the hospitals entered into a public charitable trust to provide affordable medical care to uninsured patients; according to this theory, the hospitals breached that trust by overcharging those patients, the intended beneficiaries of the trust. Not surprisingly, the courts that were called upon to evaluate these claims rejected them, holding that charitable trusts are only enforced where there is clear language in a statute or implementing regulation demonstrating a specific intent to create a trust, and plaintiffs' complaints failed to even allege that such language existed. Furthermore, as with the contract-based claims, even had a charitable trust existed, the plaintiffs would have lacked standing to bring an enforcement action; "the Attorney General of the [state in which the hospital is located] is the only proper party" to enforce such a trust.

the individuals protected . . . [there is] 'no implication of an intent to confer rights
on a particular class of person.' Accordingly, there can be no implication of an
intent to confer a private right of action on Plaintiff in this case. If Congress had
wanted to create a private cause of action for the uninsured or for indigent patients,
it knew how to do so.


54. See, e.g., Grant, 390 F. Supp. 2d at 652.


56. See, e.g., Grant, 390 F. Supp. 2d at 652.


58. Grant, 390 F. Supp. 2d at 652.


437
Often, the courts were quite dismissive of plaintiffs’ equitable claims for unjust enrichment and constructive trust. Those claims were also based on the theory that the hospitals owed a duty to provide affordable medical care to the uninsured in exchange for tax exemption. The plaintiffs complained that their tax-exempt status unjustly enriched the hospitals, which failed to utilize their substantial net assets and revenues to provide discounted care. Accordingly, plaintiffs argued entitlement to constructive trust on all profits obtained by the hospitals as a result of “charging [the plaintiffs] the highest and full undiscounted cost of medical care.” Specifically, they sought “the difference between the amount . . . charged Plaintiffs and the Class and the amount charged insured patients,” as well as “an amount sufficient to provide Plaintiffs and the Class mutually affordable medical care.”

The courts disagreed, however, holding that federal law imposes no obligation on hospitals to provide affordable medical care, and even if § 501(c)(3) did impose such a duty, the claim for unjust enrichment was merely “a collateral attack on the IRS’s decision to grant . . . tax exempt status” and therefore should fail. Plaintiffs presented insufficient evidence of the necessary scienter; a constructive trust may not be imposed without a showing that the defendants obtained the property at issue by fraud, bad faith, duress, undue influence, or other improper means. As the plaintiffs acknowledged that they received appropriate medical treatment and failed to proffer any evidence of bad faith by the defendant hospitals in requesting payment, the courts dismissed the equitable claims. Moreover, many courts noted that even had the hospitals been unjustly enriched by failing to meet their obligations under § 501(c)(3), the plaintiffs once again lacked standing to assert unjust enrichment claims, as only the IRS may challenge the tax status of a qualified tax-exempt entity.

In sum, the plaintiffs’ federal court cases were doomed when the district courts all held that § 501(c)(3) creates neither an express nor an implied contract between the recipient of the tax exemption and the federal government and that legal authority did not “support the notion that a theory of liability exists based

60. See id. As equitable claims, the allegations regarding unjust enrichment and imposition of constructive trust are valid claims to recovery in the absence of a legal contract.
61. See id.
62. See, e.g., id.
63. See, e.g., id.
64. See, e.g., id.
66. See, e.g., id.
67. See, e.g., id. at *24.
68. See Cohen, supra note 8, at 129 & n.211 (citing relevant cases).
The decisions in the cases were remarkable both for the uniformity in their outcomes and for the strong reactions evoked among the presiding judges. One district court judge admonished the plaintiffs, stating that the legal premise underlying claims was "patently untenable" and that "formulating federal health care policy is not a proper function of a [federal] court." Another chastised, "[p]laintiffs have lost their way; they need to consult a map or a compass or a Constitution because plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch." At least one judge indicated significant frustration with the plaintiffs, observing that despite the rash of dismissals that had occurred prior to his judgment, the plaintiffs "persisted in presenting the very same claims and arguments with this court." "

Responding to the initial dismissals of their claims, the plaintiffs’ attorneys voluntarily withdrew from those federal courts in which cases were still pending in order to re-file in state courts under state law. Perhaps fearing adverse judgments in state venues, or perhaps simply weary of litigation, many, if not

69. Grant, 390 F. Supp. 2d at 651.
73. Cohen, supra note 8, at 129; Zamoff & Zaetta, supra note 13.
74. Like the federal claims, the state claims alleged unlawful billing practices for medical services rendered to uninsured patients. See generally Press Release, Richard Scruggs, Statement from Dick Scruggs Nonprofit Hospital Litigation Status (Oct. 11, 2005), http://www.cliffordlaw.com/not-for-profit-hospital-class-action-litigation/press-releases/statement-from-dick-scruggs-nonprofit-hospital-litigation-status. Unlike the federal claims, however, the state claims alleged failure to comply with state common law or statutory schemes. A suit in Illinois, for example, asserted that the Carle Foundation Hospital violated the Illinois Consumer Fraud and Deceptive Business Practices Act and breached the hospital’s state law duty “to only charge people the fair and reasonable value of the services provided to them.” See Press Release, Richard Scruggs, Class Action Lawsuit Filed by Uninsured Patients Against Carle Foundation Hospital in Illinois State Court (Jan. 24, 2005), http://www.cliffordlaw.com/not-for-profit-hospital-class-action-litigation/press-releases/class-action-lawsuit-filed-by-uninsured-patients-against-carle-foundation-hospital-in-illinois-state-court. In California, the plaintiffs alleged five state law causes of action: “violation of unfair competition law, violation of the consumers legal remedies act, unjust enrichment, breach of contract and breach of the covenant of good faith and fair dealing.” In re Sutter Health Uninsured Pricing Cases, No. JC4388, 2005 WL 1842582, at *1 (Cal. Sup. Ct., July 16, 2005). Because these complaints were based on state law theories, the federal results were not necessarily indicative of favorable outcomes for the defendant hospitals in the state fora. For more on some of these various state-level regulatory schemes, see Part III, infra.
all, of these hospital systems chose to settle the plaintiffs’ claims. Although it is impossible to determine what the success of these state law-based actions would have been had they proceeded, the federal cases made it clear that any claims under the federal tax code will fail, and § 501(c)(3) may not be used to hold hospitals accountable for providing minimum amounts of free or discounted care.

II. STATUTORY AND REGULATORY REQUIREMENTS FOR FEDERAL TAX EXEMPTION UNDER § 501(C)(3) AND SUBSEQUENT IRS REVENUE RULINGS

This Part provides an overview of the statutory and regulatory framework governing federal tax exemption for not-for-profit hospitals. This Part also explains why any new criteria for hospital tax exemption may only be implemented via legislative reform or through a new IRS policy.

A. Statutory Obligations and Regulatory Interpretations of the “Charitable Purpose” Requirement

Under § 501(c)(3), not-for-profit entities are exempt from federal taxation requirements provided that they are “organized and operated exclusively for... charitable... purposes.” The provision further specifies various qualifying “exempt” purposes, including those that are “charitable.” It is this “charitable” purpose criterion that governs exemption for not-for-profit hospitals. In recognition of the lack of statutory guidance regarding the meaning of this term, the IRS has issued a series of regulatory rulings clarifying what activities qualify as “charitable” for purposes of federal tax exemption. The regulatory requirements have changed dramatically over time. In 1956, in its first revenue ruling governing hospital qualification for tax exemption, the IRS required hospitals to provide health care services either free or at discounted prices.

Since then, however, policy statements have dramatically scaled back the requirements hospitals must meet in order to qualify as exempt organizations.

In Revenue Ruling 56-185, issued in 1956, the IRS set forth four “general exemptions...
requirements” that a health care organization was obligated to meet in order to be deemed “charitable” for federal tax exemption purposes. 79 For exempt health care providers, perhaps the most notable of these requirements was that a hospital must serve those who are unable to pay for health services, and not exclusively care for patients who can afford the costs. 80 Thus, the ruling effectively obligated hospitals to provide care either free or at below-cost rates; the extent of this obligation turned on the “financial ability” of the hospital to provide discounted services to those who could not pay. In what became known as the “relief of the poor” standard, the ruling also required that the organization “not... refuse to accept patients in need of hospital care who cannot pay for such services.” 81

The IRS qualified these seemingly stringent charity care obligations, however, cautioning that “[t]he fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability.” 82 It seemed that even a relatively modest amount of charity care therefore might still be deemed to satisfy the “financial ability” standard such that a hospital would qualify for federal tax exemption. Such a provision may have seemed necessary in order to ensure that facilities would receive tax-exempt status even if they faced low market demand for discounted services in their particular community. 83

In 1969, the IRS changed course, largely in response to demands from the hospital community that it accommodate the new federal Medicare and Medicaid programs. 84 The agency articulated a new standard that measured the

79. Rev. Rul. 56-185, 1956-1 C.B. 202. Specifically, the ruling required that the institution be organized as a charitable organization that, to the extent of its financial ability, provides care for those unable to pay for services, and not only serve patients who are able to pay. The ruling also required that the hospital “have an open staff policy in that its facilities are not restricted to use or access by a particular group of physicians or surgeons” and that net earnings not “inure directly or indirectly to the benefit of any private shareholder or individual.” Id.; see also Jack E. Karns, Justifying the Nonprofit Hospital Tax Exemption in a Competitive Market Environment, 13 WIDENER L.J. 383, 401 (2004).

