

**COMMUNITY BENEFIT 501(R)EDUX: AN ANALYSIS OF THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT'S
LIMITATIONS UNDER COMMUNITY BENEFIT REFORM**

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“Mr. Chairman, exemption from taxes is a privilege for which communities have a right to expect a measureable definable benefit. Given the value of the exemption and the cost of it to every level of government, it makes sense that we scrutinize the extent to which communities are receiving a return on their investment in not-for-profit hospitals.” – Bill Thomas, *The Tax-Exempt Hospital Sector, Hearing before the House Committee on Ways and Means*, May 2005.¹

I. INTRODUCTION

A. Introduction

Many academics have addressed community benefit, and many have drawn various conclusions: community benefit is a failure;² community benefit is vague;³ community benefit lacks comparable quantifiable information;⁴ community benefit is ineffective.⁵ These are the common refrains of fellow law students and academics contemplating the oft-confusing world of community benefit for tax-exempt hospitals, and to a certain extent, they are all correct. Since 1969, the standard has provided considerable wiggle room for organizational compliance of § 501(c)(3) requirements,⁶ but media attention circa 2004⁷ proved the topic was ripe for Congressional interest,⁸ which culminated in the Patient Protection and

1. *The Tax-Exempt Hospital Sector: Hearing before the H. Comm. on Ways & Means*, 109th Cong. 7 (2005) [hereinafter *Tax-Exempt Hospital Sector*] (statement of Bill Thomas, Chairman, H. Comm. on Ways & Means) (quoting from past historical Congressional inquiries into entities exempt from federal taxes).

2. John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 29 (2005).

3. Amanda W. Thai, *Is Senator Grassley Our Savior?: The Crusade against “Charitable” Hospitals Attacking Patients for Unpaid Bills*, 96 IOWA L. REV. 761, 768 (2011) (citing Michele R. Goodman, *Putting the Community Back in Community Benefit: Proposed State Exemption Standard for Nonprofit Hospitals*, 84 IND. L.J. 713, 728 (2009)).

4. Jessica Berg, *Putting the Community Back into the “Community Benefit” Standard*, 44 GA. L. REV. 375, 388 (2010) (citing J.B. SILVERS, COSTS IN HEALTHCARE & THE CASE OF UNCOMPENSATED CARE 2 (Jan. 2007) (draft report for National Health Policy Forum) (on file with author)).

5. Laura L. Folkerts, *Do Nonprofit Hospitals Provide Community Benefit? A Critique of the Standards for Proving Deservedness of Federal Tax Exemptions*, 34 J. CORP. L. 611, 640 (2009).

6. See Rev. Rul. 69-545, 1969-2 C.B. 117 (1969), available at <http://www.irs.gov/pub/irs-tege/rr69-545.pdf>.

7. See Tom Scheck, *How Much Charity is Too Much?* MINN. PUB. RADIO (Dec. 13, 2004), http://news.minnesota.publicradio.org/features/2004/12/13_scheck_t_suit.

8. See *Tax-Exempt Hospital Sector*, supra note 1, at 1. See *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing before the S. Comm. on Fin.*, 109th Cong. 1 (2006) [hereinafter *Taking the Pulse of Charitable Care*]; STAFF OF S.

Affordable Care Act of 2010 (ACA) under § 9007, “Additional Requirements for Charitable Hospitals,” and amendments to § 501 of the Internal Revenue Code (the Code).⁹

Newly added § 501(r) outlines four new requirements for hospitals to meet in order to comply with community benefit, which will be termed “community benefit *redux*”¹⁰ for purposes of this Comment. The “Community Health Needs Assessment” (CHNA), the mantelpiece of reform, allows hospitals to identify a health need in the community and implement a strategy designed to overcome its findings (§ 501(r)(3)).¹¹ The CHNA is accompanied by § 501(r)(4)’s financial assistance and emergency medical care policies (FAP and EMC, respectively), in addition to limitations on charges (§ 501(r)(5)) and prohibitions against extraordinary collection actions for FAP-eligible patients (§ 501(r)(6)).¹² In short, the new § 501(r) provisions are meant to overcome some of the community benefit criticisms identified at the beginning of this Comment.

Yet the § 501(r) additions are nothing more than superficial misdirection from community benefit’s existing issues. This Comment’s thesis is that the sections lack genuine substance because the ACA § 9007 components are overly prescriptive,¹³ implement an “intermediate sanction”¹⁴ with widely disparate impacts on rural community hospitals,¹⁵ and, most importantly, may be wholly unworkable in practice due to the inherent difficulties in quantifying, evaluating, and analyzing data collected under the CHNA.¹⁶ Furthermore, § 501(r)’s attempt at reform forces hospitals to codify existing

COMM. ON FIN. – MINORITY, 110TH CONG., TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT (Comm. Print 2007), available at <http://www.grassley.senate.gov/releases/2007/07182007.pdf>. See also Press Release, Sen. Chuck Grassley, Grassley Releases Staff Discussion Draft of Potential Non-profit Hospital Reforms, Solicits Public Comment (July 18, 2007), available at http://www.grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=5202.

9. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007, 124 Stat. 855-858 (2010) (codified in scattered sections of 26 U.S.C.) [hereinafter ACA].

10. See Colombo, *supra* note 2, at 35, 37, 40, 42-44 (acknowledgement is required for Professor Colombo’s use of the term “community benefit plus” and “promotion of health plus” as it served as the template for “community benefit *redux*” as utilized in this Comment); ACA § 9007.

11. ACA § 9007; Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38148, 38148 (proposed June 26, 2012) (to be codified at 26 C.F.R. pt. 1).

12. ACA § 9007; Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38148 at 38148-49.

13. Letter from the Am. Hosp. Ass’n to the Internal Revenue Serv. (Oct. 12, 2012), available at <http://www.regulations.gov/#!documentDetail;D=IRS-2012-0036-0196> (arguing that the proposed regulations issued by the IRS are too prescriptive and overly burdensome for hospitals).

14. See Berg, *supra* note 4, at 405-07.

15. See Colombo, *supra* note 2, at 51.

16. See Berg, *supra* note 4, at 412-18.

practices under federal legislation, keeps financially strapped individuals among the highest paying hospital patients,¹⁷ and prohibits contemporary collection actions only constrained by a facility's own definition of what constitutes FAP-eligibility.¹⁸

This Comment suggests the lack of reform embodied in ACA § 9007's changes to the Code are largely based on a framework for meaningful community benefit changes presented in Professor Jessica Berg's *Putting the Community Back into the "Community Benefit" Standard*, a pre-ACA article exploring the potential benefits of implementing a public health focus in the community benefit arena.¹⁹ Based on Berg's framework, this Comment argues that § 501(r) wholly misses the mark.²⁰ Echoing similar academics' ruminations on the all too frequent community benefit analysis in the literature, the ACA's changes are an adequate start to addressing the oft-criticized community benefit standard,²¹ but is likely only an intermediate step between the standard's contemporary state and a complete overhaul within the next five to ten years.

B. Comment Overview

This Comment seeks to provide relevant background on ACA § 9007, the amendments to § 501 of the Code, and historic standards of federal tax-exempt status and offers an argument for why "community benefit *redux*" is merely an incremental step toward meaningful reform.²² Part II, "History and Background of Charitable Hospitals and Tax-Exempt Status," briefly outlines the roots of charitable hospitals with a nod to Paul Starr's seminal work in the health law field.²³ It next segues into historic standards for federal tax-exemption as interpreted by the Internal Revenue Service (IRS),²⁴ including IRS Revenue Rulings (Rev. Rul.) 56-185 (1956) and 69-545 (1969), which established the charity care and community benefit standards,

17. See *infra* Part IV.B.

18. See *infra* Part V.C.

19. Berg, *supra* note 4, at 402-21.

20. See *infra* Part VI.

21. Daniel B. Rubin et al., *Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption*, AM. J. PUB. HEALTH e1, e4 (2013) (published online ahead of print, Feb. 14, 2013), available at <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2012.301048>.

22. See *infra* Part II. See also Berg, *supra* note 4, at 419-21 (noting that, "[d]espite these potential problems, refocusing community benefit on population health benefit is at least a step in the right direction").

23. See *infra* Part II.A.

24. See *infra* Part II.B-C.

respectively.²⁵ Both will be discussed with their respective impacts on United States charitable care and charitable hospitals.²⁶

Parts III and IV introduce the “community benefit *redux*” additions to § 501(r) of the Code, focusing on the CHNA under § 501(r)(3) and analyzing the section utilizing Professor Berg’s framework for meaningful reform as presented in her 2010 article.²⁷ Lastly, the Comment ends with Part VI and contemplates ACA § 9007’s addition of § 501(r) to the Code in the context of the preceding arguments on the community benefit *redux*’s complete lack of substance as a result of conclusions drawn from Professor Berg’s framework and applicable analysis.²⁸ Part V explores potential limitations of the additional subsections of § 501(r).

II. HISTORY AND BACKGROUND OF CHARITABLE HOSPITALS AND TAX-EXEMPT STATUS

A. *United States Charitable Hospitals*

Charitable hospitals with religious affiliations in the nineteenth century provided healthcare for individuals who lacked the traditional framework of social support of family and friends, and this altruistic mission remains a core tenet of contemporary tax-exempt charitable hospitals.²⁹ These organizations can trace their origins to the nineteenth century where these “voluntary hospitals,”³⁰ which were traditionally characterized by religious affiliations, relied heavily on philanthropy, and the unreimbursed labor of skilled physicians and nurses.³¹ Charitable hospitals provided healthcare to the lower rungs of the socioeconomic ladder;³² they were a far cry from the pristine complete organizations associated with competent healthcare delivery today.³³ The charitable nature of these voluntary religious-affiliated organizations that was present in their origins has survived as the hospitals

25. See *infra* Part II.B-C.

26. See *infra* Part II.C-D.

27. See *infra* Part III, Part IV.B, Part V.A-C.

28. See *infra* Part VI.

29. See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 149 (5th ed. 1982) (noting the historical roots of hospitals as having a “strong communal character”).

30. Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 318 (1991) (providing a history of non-profit hospitals in America and their affiliation with religious societies).