80. Karns, supra note 79, at 401.
81. Bilimoria, supra note 35, at 135.
83. See Karns, supra note 79, at 417-18. Presumably, this qualification was intended to accommodate hospitals located in relatively affluent areas that might not see as much community demand for free or discounted services.
84. When Congress began considering the Medicare and Medicaid legislation in the mid-1960s, exempt hospitals began to advocate for reconsideration of exemption standards, largely driven by fears that between private medical insurance and the new federal programs there would be insufficient demand for charity care to satisfy existing IRS standards. See Colombo, Competitive Health Care Market, supra note 35, at 625, 628 (explaining that the community benefit standard in Revenue Ruling 69-545 “emerged from the IRS largely as the response by a staff attorney at the
“community benefit” provided by the organization rather than simply the amount of discounted care provided. In Revenue Ruling 69-545, the IRS concluded that a hypothetical institution that did not provide free or discounted services to indigent patients nevertheless qualified for a tax exemption. The agency grounded this conclusion in “the general law of charity,” and the notion 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.” The hypothetical institution’s mere “promotion of health” was therefore held to be a charitable purpose sufficient to qualify the provider for tax-exempt status.

This landmark ruling moved away from a rigorous charity care requirement, offering a far more flexible standard than the one previously imposed by Ruling 56-185. Hospitals were no longer obligated to provide charity care to non-emergent, indigent patients in order to qualify for federal tax exemption; in fact, an institution could admit only those who could pay for care and still retain its tax-exempt status. Also, a hospital could qualify for federal tax-exemption even when its annual revenues exceeded expenses and when its annual surplus was used for purposes other than to provide indigent patients with free care.

The validity of Revenue Ruling 69-545’s new, relatively lenient “community benefit” standard was quickly challenged in federal court by a class of indigent patients who had been refused medical treatment at tax-exempt hospitals due to their inability to pay. In Eastern Kentucky Welfare Rights Organization v. Shultz, the district court granted summary judgment to the plaintiffs, holding that the ruling was invalid and that exempt organizations remained obligated to admit and provide free services to indigent patients. On appeal, the D.C. Circuit held that

86. Id.
87. Id.; Karns, supra note 79, at 419; see also Aitsebaomo, supra note 35, at 82-83; Batchis, supra note 35, at 515-16; Bilimoria, supra note 35, at 135; William P. Gunnar, The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?, 15 ANNALS HEALTH L. 151, 175 (2006).
88. Revenue Ruling 69-545 provided hospitals with the same favorable tax treatment they had received under the 1956 standard, without requiring them to engage in any charity care, as the old standard did. See Colombo, Failure of Community Benefit, supra note 22, at 30-31; Noble et al., supra note 18, at 118; Quirk, supra note 19, at 73-74; Rubinstein, supra note 35, at 396; Wood, supra note 26, at 715.
89. Karns, supra note 79, at 404.
CARING FOR THE UNINSURED

the earlier, more stringent definition of “charitable” had to give way to the “changing economic, social and technological” realities of contemporary society. Accordingly, the court upheld the 1969 ruling and confirmed that it superseded the more strict “relief of the poor” standard imposed by the 1956 policy. Eventually, the case reached the U.S. Supreme Court, which reversed the judgment of the D.C. Circuit on unrelated grounds, and directed the district court to dismiss the complaint. As a result, both the 1956 and 1969 revenue rulings remained in place as originally issued by the IRS.

In 1983, the IRS modified the community benefit standard to clarify that the operation of an emergency room was only one of a number of factors that might demonstrate the hospital’s benefit to the community and that having an operational emergency department was not a necessary criterion for tax exemption under § 501(c)(3). The other requirements established by the 1969 ruling were unchanged, however; thus, the extent to which a hospital “promoted health” for the benefit of the community remained the governing standard for hospital tax exemption. Yet, the 1983 policy statement seemed to confirm the agency’s continued move away from the focus on charity and indigent care initially imposed in the 1956 ruling.

B. Evolution of the “Promotion of Health” Standard Through Regulatory Adjudications and Internal Enforcement Directives

From the late 1980s through the mid-1990s, the IRS retreated from the generous “promotion of health” standard established by the 1969 revenue ruling, primarily through a series of regulatory challenges to providers’ tax-exempt status. Although the agency did not issue a new revenue ruling or otherwise revoke the 1969 policy, its enforcement actions against providers that offered little or no discounted care allowed the IRS to establish that, for all practical purposes, charity care is a determinative factor in consideration for tax

91. Simon I, 506 F.2d at 1288.
92. Id.
93. Simon II, 426 U.S. at 37. The Supreme Court held that the federal courts should not have exercised jurisdiction because the plaintiffs lacked standing to sue, as they failed to establish that their alleged injuries were the consequence of the health care providers’ actions.
94. Id. at 46.
95. Rev. Rul. 83-157, 1983-2 C.B. 94. Other “significant factors” included “a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research.” Id.; see also Karns, supra note 79, at 404, 421-23.
96. See generally Colombo, Exemption Policy, supra note 9, at 437-49; Mancino, supra note 35, at 12; Quirk, supra note 19, at 74-75.

443
exemption. Thus, while the community benefit (or “promotion of health”) test is still the official standard by which not-for-profit hospitals are evaluated for tax-exempt status, a series of administrative and judicial decisions has suggested that the most important factor in exemption decisions is the operation of a charity care program.

The agency’s own informal position statements, including internal memoranda and audit guidelines issued throughout the 1990s and early 2000s, reinforce the notion that charity care has become a major part of exemption analysis for health care providers. A 2001 Field Service Advice (FSA) memorandum, for example, stated that a provider’s mere adoption of a charity care policy is insufficient; instead, hospitals must show that they provide a “reasonable amount” of charity care, that their charity care policy has been communicated to the public, and that charity care patients do not suffer routine discrimination. Perhaps not surprisingly, the FSA cites no legal authority for its suggestion that § 501(c)(3) establishes a minimum charity care requirement but apparently relies only on the recent trend toward such a standard. In its 2002 Healthcare Update, a yearly tax policy review that serves as a guide to field agents, the IRS reaffirmed its position that enforcement agents should hold charity care to be central to exemption determinations. Thus, by 2002, internal agency policy guidance confirmed that charity care remained a critical threshold

97. In an article reviewing the history of the community benefit test, Professor Colombo explains the agency’s effort to shift away from the text of the 1969 ruling toward a more aggressive standard, explaining that “the community benefit test as articulated in [the 1969] ruling has proven to be a complete failure” and has “failed as a legal test for tax exemption, having been virtually abandoned in practice by the courts and the IRS, who have pretty much morphed it back into a charity-care standard for exemption.” Colombo, Failure of Community Benefit, supra note 22, at 29; see also Colombo, Role of Access, supra note 35, at 349-54 (reviewing IRS rulings and court decisions that suggest that ensuring equal access to care has been a central criterion for tax exemption).


99. See Colombo, Failure of Community Benefit, supra note 22, at 35.

100. Field Service Advice is an internal procedure by which the IRS Chief Counsel’s office provides case-specific advice to field personnel. Daniel J. Wiles, Taxpayer FSA Use, TAX ADVISER, July 1, 2002, at 448.


102. Batchis, supra note 35, at 511. The update did, however, leave room for providers to argue that even though charity care was a “highly significant” factor in exemption decisions, it was not necessarily dispositive of tax-exempt status. Id.
inquiry for organizations seeking tax-exempt status, and without a demonstrated commitment to serving the indigent, a provider would face significant difficulty in obtaining exemption.

But the agency’s ability to intensify its enforcement efforts and unilaterally hold providers to a higher standard (a minimum charity care requirement, for example) is limited. In 2002, a federal district court rejected the IRS’s attempt to adopt a “financial ability to pay” standard, noting that “the government relies on this requirement as stated in Revenue Ruling 56-185,” but Revenue Ruling 69-545 unambiguously “remov[ed] that requirement.” The Fifth Circuit’s rebuke related to the IRS’s decision in 2000 to revoke St. David’s Health Care System’s tax exemption after it forged a partnership with HCA, Inc., a for-profit health care company. The IRS claimed that the partnership, combined with the fact that the health care system could no longer qualify as a charitable entity under § 501(c)(3). St. David’s formally protested the IRS action and filed suit against the IRS to recover the money. During the course of litigation, the IRS asserted—consistent with the position it had held for over a decade—that a health care organization must maintain a charity care program in order to qualify for tax exemption. This stance presented a nuanced but important change from the agency’s earlier arguments in enforcement proceedings, however. The IRS also argued that charity care alone is not enough. The existence of a charity care program is irrelevant for determining tax-exemption, the government argued, if the hospital is controlled by a for-profit entity. The government also asserted that the hospital’s collection efforts bore on the factual question of whether the care provided was charitable, stating that “aggressive collection efforts can have a chilling effect on indigent patients, preventing them from seeking care even though a hospital has an ‘open admissions’ policy.” As collections are typically sought for bad debt, but not charity care, the government also contended that an exempt provider may not treat bad debt write-offs as charity care. The


105. Id.

106. Reply Brief for the Appellant, St. David’s Health Care Sys. v. United States, 349 F.3d 232 (5th Cir. 2003) (Nos. 02-50959, 02-51312), 2003 WL 23411835, at *20 (contending that the “taxpayer should have a charity care plan and may not treat bad debt write-offs as charity care”).

107. Id. at *10.

108. Id. at *21 n.8.

109. Id. at *21 ("For almost fifty years, the IRS has taken the position that bad debts are not
unstated implication of these arguments was that health care organizations would receive tax exemption only in exchange for care delivered for free or at a discounted rate and, critically, for which the hospital never made any attempt to seek full reimbursement.