31. *Id.*

32. See *id.*; STARR, *supra* note 29, at 150-51 (citing LEONARD K. EATON, NEW ENGLAND HOSPITALS, 1790-1837 (Univ. of Mich. 1957)).

33. See STARR, *supra* note 29, at 430 (discussing that in the 1980s approximately 180 hospital systems operated nearly 294,199 hospital beds).

evolved with the changing of healthcare.³⁴ During World War II, wage freezes caused employers to find alternative methods to compete for labor.³⁵ One method became offering health insurance to employees, which led to the proliferation of United States health insurance, and the tax-exempt hospitals saw payments from patients previously unable to pay.³⁶ With a little reimbursement from landmark legislation in the mid-1960s from Medicare and Medicaid, charitable hospitals partially survived as a result of increasing reimbursement from their patient population.³⁷

B. *Charitable Hospitals, the Internal Revenue Service, and § 501(c)(3)*

Charitable hospitals are considered tax-exempt under § 501(c)(3) of the Code, although the section of the United States Code (U.S.C.) does not specifically mention hospitals as tax-exempt.³⁸ The section reads:

- (3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition . . . , or for the prevention of cruelty to children or animals, *no part of the net earnings of which inures to the benefit of any private shareholder or individual*, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.³⁹

Legally, hospitals are recognized to qualify as “organized and operated exclusively for religious [or] charitable”⁴⁰ purposes as long as “no part of the net earnings of which inures to the benefit of any private shareholder or

34. Hall & Colombo, *supra* note 30, at 319. See also STARR, *supra* note 29, at 149-50.

35. STARR, *supra* note 29, at 310-11. See also Frank R. Dobbin, *The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920-1950*, 97 AM. J. OF SOC., 1416, 1418-19 (Mar. 1992) (discussing wage freezes during WWII and the impact on healthcare).

36. STARR, *supra* note 29, at 310-11.

37. *Id.* See also Hall & Colombo, *supra* note 30, at 320 (noting that exempt hospitals became worried of the existing charity care standard for tax-exemption, underscoring the importance and implications of the Medicare and Medicaid programs).

38. See Exemption from Tax Corporations, Certain Trusts, etc., 26 U.S.C. § 501(c)(3) (2012) (which does not specifically mention hospitals under 501(c)(3), although they are traditionally considered exempt under this provision of the Code).

39. 26 U.S.C. § 501(c)(3) (2012) (emphasis added).

40. 26 U.S.C. § 501(c)(3) (2012).

individual.”⁴¹ Generally, charitable hospitals must be organized for charitable purposes, as present in their articles of incorporation, and also operate in order to achieve that goal;⁴² two tests are often referred to as the organizational and operational tests of federal tax-exemption.⁴³ In order to qualify as a § 501(c)(3) organization, charitable hospitals have historically been subject to different historical standards, including the charity care standard (1956),⁴⁴ the community benefit standard (1969),⁴⁵ and most recently the amended § 501(r) of the Code as added by § 9007 of the ACA, which includes four *additional* requirements for nonprofit hospitals to follow in order to be recognized as tax-exempt.⁴⁶ For purposes of this Comment, the new § 501(r) standards will be recognized as “community benefit *redux*,” a title inspired by the Third Circuit’s term “community benefit plus,” as discussed in *IHC Health Plans, Inc. v. Commissioner*, in addition to John D. Colombo’s discussion of the term in *Failure of Community Benefit*.⁴⁷

C. IRS Revenue Ruling 56-185 and the Charity Care Standard

Released in 1956, IRS Rev. Rul. 56-185 established the charity care standard for charitable hospitals, and noted “[t]he only ground upon which a hospital may be held to be exempt . . . is that it is organized and operated primarily for educational, scientific, or public charitable purposes.”⁴⁸ The Supreme Court’s interpretation of “charitable” in *Helvering v. Susan D. Bliss et al.*,⁴⁹ prompted the IRS to take “the position that the term ‘charitable’ in its legal sense and as it is used in section § 501(c)(3) of the Code contemplates an implied public trust constituted for some public benefit, the

41. 26 U.S.C. § 501(c)(3) (2012). See also THOMAS K. HYATT & BRUCE R. HOPKINS, THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS 6 (John Wiley & Sons eds., 3d ed. 2008).

42. BARRY A. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 977 (Thomson West, 6th ed. 2008).

43. *Id.* See also *Redlands Surgical Services v. Comm’r of Internal Revenue*, 113 T.C. 47, 71 (1999); *Redlands Surgical Services v. Comm’r of Internal Revenue*, 242 F.3d 904, 904 (2001).

44. Rev. Rul. 56-185, 1956-1 C.B. 202 (1956).

45. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

46. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38148; ACA § 9007. It should be noted that the varying standards applied to determine tax-exempt status for charitable healthcare organizations, including charity care, community benefit, and the most recent “community benefit *redux*,” are considered in concert to determine whether an organization qualifies. The most recent requirements did not supplant the historical requirements for tax-exempt status.