The IRS cited Eastern Kentucky Welfare Rights Organization for the proposition that Revenue Ruling 69-545 did not overrule Revenue Ruling 56-185, but simply provided an “alternative” test for charitable status. Through this claim, the agency effectively sought to hold health care providers to the “relief of the poor” standard first established in the 1956 ruling. But the district court, in no uncertain terms, rejected the IRS’s argument, stating that the 1969 ruling was “far more relevant” than the 1956 test, because it was “undisputed” that the institution satisfied the criteria set forth in the 1969 ruling, which had eliminated “[t]he requirement of providing free or below-cost care.” The court further explained that “it is difficult to view 69-545 as anything but an overruling of 56-185 when the later ruling says that ’56-185 is hereby modified.” Accordingly, the district court granted summary judgment in favor of the health system.

On appeal to the Fifth Circuit, the government specifically disavowed any argument that hospitals were still obligated to meet the indigent care standard established by the 1956 policy and that health care institutions had to account in “any particular way” for uncompensated care. These statements were undoubtedly responsive to the lower court’s rebuke of the government’s effort to distinguish the 1969 ruling and thereby establish an exemption standard that combined the indigent care requirement of Ruling 56-185 with the community benefit standard of Ruling 69-545. In dicta, the Fifth Circuit appeared to side with the lower court, specifically rejecting the notion that the institution’s collections efforts “create[d] a genuine issue of fact as to whether the partnership facilities dispense charity care.”

C. Regulatory and Congressional Efforts To Establish a New Statutory Standard

In recent years, the IRS has focused primarily on charity care as a major...
component of exemption determinations, and no IRS ruling or court case in the past fifteen years has approved exemption for a health care provider that lacked a substantial charity care program. Nevertheless, for the IRS, the 1969 Revenue Ruling establishes a clear rule on which third-party health care providers have relied. For the IRS to enforce a definition of "charitable" that includes a new, minimum indigent care requirement, it would need to first expressly revoke or overrule Ruling 69-545's "promotion of health" (or "community benefit") test.

Nevertheless, the IRS has begun to gather information from exempt hospitals to inform future decision-making. In April 2006, the agency announced that it would send questionnaires to approximately 600 hospitals "asking them to provide information on... how they meet the community benefit standards for purposes of § 501(c)(3)." In February 2007, the agency released a set of nine voluntary governance guidelines addressing tax-exempt organizations, including hospitals (though the guidelines did not discuss factors that may be of particular relevance to health care providers, such as the role of a charity care policy in the exemption decision or the institution's billing and collections practices). The guidelines encourage such organizations to adopt policies and procedures to ensure that their financial statements are "complete" and "accurate" and available to the public on request.

116. Colombo, Failure of Community Benefit, supra note 22.

117. See supra notes 22-23 and accompanying text.

118. The furthest courts appear comfortable deviating from the text of Revenue Ruling 69-545 is reflected in the Tenth Circuit's 2003 decision in IHC Health Plans, Inc. v. Comm'r, 325 F.3d 1188 (10th Cir. 2003), in which it adopted the IRS's "health care plus" formula. The court held that merely providing health services to all paying patients is insufficient to justify exemption; rather, not-for-profit institutions had to provide an additional "plus," such as charity care, health education, or health research programs. Id. at 1197; see also Colombo, Competitive Health Care Market, supra note 35, at 626; Quirk, supra note 19, at 79-80. Thus, the court denied exemption to an HMO whose membership was open to everyone in the community because the organization did not have any of those "pluses." IHC Health Plans, 325 F.3d 1188; see also Colombo, Competitive Health Care Market, supra note 35, at 626.

Notably, the IRS's revised Form 990 and its associated schedules do not alter the definition of "charitable." The new Schedule H only gathers information from tax-exempt hospitals about charity care, benefits to the community, calculation of bad debt expense, and emergency department policies and procedures. See IRS Releases Final 2008 Form 990, supra note 24; see also Final Form 990, Schedule H Reflects Many Changes Favored by Hospitals, AHA NEWS, Jan. 7, 2008, at 1, 1 [hereinafter Final Form 990].


121. Id.
Several months later, in June 2007, the IRS released draft revisions to Form 990 and its accompanying Schedules, the forms that tax-exempt hospitals must file annually with the IRS. After receiving numerous comments from the hospital community and Congress on its draft proposal, the IRS issued the revised Form 990 in December 2007. The new Schedule H applies solely to tax-exempt hospitals and establishes a uniform framework for how hospitals nationwide must report aggregate community benefit and related information on billings and collections, including data on charity care, benefits to the community, “community building” activities, Medicare underpayments, bad debt expenses, and emergency department policies and procedures. The new form was supported by Senator Grassley, one of the most vocal critics of the non-profit hospital industry and the ranking member of the Senate Finance Committee, which oversees tax-exempt policy. Senator Grassley said the new form will promote transparency and enable comparisons of community benefit provision across not-for-profit hospitals.

Even absent more drastic action by the IRS—issuance of a new revenue ruling, for example, or revocation of the 1969 standard—a possibility exists that Congress may nevertheless impose a minimum charity care obligation on hospitals. Both the House and Senate have launched investigations into hospital tax exemption, with the stated long-term goal of clarifying standards for hospital exemption under § 501(c)(3). The congressional attention to hospital charity care standards began in the summer of 2003, when the House Energy and Commerce Committee commenced an investigation of hospital billing and collections practices, sending letters to hospitals and health systems containing detailed questions about their charity care policies. Nearly a year later, the committee sent additional requests for information to ten leading hospitals, seeking to understand how hospital charges are presented to, explained to, and understood by medical consumers, and also requesting explanations of how patients are affected by hospital charges.

The House Ways and Means Committee has also been active in investigating

122. Form 990 Redesign, supra note 24.
123. IRS Releases Final 2008 Form 990, supra note 24. See generally supra note 24 and accompanying text.
125. Final Form 990, supra note 118, at 3.
126. See supra note 19.
127. Cohen, supra note 8, at 114.
129. Cohen, supra note 8, at 117-18.
CARING FOR THE UNINSURED

hospital exemption; in December 2006, the Congressional Budget Office released a report requested by the committee's then-Chairman Bill Thomas regarding the community benefit provided by not-for-profit hospitals.\footnote{Cong. Budget Office, \textit{supra} note 19.} The House Ways and Means Subcommittee on Oversight also held a hearing on tax-exempt organizations in July 2007, with the stated intent of reviewing "charities' efforts to assist diverse communities" including "activities and measures" taken by not-for-profit organizations "for ensuring public accountability and good governance."\footnote{Press Release, H. Comm. on Ways & Means Subcomm. on Oversight, Lewis Announces Overview Hearings on Tax-Exempt Charitable Organizations (July 9, 2007), http://waysandmeans.house.gov/hearings.asp?formmode=view&id=6224.}

The Senate has also initiated investigations of its own. In May 2005, then-Chairman of the Senate Finance Committee Charles Grassley sent letters to not-for-profits demanding that they justify their federal tax exemptions.\footnote{Quirk, \textit{supra} note 19, at 88-89.} Senator Grassley sought information on the IRS's review and enforcement activities regarding tax-exempt hospitals in the spring of 2006.\footnote{IRS Tax-Exempt Info Sought by Grassley, AHA News, June 12, 2006, at 6.} At the behest of the Finance Committee, the Treasury Inspector General for Tax Administration began to review the IRS's planned actions regarding the community benefit standard and, in March 2007, recommended that the IRS present its plans to address the community benefit standard in its July 2007 interim report.\footnote{Treasury Inspector Gen. for Tax Admin., \textit{TAX-EXEMPT HOSPITAL INDUSTRY COMPLIANCE WITH COMMUNITY BENEFIT AND COMPENSATION PRACTICES IS BEING STUDIED, BUT FURTHER ANALYSES ARE NEEDED TO ADDRESS ANY NONCOMPLIANCE (2007), available at http://www.treas.gov/tigta/auditreports/2007/reports/200710061fr.pdf. The IRS responded and, in its July 2007 report, the agency summarized hospital responses to its May 2006 questionnaire. Internal Revenue Serv., Executive Summary: Hospital Compliance Project Interim Report (2007), available at http://www.aha.org/aha/content/2007/pdf/070719-IRSReport.pdf. The agency determined that 97% of respondents provided uncompensated care to the community. Id. at 3. It also determined that those institutions reported providing $9.3 billion in community benefit expenditures. Id. at 48. The study reported that the mean percentage of total revenues spent by the 487 hospital respondents on potential community benefit expenditures was 8.8%, and the median percentage of total revenues spent on all community benefit expenditures by those institutions was 5.4%. Id. at 50. Over 20% reported spending less than 2% of total revenue on community benefit, however, and a little more than half of the institutions spent more than 5% on community benefit. Id. at 50.}

Members of both the House and the Senate have sent strong signals that new legislation may be forthcoming. Representative Thomas proposed the Tax Exempt Hospitals Responsibility Act of 2006 in December 2006; the bill would impose penalties on not-for-profit hospitals that fail to deliver a minimum level

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\item[130.] Cong. Budget Office, \textit{supra} note 19.
\item[132.] Quirk, \textit{supra} note 19, at 88-89.
\item[133.] IRS Tax-Exempt Info Sought by Grassley, AHA News, June 12, 2006, at 6.
\item[134.] Treasury Inspector Gen. for Tax Admin., \textit{TAX-EXEMPT HOSPITAL INDUSTRY COMPLIANCE WITH COMMUNITY BENEFIT AND COMPENSATION PRACTICES IS BEING STUDIED, BUT FURTHER ANALYSES ARE NEEDED TO ADDRESS ANY NONCOMPLIANCE (2007), available at http://www.treas.gov/tigta/auditreports/2007/reports/200710061fr.pdf. The IRS responded and, in its July 2007 report, the agency summarized hospital responses to its May 2006 questionnaire. Internal Revenue Serv., Executive Summary: Hospital Compliance Project Interim Report (2007), available at http://www.aha.org/aha/content/2007/pdf/070719-IRSReport.pdf. The agency determined that 97% of respondents provided uncompensated care to the community. Id. at 3. It also determined that those institutions reported providing $9.3 billion in community benefit expenditures. Id. at 48. The study reported that the mean percentage of total revenues spent by the 487 hospital respondents on potential community benefit expenditures was 8.8%, and the median percentage of total revenues spent on all community benefit expenditures by those institutions was 5.4%. Id. at 50. Over 20% reported spending less than 2% of total revenue on community benefit, however, and a little more than half of the institutions spent more than 5% on community benefit. Id. at 50.
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of charity care. In July 2007, the Republican minority staff on the Senate Finance Committee issued a “discussion draft” on potential reforms for not-for-profit hospitals. The draft recommended that hospitals seeking exemption under § 501(c)(3) be required to conform to new standards regarding, in part, 1) the creation and publication of charity care policies, 2) “quantitative” (i.e., percentage-based) standards for charity care, 3) “limiting charges billed to the uninsured,” 4) “curtailing unfair billing and collection practices,” 5) “transparency and accountability requirements,” and 6) “sanctions for failure to comply.” Significantly, the minority staff draft suggested abolishing the community benefit standard for tax exemption and replacing it with a percentage-based test for charity care—the very kind of test that was rejected by the courts and Congress in the 1960s.

All of these efforts—both congressional and administrative—indicate that a new tax exemption standard for not-for-profit health care providers may be forthcoming. Providers are bracing for this event, though many are hoping to forestall the congressional reform proposals through enhanced lobbying efforts. Hospitals have lodged strenuous objections to the minority staff discussion draft through the American Hospital Association (AHA). In October 2007, an AHA board member spoke at the Senate Finance Committee roundtable meeting and warned that the discussion draft presented “problematic” proposals. He was particularly critical of a recommendation that would require hospitals to dedicate a minimum of 5% of their operating expenses to charity care in order to maintain tax-exempt status; he warned that such a requirement “will not capture the many contributions that hospitals make to those they serve.”

137. SENATE COMM. ON FINANCE—MINORITY, supra note 136, at 3, 7.
138. Id. at 3 (stating that the proposal would replace Rev. Rule 69-545, which articulates the community benefit test).
139. Id. at 7 (proposing a percentage-based standard).
140. Kane, supra note 35, at 461 (stating that “the federal government is likely to pass a bill in the near future”).
142. Id. The statement likely references services such as health education, screening programs, support groups, health promotion events, and clinic services for indigent populations. See, e.g., Sister Carol Keehan, Commentary, Charitable Formula: Catholic Hospitals More Clearly Define
Caring for the Uninsured

The evidence to date indicates that the hospital lobbying efforts have been effective. Notably, more than five years after the Wall Street Journal placed the spotlight on non-profit hospitals, Congress has not passed any major reforms. In addition, more than 300 members of the House called for improvements to the IRS’s proposed new Schedule H because of the “unnecessary reporting burdens” it imposed on hospitals. In response, the IRS did in fact remove the most objectionable portions of the Schedule in its final draft, including a section on hospital billing information. The IRS also agreed to give hospitals a year before they will be required to submit the information contained in Schedule H.143 Despite this initial success, however, the investment that both houses of Congress have made to investigate hospital tax exemption suggests that legislators will not abandon the issue easily. Thus, even if the IRS’s revised forms prove helpful in ameliorating legislators’ concerns about the tax-exempt hospital industry, hospitals may still face an uphill battle in their efforts to convince federal lawmakers that new exemption criteria are unnecessary.144

III. Imposing a Heightened Charity Care Requirement:
Lessons from the States

Although it is clear that federal lawmakers are contemplating new exemption criteria, it is far less clear how effective a new standard would be. In fact, it is entirely possible that even a minimum charity care requirement might do little to enhance the amount of free care and other health-related services not-for-profit hospitals provide their communities. To understand this claim, it is instructive to first assess state legislative reforms regarding the tax-exempt hospital sector.145

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143. Final Form 990, supra note 118; Letter from Rick Pollack, supra note 27.
144. It is far too early to determine if the revised Form 990 and Schedule H will delay or even ward off additional, congressionally-imposed changes to existing requirements for not-for-profit hospitals.
145. Most of these efforts occurred in the late 1980s and early 1990s. See Colombo, Competitive Health Care Market, supra note 35, at 627; Colombo, Exemption Policy, supra note 9, at 443. I do not address very recent state legislative efforts to ensure that all citizens receive minimum amounts of health care through state-run universal insurance coverage. Massachusetts launched a landmark reform effort in 2007 that requires most uninsured adults in the state to have insurance coverage and provides free or subsidized insurance for the lowest income population. Other states are contemplating similar reforms. DRAPER & GINSBURG, supra note 5, at 5-6.
A. State-Level Reforms

In 1993, Texas became the first state to pass legislation requiring hospitals to allocate a specific percentage of hospital revenues for charity care and community benefit.146 Under the Texas statute, to qualify for tax-exempt status, a hospital must provide community benefits. The exact amount of the benefits must reflect: 1) a level reflective of a community needs assessment; 2) an amount equal to or at least 100% of the hospital’s or system’s tax-exempt benefits; or 3) an amount equal to at least 5% of the institution’s net patient revenue.147

Only a few other states, such as Pennsylvania, Utah, and West Virginia, have passed similarly prescriptive statutes requiring hospitals to provide a minimum amount of community benefit (and threshold amount of charity care) in exchange for state and local tax exemptions.148 In Illinois, legislators passed a law requiring community benefit reporting in 2003.149 Several years later, during the 2006 legislative session, the state Attorney General proposed a far more rigorous standard, one that would mandate that hospitals commit 8% of their annual operating costs to charity care. But the Attorney General later withdrew the proposal in order to allow her to discuss the merits of the proposal with representatives from the state hospital association.150 Lawmakers also proposed regulations in Rhode Island that would require that 1% of net patient revenue should be used for charity care purposes, though the final rules did not reflect this proposal.151

Although many of the proposals that would require a minimum level of

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146. TEX. TAX CODE ANN. § 11.1801 (Vernon 2008). The Texas law applies to those hospitals that wish to qualify as charitable organizations and thus receive exemptions from state property taxes. See Bilimoria, supra note 35, at 137; Burns, supra note 29, at 680; Hanson, supra note 35, at 399; Wood, supra note 26, at 725.
147. TEX. TAX CODE ANN. § 11.1801 (Vernon 2008).
149. Kane, supra note 35, at 460.
150. SENATE COMM. ON FINANCE—MINORITY, supra note 136, at 9 n.22; Colombo, Exemption Policy, supra note 9, at 444 (citing Shruti D. Singh, Madigan To Negotiate Terms of Charity Care Bill—To a Point, CHICAGO BUS., Apr. 26, 2006, http://www.chicagobusiness.com/cgi-bin/news.pl?post_date=2006-04-26&id=20365).
community benefit have not passed into law, legislators in numerous other states have taken a more process-oriented approach to enhancing charity care. While the laws do not impose minimum charity care obligations, they do require not-for-profit health care institutions to conduct community health needs assessments and to develop community health benefit plans in return for state and local tax exemptions. In addition, these laws often require that hospitals report the amount of charity care they provide to the state agency responsible for regulating the health care sector.

Using yet another strategy, other state legislatures have proposed various measures to restrict hospitals’ current financial billing and collection practices. Rather than regulating hospital charity care at an organizational level, these states directly regulate hospital interactions with individual uninsured patients. In Connecticut, for example, recently passed laws prevent hospitals from collecting more than the cost of care from patients that meet a statutory definition of “uninsured.” The law also imposes collection restrictions, limiting the extent to which hospitals may levy on or execute against a patient’s property.