47. Colombo, *supra* note 2, at 35, 37, 40, 42-44. Acknowledgement is required for Professor Colombo’s use of the term “community benefit plus” and “promotion of health plus” as it served as the template for “community benefit *redux*” as utilized in this Comment. *Id.*

48. Rev. Rul. 56-185, 1956-1 C.B. 202 (1956).

49. 293 U.S. 144, 150 (1934).

income . . . of which may not inure to the benefit of any private shareholder or individual.”⁵⁰ Thus, as long as the hospital provided care to the poor and those unable to pay to the extent of its financial ability, it was viewed as meeting the charity care standard.⁵¹

D. IRS Revenue Ruling 69-545 and the Community Benefit Standard

But the charity care standard to qualify experienced increasing scrutiny between 1956 and the latter part of the next decade.⁵² Medicare and Medicaid provided federal dollars for healthcare of the aged and poor, respectively, and forced the IRS to reconsider the charity care standard.⁵³ This was partially due to increasing anxiety from healthcare institutions concerned about meeting the standard in concert with the new Medicare and Medicaid programs.⁵⁴ In response, the IRS released Rev. Rul. 69-545 in 1969, which introduced the enigma of community benefit for qualification of tax-exempt healthcare organizations.⁵⁵ Although the IRS introduced the community benefit standard in 1969, IRS Rev. Rul. 56-185:

was not repealed when the community benefit standard was adopted. Rev. Rul. 69-545 did not revoke Rev. Rul. 56-185; it merely modified it. While a hospital is no longer required to operate to the extent of its financial ability for those not able to pay, doing so is a major factor indicating that a hospital is operated for the benefit of the community.⁵⁶

Thus, the community benefit standard did not supplant the original charity care standard, but was introduced as an additional option for tax-exempt hospitals to fulfill their requirements to qualify for tax-exempt status.⁵⁷

50. Rev. Rul. 56-185, 1956-1 C.B. 202 (1956).

51. *The Concept of Charity*, in INTERNAL REVENUE SERV., EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION (CPE) TECHNICAL INSTRUCTION PROGRAM FOR FISCAL YEAR 1980, 4 (1980), available at <http://www.irs.gov/pub/irs-tege/eotopicb80.pdf> (noting “Rev. Rul. 56-185 . . . reflected the traditional approach in that exemption was allowed only if the health care provider was ‘operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay’”).

52. Colombo, *supra* note 2, at 30-31 (noting that “[c]oncurrent with Congressional consideration of the Medicare and Medicaid legislation in the mid-1960s, however, exempt hospitals began pushing the IRS for reconsideration of exemption standards. The common complaint (almost hilarious, in retrospect, for its inaccuracy) was that between private medical insurance and the ‘new’ Medicare and Medicaid programs, there simply would not be enough of a demand for charity care to satisfy the IRS, and hence exemption standards should become more flexible in order to maintain exempt status for hospitals.”).

53. *Id.*

54. *Id.*

55. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

56. *Tax-Exempt Hospital Sector*, *supra* note 1, at 13.

57. *See id.*

Under community benefit, the IRS specified four additional activities that would benefit the community, including:

- (1) "excess funds [used for the] expansion and replacement of existing facilities and equipment,"⁵⁸
- (2) "amortization of indebtedness,"⁵⁹
- (3) "improvement in patient care,"⁶⁰ and
- (4) "medical training, education, and research."⁶¹

It was noted that the four requirements specified in IRS Rev. Rul. 69-545 did not replace the "charity care" standard that came before it,⁶² but it acted as a supplement or a companion standard that hospitals needed to meet in order to qualify for tax-exempt status.⁶³ Thus, the practical impact of the "community benefit" ruling was to provide an additional outlet for hospitals to meet the tax-exempt requirements who had originally expressed concern over failing to meet the requirements as a result of Medicare and Medicaid.⁶⁴

Unlike the previous standard, community benefit provided options that would indirectly benefit patient care. Typical elements considered to fulfill community benefit include the promotion of health, "a community board, an open medical staff, treatment of Medicare and Medicaid patients, and the operation of an emergency room that provided emergency treatment to charity patients."⁶⁵ However, a 1983 ruling by the IRS eliminated the operation of an emergency room as an element.⁶⁶ Under community benefit, net income for tax-exempt entities was allowed to be reinvested into plant, property, and equipment; debt expense; advancements for the care of patients; and also improvements in medical training, education and research.⁶⁷ These elements qualified for fulfilling community benefit obligations.⁶⁸

58. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

59. *Id.*

60. *Id.*

61. *Id.*

62. See *Tax-Exempt Hospital Sector*, *supra* note 1.

63. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

64. Colombo, *supra* note 2, at 30-31.

65. *Id.* at 31.

66. *Id.* at 31-32.

67. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

68. *Id.*

E. Criticisms of the Community Benefit Standard

The community benefit standard, however, is not without its critics.⁶⁹ John D. Colombo, a preeminent tax-exempt organization scholar, published a blistering critique of the standard in a 2005 Health Matrix article titled, "The Failure of the Community Benefit Standard."⁷⁰ Colombo traces the standard from its start in the late 1960s and argues that it was not only undermined by the IRS almost immediately, but also was "essentially abandoned" by the late 1980s⁷¹ and wiped out by rulings on whether integrated delivery systems (IDS)⁷² and health maintenance organizations (HMO)⁷³ qualified for tax-exempt status.⁷⁴ After twenty years, industry stakeholders highlighted the need for a way to measure how charitable hospitals provide a benefit to their communities and its impact on their community's health.⁷⁵ Today, contemporary criticisms circle around the idea that many "community benefit activities,"⁷⁶ such as community health fairs and outreach, can mask a financial benefit for tax-exempt organizations:⁷⁷ "[m]oreover, many services that nonprofit hospitals pointed to as 'community benefit' had commercial potential: outreach programs, for example, such as community education and health screening 'may serve marketing and other promotional purposes for hospitals, just as sponsorship of sporting events or the arts does for many for-profit corporations.'"⁷⁸ Further, in reference to studies that highlight any behavioral or outcome differences between the for-profit and not-for-profit hospitals, Colombo

69. See Colombo, *supra* note 2, at 30-31 (noting at the beginning of his article, "to paraphrase Marc Antony's famous speech in *Julius Caesar*, I come to bury the community benefit test, not to praise it").

70. See Colombo, *supra* note 2.

71. *Id.* at 40. "The community benefit test, therefore, failed to isolate any significant quantifiable behavioral differences between for-profit and nonprofit health care providers, and hence it probably was doomed as a doctrinal legal test of exemption literally from its inception." *Id.* at 42.

72. *Id.* at 33-34 (citing *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1219-20 (3d Cir. 1993)).

73. *Id.* at 36-37 (citing *IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188 (10th Cir. 2003)).

74. *Id.* at 40, 42.

75. *Id.* at 42 ("In fact, the problem of identifying specific, quantifiable 'community benefits' became so severe that supporters of the nonprofit exempt hospital industry published a number of articles in the early 1990s warning of the need to quantify these other community benefits to preserve exemption.").

76. *Id.*

77. *Id.*

78. *Id.* at 42 (citing Mark A. Schlesinger & Bradford Gary, *A Broader Vision for Managed Care, Part 1: Measure the Benefit to Communities*, 17 HEALTH AFF. 152, 155 (May-June 1998)).

notes that the academic literature and governmental inquiries have found little to no difference between the two.⁷⁹

Although an analysis of the community benefit standard's effectiveness in patient treatment or to induce behavioral differences between for-profits and not-for-profits is outside the academic scope of this Comment, perhaps the most sobering view of the standard's role in contemporary healthcare can be highlighted by a 2005 Government Accountability Office (GAO) report.⁸⁰ In that report, the GAO studied five cities to determine what difference, if any, existed between the charity care and community benefit of for-profit, nonprofit, and government hospitals.⁸¹ The report stated,

As for the other community benefit hospitals reported providing, we were not able to discern a clear distinction among the government, nonprofit, and for-profit hospital groups. Hospitals in the five states reported conducting a variety of activities, which the hospitals themselves considered community benefits. We were unable to assess the value of these benefits or make systematic comparisons between hospitals across states.⁸²

The report also noted that a significant portion of community benefit activities were concentrated in a few urban hospitals and were not uniformly spread across the tax-exempt charitable hospital sector.⁸³ The GAO Comptroller continued to note that the "current tax policy lacks specific criteria" to guide the hospitals in their charity care efforts, and called for clearly defined goals.⁸⁴

Many commentators have argued that a repeal of the standard is likely the most plausible solution to induce the charitable healthcare entities to return to a semblance of their modern roots.⁸⁵ However, not all commentators share the "scorched Earth" solution to resolving the problem, and some have even highlighted the positive aspects the standard has brought to the nonprofit sector, such as unprofitable services that the for-profit sector is unwilling to offer.⁸⁶ Thus, despite the community benefit

79. Colombo, *supra* note 2, at 44-45.

80. See *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits*, Hearing before the H. Comm. on Ways & Means, 109th Cong. (2005) [hereinafter *GAO Uncompensated Care Testimony*] (Statement of David M. Walker, Comptroller General of the United States).

81. *Id.* at 6.

82. *Id.* at 19.

83. *Id.* at 8.

84. *Id.* at 19.

85. See Colombo, *supra* note 2, at 52-53.

86. *Id.* at 56 (citing Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1407 (2003)) (noting that "Professor Horwitz asserts that non-profits are necessary because they bring a mix of health services that for-profits do not provide, and offer protection against 'a class-based two-tiered

standard's perceived widespread dysfunction, some academic commentators have noticed its positive impact within the industry.⁸⁷ However, the increasingly murky gap between hospitals' actions to fulfill the standard, and the public knowledge of how these actions actually benefit the surrounding community, eventually gave rise to Congressional interest in how to overhaul the Code and promote more tangible outcomes.⁸⁸ This largely culminated with § 9007 of the ACA and the addition of § 501(r) to the Code.⁸⁹

III. CHARITABLE HOSPITALS, THE ACA, AND THE COMMUNITY HEALTH NEEDS ASSESSMENT

A. *The ACA, § 501(r) of the Code, and the "Community Benefit Redux" Standard*

The recent additions to the Code can only be understood in the context of community benefits meandering and maligned history through Rev. Rul. 69-545 and its influence on the tax-exempt charitable hospital sector.⁹⁰ The charity care standard was a black or white affair; hospitals either provided reduced-cost or free care to qualified individuals or they did not.⁹¹ Whether hospitals qualified for tax-exempt status was easily determined by the IRS. However, as a result of judicial interpretation of "community benefit," it was subject to interpretation and potential abuse by hospital systems.⁹² A 2008

medical system' in which the poor are treated by government-owned hospitals while the well-insured have access to private hospitals").