152. Kane, supra note 35, at 461.
153. Colombo, Competitive Health Care Market, supra note 35, at 627; Hanson, supra note 35, at 399.
154. Hanson, supra note 35, at 399. A community benefit plan (CBP) sets forth how an institution will “serve the community’s health care needs,” as determined by community-wide needs assessments. See, e.g., TEX. HEALTH & SAFETY CODE ANN. §§ 311.041 to .048 (Vernon 2008); TEX. TAX CODE ANN. § 11.1801 (Vernon 2008). Indiana, for example, passed legislation requiring “enhanced financial reporting” and the development of CBPs. Noble et al., supra note 18, at 123-28; Wood, supra note 26, at 723-24. The state’s reporting requirements are intended to capture and make available to the public specific information about levels of charity and government-sponsored indigent care provided by local hospitals. Noble et al., supra note 18, at 123-28; Wood, supra note 26, at 723-24. The New York legislature began to require submission of an annual Community Service Plan (CSP) in 1991 and, since 1996, has required that hospitals file CSPs every three years. Noble et al., supra note 18, at 123-28; Wood, supra note 26, at 723-24. The California legislature has also required not-for-profit hospitals to develop annual CBPs and to conduct community needs assessments, which are reported annually to the state. Noble et al., supra note 18, at 123-28; Wood, supra note 26, at 723-24. Massachusetts and Missouri have created reporting systems that “encourage” hospitals to voluntarily report the community benefits they provide in order to promote uniform standards for the hospital industry. Noble et al., supra note 18, at 123-28; Wood, supra note 26, at 723-24. Finally, states such as Virginia, Montana, North Carolina, and South Carolina have taken a different approach, and often condition approval of certain transactions or certificate-of-need applications on whether hospitals provide a “reasonable amount” of care to the poor. Noble et al., supra note 18, at 123.
156. Jacoby & Warren, supra note 11, at 541 & nn.42-47.
157. Id. at 540-41.
B. State Efforts Achieve Limited Success

Academics and industry experts have criticized most of the state-level approaches as ineffective in actually enhancing levels of discounted or free care.\textsuperscript{158} The relatively lax reporting requirements often add little transparency to the process of indigent care delivery, and, due to a lack of resources devoted to oversight, many statutes have effectively become self-reporting mechanisms, rather than true regulatory enforcement tools.\textsuperscript{159}

Under the most prevalent strategy, in which state laws mandate that hospitals conduct community health assessments and draft community benefit plans,\textsuperscript{160} the reports generated often receive little attention from state officials, likely due to a lack of sufficient funding for officials to properly evaluate and audit the data that is submitted.\textsuperscript{161} When reports are read by state officials, they may be of little value, as they may lack depth, or the attached financial statements may have inconsistencies in data reporting.\textsuperscript{162} Making matters worse—and severely undermining regulators’ ability to monitor hospital performance—the states that
have adopted these reforms may lack uniform quantitative and qualitative standards for determining what constitutes a community benefit across different hospitals. In Texas, for example, which requires hospitals to file an Annual Statement of Community Benefits Standard documenting compliance with the state’s statutory charity care requirement, not only is the state agency responsible for monitoring compliance unable to compare community benefit information to other hospital financial data due to definitional differences and varying timing for reports, but because the definitions for critical reporting terms have changed over time, regulators are unable to effectively track hospital performance over time. This lack of uniform, consistent, and easy to scrutinize data may allow hospitals with poor revenue collection processes or inflated charges to appear to provide higher levels of charity care than their peers. Thus, as Professor Nancy Kane summarized in her testimony before the House Ways and Means Committee: “[Ambiguous state standards of community benefit, coupled with limited resources for monitoring and enforcement, have hampered state efforts to increase the provision of charity care by exempt hospitals.”

Even Texas-style requirements that all hospitals commit to delivering a set amount of charity care are subject to criticism and may be fraught with pitfalls. Indeed, the many secondary questions such approaches generate reveal that they do not present the panacea that many legislators might initially hope. Although fixed standards may provide an “objective tool for determining whether nonprofit hospitals are satisfying their respective obligation to the communities they serve,” they also may impose a disproportionate burden on smaller hospitals or single-facility institutions located in rural areas or lower socio-economic neighborhoods. By contrast, the ability of some systems to report community benefits at aggregate levels (accounting for multi-hospital systems in one report) may mask lower amounts of care provided by hospitals located in more affluent settings. Furthermore, the implementation of strict charity care standards requires that legislators confront significant practical hurdles and make difficult policy decisions. John D. Colombo, an expert in hospital tax exemption, highlighted some of these difficult policy choices:

163. Noble et al., supra note 18, at 128-29.
164. Id. at 129.
165. Wood, supra note 26, at 735-36. In fact, Texas legislators explicitly created such a loophole in the state’s charity care statute by amending the law in 1995 to allow the inclusion of bad debt in annual charity care reports. Noble et al., supra note 18, at 129.
166. Hearing on the Tax-Exempt Hospital Sector, supra note 27, at 118 (statement of Nancy M. Kane, Professor of Mgmt., Harvard Sch. of Pub. Health).
167. Hearing on the Tax-Exempt Hospital Sector, supra note 27, at 99 (statement of John T. Thomas, Senior Vice President, Baylor Health Care Sys.).
168. Noble et al., supra note 18, at 130; Wood, supra note 26, at 736.
whether to measure charity care on the basis of costs or charges, and if on costs, whether to use marginal or average costs; what the minimum level of charity care would be to justify exemption; whether that minimum level would have to be in excess of what for-profits write off each year in bad debt (since presumably this is the baseline of "free care" that is being provided by the for-profit providers without tax exemption); and whether nonprofits should have to separate "true" charity care from bad debt in making a charity care measurement (e.g., whether the measurement should be total uncompensated care or a more narrow subset of uncompensated care involving up-front decisions that a patient is a "charity" patient and will not be charged for service). 170

An effort to impose a federal minimum charity care requirement—whether initiated by Congress or by the IRS—would face similar obstacles and therefore might encounter a significant uphill battle to passage. 171 As Professor Colombo notes, the policy issues he identifies “certainly can be resolved.” But doing so will not be easy, and would likely generate lengthy, and perhaps intractable, debate. 172 Moreover, enforcement costs would also undoubtedly be high, perhaps prohibitively so, particularly given that the IRS already receives inadequate funding to review hospital finance data. 173 Professor Nancy Kane reported, for example, that “[f]rom 1996 through 2001, staffing for the tax-exempt division of the I.R.S. fell by 15%, while the number of Form 900s filed by charities increased by 25%. The Form 990 examination rate for all charities was less than
1% over that period.” In short, even if a uniform, federal charity care mandate did provide an “administrable standard of accountability” that invited straightforward comparisons across institutions, it is possible that a poorly enforced regulation seeking to standardize complex not-for-profit finance metrics would do little to drive change in the day-to-day operations of not-for-profit health care organizations.

IV. VOLUNTARY CHANGES AND PROPOSALS FOR LEGISLATIVE REFORM

A. Voluntary Reforms to Charity Care Policies and Billing Practices

Providers acknowledge the need for reforms to hold hospitals more accountable for delivering community benefit services, but they are nevertheless quick to note that they have already made a number of voluntary reforms to their charity care policies and have substantially curbed overly aggressive billing and collections practices. A 2005 study by PriceWaterhouseCoopers supports this claim; the firm found “that nearly 70 percent of hospitals had voluntarily revised their charity care policy within the last year.” It reported that “[i]n almost every case, the change was to expand eligibility” for charity care, and that “[m]any hospitals also instituted sliding scale discounts or made existing sliding scale discounts more liberal.” The study also found that many hospitals had moved toward flat-fee discounts for uninsured patients who did not qualify for free care, charging uninsured patients at rates equivalent to those applied to bills for Medicare or managed care patients. By expanding eligibility for charity care programs and changing their billing policies to offer greater discounts to uninsured patients, hospitals both expanded access to care for uninsured patients and ensured more consistent delivery of community benefit to this population.

Many institutions made these changes in response to intense public criticism

174. See Kane, supra note 35, at 470.
175. Hearing on the Tax-Exempt Hospital Sector, supra note 27, at 90 (statement of John D. Colombo, Professor, Univ. of Ill. Coll. of Law).
176. See Kane, supra note 35, at 470. Of course, as noted previously, a strict charity care standard might ensure that hospitals satisfy their obligations to taxpayers to provide a sufficient amount of community benefit in exchange for tax exemption. See supra notes 31-34 and accompanying text.
177. See Hearing on the Tax-Exempt Hospital Sector, supra note 27, at 103 (statement of Sister Carol Keehan, Chair, Bd. of Trs., Catholic Health Ass’n).
179. Id.
180. Id. at 15-17.
of their own practices. They found themselves as defendants—or potential defendants—in the recent wave of federal litigation. Others simply felt the aftermath of the lawsuits, as their communities began to also question whether local hospitals made adequate efforts to ensure access to care for the uninsured—and whether, therefore, those institutions remained deserving of local and state tax exemptions. Thus, such hospitals may have developed more clear charity care policies in order to preempt state legislation.

Examples abound nationwide. The Center for Studying Health System Change reported that, in each of the twelve nationally-representative communities it studies, most hospitals have “many hospitals have modified billing and collection practices, for low income, uninsured patients.” Most hospitals interviewed through the Center’s research also increased the income threshold at which the organization provides full charity care or discounted services. North Shore-Long Island Jewish Health System provides reduced fees to patients earning up to 300% of the federal poverty level. Baptist Health System of South Florida increased its charity care income threshold from 200-300% of the national poverty level and reports that it is considering increasing charity care eligibility to 500% of the poverty level. Other providers have developed prompt-pay discounts for self-pay patients; these discounts may bring prices down to the level of rates negotiated with major private insurers or government reimbursement programs.

National and state-level provider associations have strongly encouraged these reform efforts by issuing recommendations and guidelines regarding provider billing and collection polices.

181. Id. at 1, 15-17; Staiti et al., supra note 25. While plaintiffs suing not-for-profit hospitals have so far fared poorly in federal courts, providers may have continued to reform their billing and collections procedures—and publicize their new practices—in part to avoid litigation in state forums. See supra note 74 and accompanying text.

182. See infra notes 233-238 and accompanying text.

183. See Staiti et al., supra note 25, at 3, for descriptions of some of the varying approaches taken by health care providers. Some received publicity on the changes they have made. Id. at 4.