87. *Id.*

88. See *Tax-Exempt Hospital Sector*, *supra* note 1, at 2-3; *Taking the Pulse of Charitable Care*, *supra* note 8, at 2; S. COMM. ON FIN. - MINORITY, 110TH CONG., *TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT 7* (2007), <http://www.grassley.senate.gov/releases/2007/07182007.pdf>. See also Memorandum from Sen. Chuck Grassley, Ranking Member, U.S. S. Comm on Fin., to Reporters and Editors (July 18, 2007), available at <http://www.finance.senate.gov/newsroom/ranking/release/?id=4e7e7efc-806d-4a02-a4bf-d41f9a5dd55f>.

89. See John Carreyrou & Barbara Martinez, *Grassley Targets Nonprofit Hospitals on Charity Care*, WALL ST. J., Dec. 18, 2008, at A5. No discussion of § 9007 of the ACA is complete without mention of Senator Charles Grassley (R-IA) for his integral role in the additional requirements for charitable hospitals. See *Grassley Provisions Make Tax-Exempt Hospitals Accountable for Status under New Healthcare Legislation*, BECKER'S HOSP. REV., (Mar. 25, 2010), <http://www.beckershospitalreview.com/news-analysis/grassley-provisions-make-tax-exempt-hospitals-accountable-for-status-under-new-healthcare-legislation.html>. See also Memorandum from Sen. Chuck Grassley, Ranking Member, U.S. S. Comm on Fin., to Reporters and Editors (Mar. 24, 2010), available at http://www.grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=25912. See also Thai, *supra* note 3, at 772.

90. See *supra* Part II.B-E.

91. Rev. Rul. 56-185, 1956-1 C.B. 202 (1956).

92. See Colombo, *supra* note 2, at 42-43 (discussing problems with quantifying community benefit standards).

report by the GAO highlighted a Congressional Budget Office finding that “[n]onprofit hospitals may not be defining community benefit in a consistent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status.”⁹³ This 2008 report was in response from a request by Senator Charles Grassley (R-IA) and the Senate Finance Committee to prepare a report about U.S. tax-exempt hospitals.⁹⁴

B. CHNA Requirements, IRS Notice 2011-52 & Proposed Regulations

The CHNA is an additional requirement for tax-exempt hospitals and was added by § 9007 of the ACA.⁹⁵ Section 9007 of the ACA amended the Code of 1986 by striking the existing subsection (s) and designating a new subsection (r), which requires four additional requirements for hospitals to qualify for tax-exempt status.⁹⁶ In addition to the CHNA, the § 501(r) requirements include (1) the FAP and EMC policies, (2) a limitation on charges to patients who qualify for the FAP, and finally (3) restrictions on billing and collections, barring the hospital from engaging in extraordinary collections actions (ECAs) against FAP qualified individuals.⁹⁷

Here, this section will focus on the practical implications of the CHNA and how it will impact hospitals as originally proposed. Section 9007 of the ACA notes that the CHNA has three core requirements:

93. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 3 (2008). See also GAO *Uncompensated Care Testimony*, *supra* note 80, at 16 (2005) (highlighting a general overview of the community benefit activities reported by hospitals including (a) community health education such as parenting education, smoking cessation, fitness and nutrition, health fairs, and diabetes management; (b) health screening services such as screening for high cholesterol, cancer, and diabetes; (c) clinic services, including clinics targeted to specific groups in the community, such as indigent patients; (d) medical education for physicians, nurses, and other health professionals; (e) financial contributions, including cash donations and grants, to community organizations; (f) coordination of community events and in-kind donations – such as food, clothing, and meeting room space – to community organizations; and (g) hospital facility and other infrastructure improvements).

94. Memorandum from U.S. S. Comm. on Fin. to Reporters and Editors (Oct. 14, 2008), available at <http://www.finance.senate.gov/newsroom/ranking/release/?id=009896fa-cf35-4d04-93e9-d1cc0fe03994>.

95. ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

96. *Id.*

97. *Id.*; Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38148.