186. Staiti et al., supra note 25, at 2.

187. Id.

188. Of course, the fact that hospital associations have adopted guidelines or recommendations does not ensure that the member hospitals in fact follow the recommended practices. It is in the associations’ interests to adopt such policies and advertise that fact when lobbying members of Congress or defending their member institutions to the public. The associations may be particularly
clearly state their charges to patients before treatment, work to identify patients that might qualify for free or discounted care, and cease harsh collection tactics.\textsuperscript{189} It also encouraged hospitals to communicate clearly with patients about charges, counsel low-income and uninsured patients about payment options, assist such patients in applying for free or discounted care, double-check bills as a way to make sure they are fair, and pursue patient accounts in a fair manner.\textsuperscript{190} The AHA also strongly urged hospitals to report the full value of the community benefit they provided—including “bad debt and the unpaid costs of government-sponsored health care—in part so “that the information could be shared with elected officials and government agencies.”\textsuperscript{191} Initial results indicate that AHA’s guidelines have been adopted by 3000 of its member hospitals.\textsuperscript{192}

State hospital associations, too, have published billing and collections guidelines for not-for-profit hospitals and urged more generous financial aid policies for uninsured patients.\textsuperscript{193} The Healthcare Association of New York State, for example, recommended that not-for-profit hospitals establish policies to financially assist all patients below 200\% of the federal poverty level, as well as offer sliding-scale discounts to indigent patients who earn more than the federal poverty level.\textsuperscript{194} The Association also suggested that hospitals charge uninsured patients the same rates provided to Medicaid or private insurers and then offer to educate patients about their billing policies.\textsuperscript{195} Finally, it advocated against foreclosure on patients’ primary residences and requested that hospitals not garnish patients’ wages unless the hospitals had evidence that patients are able to pay the bills.\textsuperscript{196} State hospital associations in California, Oregon, Illinois, and Tennessee have urged their members to adopt similar billing and collection guidelines.\textsuperscript{197}

Although providers have not made the argument explicitly, one might read the reported adoption of these voluntary guidelines to indicate that additional regulatory or statutory reforms are unnecessary to improve the actual amount of

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\footnotetext{189} Batchis, supra note 35, at 538-39; Cohen supra note 8, at 139.
\footnotetext{190} Cohen, supra note 8, at 139.
\footnotetext{191} Hospitals Urged To Report Dollar Value of Their Community Benefit, AHA News, Nov. 13, 2006, at 1, 3.
\footnotetext{192} Cohen, supra note 8, at 139.
\footnotetext{193} Id. at 139-40 nn.271-76; Jacoby & Warren, supra note 11, at 541 & n.49.
\footnotetext{194} Cohen, supra note 8, at 139-40 (citation omitted).
\footnotetext{195} Id.
\footnotetext{196} Id.
\footnotetext{197} Id. at 140.
\end{footnotes}
As this argument would go, providers have already made sufficient improvements, and further regulatory or legislative efforts would merely duplicate voluntary reforms. Moreover, one might argue that hospital associations have become more attuned to the attention their member institutions have received from trial attorneys, government officials, and the media, and that they will ensure that their member institutions follow the recommended guidelines. But those arguments hinge on the theory that the current public attention to hospitals will last indefinitely, or, if it does not, then providers will have other incentives to sustain recently implemented reforms. But however powerful they may be for public relations purposes, the “recommended guidelines” that associations have promulgated are non-binding and cannot, themselves, drive actual operational changes in hospitals. One must also be skeptical of what it means when hospitals announce that they have rededicated themselves to serving the indigent in their communities. Surely, such actions are motivated by a true desire to ensure that uninsured patients receive necessary care. But the timing of these recent reforms indicates that they may be, in equal part, calculated public relations efforts to both mitigate and ward off criticism regarding charity care policies. For these reasons, more lasting reforms can only be achieved through either regulatory or statutory measures that, themselves, obligate hospitals to modify their current practices.

B. Improving Transparency in Hospital Billing and Collections Policies and Standardizing Community Benefit Reporting

Many federal, state, and local lawmakers have endorsed reforms that would impose voluntary disclosure and reporting requirements upon not-for-profit hospitals, presumably on the theory that if hospitals must disclose their charity and collections policies they will be pressured to adopt more “charitable” policies and procedures. The AHA, too, has proposed that states, hospital associations, and insurance companies collaborate to make pricing schemes available to

198. See, e.g., Hearing on the Tax-Exempt Hospital Sector, supra note 27 (statement of Sister Carol Keehan, Chair, Bd. of Trs., Catholic Health Ass’n).

199. Cohen, supra note 8, at 141-43. Congress has, for example, considered a statute that would require not-for-profit providers to disclose their charges. Id. at 143 (citing Hospital Price Disclosure Act of 2005, H.R. Res. 1362, 109th Cong. (2005) (requiring hospitals and ambulatory surgery centers to disclose charges for their twenty-five most frequently performed inpatient and outpatient procedures, and their fifty most frequently administered drugs dispensed to inpatients)); see also HEALTH RESEARCH INST., PRICEWATERHOUSECOOPERS, MY BROTHER’S KEEPER: GROWING EXPECTATIONS CONFRONT HOSPITALS ON COMMUNITY BENEFITS AND CHARITY CARE 10-11 (2006) (hereinafter MY BROTHER’S KEEPER) (describing community benefit reporting measures adopted in a number of states).
consumers so they can compare services across institutions and make an educated choice before they receive treatment.\(^{200}\)

When it comes to pricing schemes and billing policies, these lawmakers and industry advocates may be correct that disclosure requirements alone will suffice to pressure providers into adopting approaches that are in line with those of their competitors.\(^{201}\) As those hospitals subject to the Wall Street Journal’s scathing reports found, negative media attention about “uncharitable” billing and collection policies can be devastating to a hospital’s reputation within the community and with local lawmakers.\(^{202}\) Thus, if one’s only concern is ensuring that uninsured patients receive affordable medical care, then disclosure requirements, alone—whether self-imposed, adopted pursuant to an association’s “recommended guideline,” or mandated by state or federal lawmakers—may be sufficient to ensure that not-for-profit hospitals reform their billing and collections procedures and provide adequate care to self-pay patients.\(^{203}\)

But when it comes to the larger issue of whether not-for-profit hospitals are in fact “earning” their tax exemptions, disclosure requirements, alone, may be of little benefit to consumers and lawmakers unless those requirements also contain standardized metrics for reporting community benefit.\(^{204}\)

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200. My Brother’s Keeper, supra note 199, at 19.

201. Cf id. (observing that public access to pricing and quality information may drive improvements in quality even if prices remain consistent because consumers will be able to make direct comparisons across institutions; also noting that disclosure of pricing data “empowers” uninsured patients by allowing them to make price-conscious decisions about their care).

202. See generally supra note 17 and accompanying text.

203. One might nevertheless argue that legislation requiring only voluntary disclosure of billing and collection practices would be of little marginal value, as hospitals already face sufficient pressure from their communities, peer facilities, and trade associations to increase access to care for the uninsured, offer discounted prices, and engage in compassionate collection practices—or at least promote the fact that they will do so. But this claim is subject to multiple criticisms. First, as with mandatory disclosure requirements, there is little reason to believe that hospitals would change their practices any more than absolutely necessary to avoid further public scrutiny. Nor is there reason to believe that this level of change would strike the appropriate balance to warrant continued tax exemption. Second, although recent public scrutiny has driven many institutions to change their billing and collections practices, there is no way to “enforce” voluntary adherence to a self-imposed standard. Thus, should the public criticism fade, hospitals would be free to revert to their old ways. Finally, as discussed above, supra note 18, demand from community members and lawmakers that hospitals meet minimal community benefit standards shifts over time, as federal reimbursement rates change and hospitals alter their baseline levels of free and discounted care in response to changing margin pressure. These shifts in public scrutiny make it all the more likely that voluntary measures would be short-lived.

practices, differences in how hospitals chose to report this data would render it difficult to compare self-calculated community benefits across institutions. Accordingly, even if the IRS were to dramatically increase enforcement efforts based on the information hospitals currently disclose to the agency, those efforts would still be hamstrung by the fact that the agency lacks a clear standard by which to measure whether hospital exemption status is merited.  

The solution to lawmakers' concerns about hospital exemption, therefore, may lie instead in a requirement that both requires hospitals to disclose their self-calculated community benefit and that prescribes precise metrics for how hospitals may calculate the community benefit they are reporting. This type of approach would leverage existing pressures on providers to disclose billing and charity care information. At the same time, it would ensure that the data provided could be used in a meaningful manner by local and national lawmakers and administrators. But, because such a requirement would not impose any of the more draconian measures that some providers fear—notably, a percentage-based minimum charity care requirement or revocation of hospital tax exemption—it would be far more likely to generate support among industry interest groups. Hospitals would be happy to avoid mandatory charity care requirements, which threaten to increase the already-heavy burden not-for-profit hospitals bear in caring for the nation's underinsured and uninsured populations. Industry reforms must include more clear guidance regarding what qualifies as a community benefit).

205. There remains significant disagreement, even among industry experts, about whether charity care should account for costs or charges and whether and how disclosure must account for bad debt, as well as inevitable “Medicare shortfalls.” Id. at 468; see also Nancy M. Kane & William H. Wubbenhorst, Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption, 78 MIlbank Q. 185, 190 (2000).

206. The effect of the new disclosure requirements imposed by the revised Form 990 and Schedule H will remain unclear until hospitals actually submit that data for fiscal year 2008.

207. Although not addressed by this Note, revocation of hospital tax exemption altogether poses a number of critical flaws and would likely deny hospitals far more funds than the federal government would realize in tax revenues due to loss of grant money and donations and the elimination of eligibility for tax-exempt debt. Kane, supra note 35, at 471; see also McGregor, supra note 204, at 338-39; Quirk, supra note 19, at 102-03. But see Colombo, Competitive Health Care Market, supra note 35, at 629-35 (describing conflicting findings in empirical studies regarding the value of hospital tax exemption).

208. See, e.g., Letter from Rick Pollack, supra note 27 (noting that federal programs often do not pay the full cost of care for covered patients, and hospitals must absorb the shortfalls); Am. Hosp. Ass'n, Issue Paper, Improving Accountability for Tax-Exempt Status (May 2007), http://www.aha.org/aha/content/2007/pdf/07-am-accountability-tax-exempt.pdf (“[H]ospitals shoulder the burden of bad debt, much of which comes from low-income patients, who . . . do not apply for financial assistance.”). What providers frequently fail to note in these communications is that there are significant differences between hospitals in the provision of uncompensated care (including both bad debt and
members objected strenuously to a draft proposal for revising the IRS Form 990, for example. They complained, in particular, that the proposed Schedule H, which sought information regarding hospital compliance with the community benefit standard, failed to “incorporate the full value of community benefit that hospitals provide,” including Medicare underpayments and bad debt, and also imposed “burdensome and misleading questions . . . unrelated to community benefit or compliance.”

Perhaps in recognition of the fact that an approach based on precise disclosure standards is most likely to satisfy lawmakers and also avoid more drastic changes for the industry, the Catholic Healthcare Association (CHA), the VHA, and the AHA have all proposed new standards for reporting community benefits. The VHA and the CHA released “Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability,” which provides guidelines regarding how hospitals should account for and quantify community benefit. The report identifies eight

free care) among private not-for-profit hospitals and for-profit hospitals that are publicly and privately owned. A 2005 Government Accountability Office (GAO) report concluded that government-owned hospitals had significantly higher uncompensated care burdens (i.e., the ratio of uncompensated care relative to total operating expense) than privately owned institutions. DAVID M. WALKER, U.S. GOV’T ACCOUNTABILITY OFFICE, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS 3 (2005), available at http://www.gao.gov/new.items/d05743t.pdf. The report found differences in uncompensated care burden between not-for-profit private and investor-owned hospitals. Id. It also noted that a relatively small proportion of hospitals maintained the greatest proportion of the private, not-for-profit uncompensated care burden. Id.; see also Kane, supra note 35, at 465 (describing GAO findings). A new standard would likely have little impact on the amount of care provided by those hospitals that currently provide the greatest share of the uncompensated care burden.

209. Am. Hosp. Ass’n, Comments on Draft Schedule H, Aug. 21, 2007, available at http://www.aha.org/aha/letter/2007/070821-let-IRSSchH.pdf; see also Letter from Representatives Tubbs Jones and Porter, supra note 27 (noting concern that the proposed “new form and schedules [Form 990 and Schedule H] will place a disproportionate burden on these hospitals, which already are overburdened with the many challenges of providing care in their communities”).

210. See Hearing on the Tax-Exempt Hospital Sector, supra note 279, at 103 (statement of Sister Carol Keehan, Chair, Bd. of Trs., Catholic Health Ass’n); Id. (statement of Edward Goodman, VHA, Inc.); Kane, supra note 35, at 468. The CHA is the national membership association of the Catholic health ministry; it represents more than 2000 sponsors, systems, facilities, and related organizations. See generally Catholic Health Ass’n, http://www.chausa.org (last visited Apr. 28, 2008). VHA, Inc. is a national cooperative of community-owned health care systems and physicians; it serves more than 1400 not-for-profit hospitals and more than 21,000 non-acute health care organizations nationwide. See generally VHA, Inc., https://www.vha.com (last visited Apr. 1, 2008).

211. CATHOLIC HEALTHCARE ASS’N & VHA, INC., COMMUNITY BENEFIT REPORTING: GUIDELINES AND STANDARD DEFINITIONS FOR THE COMMUNITY BENEFIT INVENTORY FOR SOCIAL

463
categories of community benefits, and also argues that hospitals should not count either bad debt or Medicare shortfalls in their community benefit reports, though they may include Medicaid shortfalls, given the relative consensus regarding the under-funded nature of that program. Critically, the CHA/VHA report also prescribes accounting methods based on hospital costs rather than hospital charges.

In May 2006, the CHA released a separate document, “A Guide for Planning and Reporting Community Benefit,” which combines the standard definitions and guidelines developed by CHA and VHA with CHA consensus guidelines for accounting for charity care. CHA officials encouraged providers to adopt these common reporting mechanisms for charity care not only to improve provider-specific budgeting and advocacy, but also to enable analysis of consolidated information across institutions and respond to both local and congressional concerns about whether not-for-profit providers are charitable enough to merit continued tax exemption. Initial data suggest that the CHA and VHA efforts

ACCOUNTABILITY (2005), available at http://www.chausa.org/NR/rdonlyres/1E9B545E-BD93-4F46-B6F2-3FE18578CB41/0/commbenguidelines.pdf. The guidelines explain that providers should include within a quantifiable inventory services that, 1) “result in a financial loss to the organization, requiring subsidization of some sort,” 2) may “[b]est be quantified in terms of dollars spent or numbers of persons served,” 3) are not “of a questionable nature that jeopardizes the credibility of the inventory, and 4) are accounted for within “an explicit budget.” Id. at 8. The guidelines also suggest that other items may be accounted for within a narrative summary, such as services that 1) “Are of significant community benefit, but break even or involve minimal cost”; 2) “Are better appreciated by a reader when described in terms of benefit provided or numbers served rather than dollars spent”; 3) “Are provided entirely by volunteers or involve staff donating their own time to the program”; and 4) “Are somewhat controversial as to whether they represent a ‘true’ community benefit.” Id.

212. Those eight categories include: charity care, shortfalls from Medicaid and other government-funded indigent care programs, community health improvement services, health professional education, subsidized services, research, financial contributions, and community-building activities. See Becker, supra note 148; Keehan, supra note 142; Professor Nancy M. Kane has endorsed the exclusion of Medicare shortfalls from the accounting formula, explaining that “Medicare payment rates are supposed to be what efficient hospitals can live with.... If the payment rates are below cost, the suggestion is that (the hospital) is inefficient and it’s not doing the community a big favor.” Id.; see also Keehan, supra note 142.

213. Charitable Formula, supra note 142, at 18 (stating, on behalf of CHA, that “we have worked with the VHA to identify eight categories of community benefit, including charity care (reported as cost, not charges”)).

214. For information on the guide, see Quirk, supra note 19, at 98; see also Catholic Health Ass’n, Executive Summary, http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/Resources/TheGuide/.

have been successful; in the fall of 2007, the CHA announced that its May guidelines were formally adopted by 95% of its member health systems and 90% of its member hospitals.²¹⁶

The AHA proposal resembles the CHA guidelines and also supports improvements in pricing transparency and community benefit reporting.²¹⁷ The association encouraged hospitals to provide free care to uninsured patients with incomes below 100% of the federal poverty line, and suggested that hospitals bill those with incomes between 100-200% of the poverty level no more than 125% of the rate established by either Medicare or other public or private payors.²¹⁸ Unlike the CHA and VHA guidelines, however, the AHA would permit hospitals to also account for both bad debt and Medicare shortfalls when accounting for charity care.²¹⁹

Perhaps not surprisingly, given that they have been proposed by industry leaders, these proposals have been well received within the industry. Some experts, however, continue to suggest that even more comprehensive reforms may be needed.²²⁰ Professor Nancy Kane proposes a slightly more rigorous approach, one that encompasses more “meaningful behavioral expectations of tax exempt hospitals.”²²¹ Although providers would likely resist a standard that would afford them less accounting flexibility than the CHA and AHA guidelines provide, Professor Kane’s proposals arguably would provide legislators and communities with more concrete tools with which to hold hospitals accountable for maintaining adequate community benefit programs. She suggests, first, that hospitals tie eligibility for free care to the magnitude of the self-pay portion of the patient’s bill relative to that individual’s ability to pay; further, she proposes that hospitals post their billing policy both on their websites and on a disclosure

²¹⁷. See Zigmond & Evans, supra note 153.
²¹⁸. Id.
²¹⁹. Quirk, supra note 19, at 103-04. A fourth industry association, the Healthcare Financial Management Association (“HFMA”), adopted standards that incorporate elements of both the AHA proposal and the CHA/VHA standard. Melanie Evans, Tussling Over Benefits: HFMA Accounting Rules Straddle AHA, CHA Methods, MODERN HEALTHCARE, Dec. 4, 2006, at 12. The HFMA would exclude bad debt as a community benefit, but would permit hospitals to count Medicare losses toward community benefit expenses. Id. The association also endorsed the use of costs, rather than charges, to value these expenses. Id.
²²⁰. See Quirk, supra note 19, at 98, 103-04 (describing positive response among legislators). But see Kane, supra note 35, at 468 (criticizing the lack of a uniform and easily enforced reporting standard); Quirk, supra note 19, at 104 (observing that the AHA proposal, in particular, “fails to provide objective benchmarks for levels of ‘charity care’ and other ‘community benefits,’” and concluding that therefore “it is unsuccessful in remedying the problems of uncertainty inherent in Revenue Ruling 69-545’s ‘Community Benefit Standard’”).
²²¹. Kane, supra note 35, at 471-72.
form attached to the IRS Form 990. If hospital bills are tied to patient resources, she explains, patients might be more likely to actually pay for the services they receive. Second, she would require health care providers to improve communication with uninsured patients; administrators would enforce this provision by “monitoring of the level of awareness in the community of the hospital’s charity care and discounted care policies.” Third, hospitals would have to justify their debt collection practices to the IRS in terms of the methods they employ and the rates at which they collect. The IRS, in turn, would regularly review the hospital reports to police against overly aggressive collection practices. Fourth, hospitals would be required to partner with community groups to improve access to care and report on their efforts to both the IRS and the board of the provider institution. Fifth, hospital boards would be required to maintain a permanent committee to review, monitor, and report on compliance with exemption requirements. Finally, and perhaps more importantly, hospitals would be required to produce a community benefit report in accordance with the CHA guidelines and make that report available both as an attachment to the IRS Form 990 and on hospital websites. Professor Kane explains that these goals would not be “onerous” for hospitals already providing sufficient levels of charity care and would simply “set forth more clearly than does current law what behaviors are expected of our charitable hospitals.”