- (1) it “takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health,”⁹⁸
- (2) the hospital “has adopted an implementation strategy to meet the community health needs identified through such assessment,”⁹⁹ and
- (3) that the CHNA “is made widely available to the public.”¹⁰⁰

A hospital failing to meet the CHNA requirements for any taxable year is subject to a \$50,000 excise tax.¹⁰¹ The IRS discussed provisions of new § 501(r) of the Code in the June 2012 Federal Register,¹⁰² but only briefly touched on the CHNA requirements because of in-depth treatment in its Notice 2011-52 (Notice), which requested public comments of how the agency would enforce and implement the CHNA requirements.¹⁰³ The agency released proposed regulations for the CHNA in early 2013 that provided further clarification for tax-exempt organizations.¹⁰⁴

Second, the Notice stated that “only organizations operating State-licensed hospital facilities will be considered ‘hospital organizations’ that must satisfy the CHNA requirements.”¹⁰⁵ The Notice also highlighted § 501(r)(2)(B), which noted “(i) the organization shall meet the requirements of § 501(r) separately *with respect to each hospital facility*, and (ii) the organization shall not be treated as described in section 501(c)(3) with respect to any hospital facility for which the requirements of § 501(r) are not separately met.”¹⁰⁶ The IRS highlighted that they “intend to require a hospital organization operating multiple hospital facilities to document separately the CHNA and the implementation strategy for each of its hospital facilities.”¹⁰⁷ It is still unclear what impact failing to meet the CHNA requirements for one facility will have on the organization as a whole.¹⁰⁸ Commentators were divided on the level of specificity desired from the IRS,

98. I.R.S. Notice 2011-52, 2011-30 I.R.B. 60, 62-63.

99. *Id.* at 66.

100. *Id.* at 62.

101. *Id.* at 65.

102. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38149.

103. I.R.S. Notice 2011-52, 2011-30 I.R.B. 60.

104. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20523 (Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1 and 53).

105. I.R.S. Notice 2011-52, 2011-30 I.R.B. 61. This Comment will not discuss the tax-implications or potential impact of complex business associations. These include organizations that “operate[] a State-licensed hospital facility through a disregarded entity or a joint venture, limited liability company, or other entity treated as a partnership for federal income tax purposes.” *Id.*

106. *Id.* (emphasis added).

107. *Id.* at 61-62.

108. *Id.* at 62.

splitting between defined guidelines for facilities to follow and loose regulations for facilities to design a CHNA that reflects their community.¹⁰⁹ In the end, the IRS identified five requirements:

- (1) “[a] description of the community served by the hospital facility,”¹¹⁰
- (2) “[a] description of the process and methods used to conduct the assessment,”¹¹¹
- (3) “[a] description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility,”¹¹²
- (4) “[a] prioritized description of all of the community health needs identified through the CHNA, [and] a description of the process and criteria used in prioritizing such health needs,” and¹¹³
- (5) “[a] description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.”¹¹⁴

It further noted that the CHNA will be considered “conducted” when the report is published and made widely available to the public.¹¹⁵ Hospitals are allowed to define their own “community” that is targeted in their CHNA by taking into account “all of the relevant facts,” which include the target population of the hospital (i.e., cancer specialty or children’s hospital) or common geographic areas like cities, counties, or districts.¹¹⁶ Self-serving definitions are prohibited.¹¹⁷

The IRS considered public feedback from Notice 2011-52 in the April 2013 proposed regulations and implemented a significant suggestion from

109. *Id.*

110. I.R.S. Notice 2011-52, 2011-30 I.R.B. 62.

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. I.R.S. Notice 2011-52, 2011-30 I.R.B. 62.

116. *Id.* at 63.

117. See *id.* (noting “a community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs”). See also *id.* at 64 (noting that one of the requirements to comply with the CHNA is to make it widely available to the public; the agency noted similar requirements for hospital’s Forms 990 under Treas. Reg. § 301.6104(d)-2(b) where hospitals either need to make the CHNA easily accessible on its website, or provide a link from its website to a companion website).

the commenters.¹¹⁸ Noticeably absent from the IRS's initial CHNA notice was an evaluation of the impact or "outcomes" from programs designed to address significant health needs identified through the CHNA process.¹¹⁹ The proposed rule notes "the implementation strategy must describe the actions the hospital facility intends to take to address the health need, the anticipated impact of these actions, and a plan to evaluate such impact."¹²⁰ It is arguable that the evaluation component included in the proposed regulations pushes health systems to identify programs that will have a quantifiable outcome compared to the guidance issued in the initial CHNA notice; in other words, the April 2013 proposed regulations will establish increased accountability for health systems to identify an internal metric for evaluation that will allow the IRS to identify whether or not the programs designed to address significant health needs are successful.

At this point in the CHNA process, it is likely that a hospital organization will be able to partner with community public health stakeholders to identify vulnerable populations that reside in its self-defined community.¹²¹ From here, the individual hospitals must address the findings of their CHNA research with an "implementation strategy"¹²² that takes into account the needs identified in the early parts of a CHNA and how the facility plans to address those needs using the resources in its facility and its community.¹²³

118. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20523, 20524, 20534 (Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1 and 53).

119. See I.R.S. Notice 2011-52, 2011-30 I.R.B. 60.

120. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. at 20542.

121. See I.R.S. Notice 2011-52, 2011-30 I.R.B. 63 (noting that the health care facilities can obtain the requisite knowledge for adequate CHNAs from the following qualified individuals: "(1) [p]ersons with special knowledge of or expertise in public health; (2) Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and (3) [l]eaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility").

122. *Id.* at 64.