Despite these varied proposals for enhancing and standardizing community benefit reporting, some industry analysts still maintain that reporting requirements are insufficient to ensure that hospitals deliver charity care equal to or in excess of the tax benefits they receive. These analysts argue that only a minimum charity care requirement will suffice. Ultimately, these critics may prove correct; when the data from the revised Form 990 and Schedule H becomes available, it may in fact demonstrate that minimum charity care requirements are necessary. But this will not occur for at least another year. For an industry known for its slow rate of change, particularly when it comes to financial and accounting matters, prescriptive reporting and disclosure guidelines are a necessary interim step toward resolving concerns about not-for-profit hospitals’ charity care practices. Therefore, federal lawmakers should reject proposals to adopt a minimum charity care standard and instead adopt a wait-and-see approach before

222. Id. at 471.
223. Id. at 471-72.
224. Id. at 472.
225. Id.
226. Id.
227. Id.
228. Id. at 471-72.
229. See, e.g., McGregor, supra note 204, at 335-36.
initiating more sweeping—and controversial—reforms. This would allow the IRS to gather community benefit data from its revised Form 990 and Schedule H and use that information to help legislators determine whether, and to what extent, additional reforms are necessary. The Form 990s may reveal that many hospitals already provide sufficient community benefits, and that there is no need for specific expenditure requirements in order to justify the hospitals’ tax-exempt status. Alternatively, the new forms may reveal that hospitals are not spending nearly enough on their communities. The point is that we will not know until the results come in from the new reporting requirements.

That said, the IRS should incorporate into its existing requirements more prescriptive guidelines such as those suggested by Professor Kane. Professor Kane’s proposals would ensure that hospitals receive adequate guidance, and also guarantee that the IRS receives data that allows for meaningful aggregation and comparison across institutions. As noted above, providers may feel free to disregard or abandon purely voluntary standards, and the IRS would be unable to enforce such guidelines if that occurred. The agency must, therefore, incorporate more detailed guidance into its existing Form 990 requirements, using the industry-based proposals as a starting point. This approach would strike an appropriate balance between allowing providers to initiate improvements within their industry and assuring lawmakers and taxpayers that those changes will be lasting and that hospitals may be held accountable for any underperformance.

CONCLUSION

Although the 2004 lawsuits helped to shed light on the question of whether hospitals are providing sufficient amounts of care to uninsured populations, developments since those suits were filed have reinforced the district court decisions in favor of the defendant health care institutions. Had the courts permitted individual patients to enforce federal tax exemption standards, and had the judges, themselves, fashioned the remedy for those patients, there would have been enormous and likely ill-fated repercussions on the health care industry. Not only would such a regime be difficult to manage from a judicial standpoint, but it also could potentially expose providers to virtually unending suits from indigent patients (and the plaintiffs’ bar). The critical questions underlying the present uninsurance crisis are not ones that can or should be answered in an ad hoc manner with only one provider or set of community standards in mind. Rather, these questions are ones that should be addressed in a political forum with opportunities for debate from both government and industry representatives.

Moreover, had the judiciary ceded to plaintiffs’ requests to return to a standard akin to the 1956 Revenue Ruling and read into the federal tax code a minimum charity care requirement—and, further, allowed third-party patients to enforce this standard—hospitals would have faced an enormous burden to pay for indigent care. As most not-for-profit institutions already struggle to attain
financial margins sufficient to support their operations, this type of cost-shifting would have a major impact on health care providers. Somewhat ironically, many would likely increase their prices—both the “list” prices that some institutions still charge to self-pay patients and the negotiated rates offered to managed care companies—in order to maintain their financial margins. Of course, because uninsured patients rarely pay the full list price, these individuals would likely see little, if any, effect of across-the-board rate increases. Rather, the impact of price increases would be felt primarily by third-party payors, who would almost certainly then pass the increased costs on to employers. And, as current efforts to manage employer health care costs demonstrate, this problem is too large and too pervasive for the judiciary to augment it by construing the federal tax code to include new charity care obligations on not-for-profit providers.

It is important to recognize, however, one of the major lessons of the recent lawsuits and legislative debates: increased public scrutiny has the power to drive

230. Despite the outcry within the industry that a minimum charity care standard would spell disaster for hospitals’ abilities to maintain sustainable margins, no expert to assess the issue has concluded that hospitals would become financially insolvent if Congress were to reformulate the community benefit standard or impose a strict charity care standard. See, e.g., Kane, supra note 35, at 472 (concluding that “[t]hese guidelines would not be onerous for the many hospitals seeking to behave appropriately”). But hospitals already operate at extremely thin margins, and many operate at a loss. One author notes that although hospital financial performance has improved steadily since 2002, for not-for-profit hospitals rated by Moody’s investment service, operating margins slipped in 2006 to only 2.3% and expenses exceeded revenues, suggesting future operating pressures. The author also observed that roughly one-third of hospitals currently operate at a loss. See Melanie Evans, On Solid Ground: Revenue Gains Continue To Outpace Growth In Expenses, Allowing U.S. Hospitals To Enjoy Record Profit and Margins, MODERN HEALTHCARE, Oct. 29, 2007, at 6-7. Many hospitals do not, however, have room in their margins to accommodate significantly greater amounts of charity care. See also DRAPER & GINSBURG, supra note 5, at 5-6 (observing that safety net providers have had to “pursu[e] strategies aimed at improving their financial health,” including seeking higher reimbursement rates from federal payors and referring patients to outpatient clinics in order to manage costs associated with increased demand for safety net services).

231. Even if hospitals were to abandon charging uninsured patients based on charges rather than costs, as the CHA and VHA have proposed, if those institutions were to tie rates for uninsured patients to those rates paid by private payors, an increase in negotiated rates would also affect self-pay patients.

enormous voluntary reforms industry-wide. The recent attention has also spurred political entities—which are far more suited to the task than the judiciary—to initiate steps toward effecting more lasting changes. Thus, the plaintiffs in the Scruggs litigation have succeeded in generating change within the health care industry, even if, as individuals, they were denied the direct relief they sought.

Notwithstanding these widespread changes within the industry, increased grassroots activity at the state level confirms that local advocacy groups still fear that voluntary hospital efforts and slow-moving federal reforms may be insufficient to ensure that hospitals are meeting their obligations to provide discounted medical services to their local communities. Under pressure from local activists, state tax officials have begun to examine more closely the community benefits delivered by health care providers and, in some cases, have sought to revoke state and local property tax exemptions.

Responding to—and hoping to leverage—these local concerns about whether not-for-profit hospitals continue to merit state and local tax breaks, Richard Scruggs and his colleagues re-focused their attention on state-level litigation efforts against not-for-profit providers. Early results suggest that the state court venues are more receptive to the plaintiffs' claims; judges in several states certified plaintiffs' classes. Hospitals appeared concerned enough about the possibility of adverse judgments—or at least protracted litigation, expensive legal fees, and negative media attention—to settle the claims. Thus, even if they have yet to succeed on the legal merits, the plaintiffs in these actions have kept the spotlight on local providers’ charity care policies. They have also, somewhat ironically, caused a possible negative effect. The money hospitals used to pay the legal bills could have instead been given directly to charity care.


234. See, e.g., Cohen, *supra* note 8, at 138 (describing efforts by Illinois tax officials to deny property tax exemptions for parcels of land owned by the Carle Foundation); Heather Knight, *Report Ranks 2 Hospitals on Charity Care*, S.F. Chron., Jan. 29, 2008, at D1 (comparing charity care among five San Francisco-area hospitals); see also Colombo, *Hospital Property Tax Exemption, supra* note 233.


236. *See supra* note 74.

237. *Id.* Because the state claims all depend on unique interpretations of common law or upon particular language of state statutes, however, outcomes in one set of state courts do not predict success in other states.

238. *See* Cohen, *supra* note 8, at 144.
For individual patients, litigation may appear to address the problems they face in obtaining affordable care. But even if plaintiffs achieve indirect success on that front—through favorable settlement negotiations, for example—these lawsuits cannot solve the problems identified by Senator Grassley and others who have challenged the underlying rationale for hospital tax exemption. When it comes to ensuring that not-for-profit providers are delivering adequate and consistent amounts of community benefits, only legislatures can make the systematic and lasting changes needed to hold hospitals accountable for adhering to any new charity care standards. However painful a new federal standard may be to not-for-profit hospitals, and however limited the final compromise may be, a legislative response will be far superior to a litigation strategy in providing a more equitable and sustainable long-term solution. A legislative solution is more likely to balance taxpayers’ interest in obtaining a public good from tax-exempt hospitals with the concern that hospitals not bear a disproportionate burden of covering the costs of caring for the nation’s uninsured.