123. *Id.* ("For these purposes, Treasury and the IRS intend to provide that an implementation strategy will address a health need identified through a CHNA for a particular hospital facility if the written plan either – (1) describes how the hospital facility plans to meet the health needs; or (2) identifies the health need as one the hospital facility does not intend to meet and explains why the hospital facility does not intend to meet the health need. In describing how a hospital facility plans to meet a health need identified through a CHNA for purposes of paragraph (1), the implementation strategy must tailor the description to the particular hospital facility, taking into account its specific programs, resources, and priorities. For example, an implementation strategy could describe a hospital facility's plan to meet a health need by identifying the programs and resources that the hospital facility plans to

The “strategy” is considered formally adopted on the date it is approved by the individual hospital facility’s governing board or delegated committee.¹²⁴ A hospital is liable for a \$50,000 excise tax for each of its hospital facilities it operates if it fails to satisfy any of the CHNA requirements for any of the three taxable years in the “CHNA window.”¹²⁵ If an organization continually fails to meet the specified requirements after being subject to the \$50,000 excise tax, the organization will have to pay the excise tax penalty in each year after it initially does not meet the CHNA requirements.¹²⁶ For example, if hospital A’s “CHNA window” is in taxable years 2016-2018, and it has not met the CHNA requirements by the last taxable day in 2018, it will be subject to a \$50,000 excise tax for that year.¹²⁷ If the hospital fails to meet the requirements in 2019 and 2020, it will also be subject to an excise tax of \$50,000 in 2019 and 2020.¹²⁸ Moreover, if the hospital is responsible for “n” facilities which do not meet the CHNA specifications, its excise tax would be calculated as \$50,000 times n.¹²⁹

The ACA amended § 6033 of the Code and “requires a hospital organization to report . . . a description of how the organization is addressing the needs identified in each CHNA and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.”¹³⁰ The IRS has also included additional questions to Form 990 Schedule H.¹³¹

commit to meeting the health need and the anticipated impact of those programs and resources on the health need.”).

124. *Id.* at 65.

125. *Id.*

126. I.R.S. Notice 2011-52, 2011-30 I.R.B. 65.

127. *See id.*

128. *See id.*

129. *See id.*

130. *Id.* *See also* ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

131. I.R.S. Notice 2011-52, 2011-30 I.R.B. 65. Schedule H was adopted by the IRS in 2008 to standardize reporting requirements for tax-exempt hospitals. INTERNAL REVENUE SERV., BACKGROUND PAPER, FORMS 990, MOVING FROM THE OLD TO THE NEW 31 (2008), available at http://www.irs.gov/pub/irs-tege/moving_from_old_to_new.pdf. The CHNA “implementation strategy” must be attached to the Form 990 in each of the three years of the “CHNA window.” I.R.S. Notice 2011-52, 2011-30 I.R.B. 65-66 (“If a hospital organization only conducts one CHNA and adopts one implementation strategy for a hospital facility in a given three-year period, Treasury and the IRS intend to allow it to attach the same implementation strategy for that hospital facility to the Form 990 for each of those three years.”).

IV. ANALYZING §501(R) AND THE CHNA UNDER PROFESSOR JESSICA BERG'S
FRAMEWORK AS ILLUSTRATED IN *PUTTING THE COMMUNITY BACK INTO THE*
"COMMUNITY BENEFIT STANDARD," A FRAMEWORK FOR ANALYSIS

Professor Jessica Berg, in *Putting the Community Back into the "Community Benefit Standard,"* argues that the historic community benefit standard implemented in Rev. Rul. 69-545 could be improved by implementing changes focused on public health initiatives.¹³² Her thesis is largely driven by public health concerns with a community focus,¹³³ providing that community benefit interventions should benefit a community population and not the individual.¹³⁴ In her article, she notes that it has traditionally been the role of the federal government to take care of a population, and not necessarily the individual.¹³⁵ As a result of this traditional role, any federal mandates for community benefit should focus on communal outcomes in the service areas of the health systems and not focus on traditional charity care requirements, which are solely focused on healthcare provided at the individual level.¹³⁶ Similar to the CHNA adopted in ACA § 9007 and implemented in § 501(r), Professor Berg's pre-ACA suggestions may be seen as a corollary to the changes adopted in § 501(r)(3).¹³⁷ The suggestions provide a framework to analyze whether the ACA achieved her goals of meaningful reform within the community benefit arena, with a particular focus on policy and intermediate sanctions at the federal level,¹³⁸ a "community benefit board,"¹³⁹ and a tool to assess public health outcomes related to community benefit activities.¹⁴⁰ In her suggestions for reform, Berg also recommends adopting a novel approach to tracking community benefit initiatives through accounting practices adopted in other business disciplines.¹⁴¹ This ultimate provision will not be discussed.

132. Berg, *supra* note 4, at 395-402.

133. *Id.* at 377-79.

134. *Id.* at 393-94.

135. *Id.* at 396.

136. *Id.* at 401-02. See also Colombo, *supra* note 2, at 32-35 (discussing how the tax courts and the federal courts started to undermine Revenue Ruling 69-545 by removing the ruling's focus on "community" efforts to a focus on "charity care" in the late 1980s and early 1990s).

137. See ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.). See also Berg, *supra* note 4, at 403.

138. Berg, *supra* note 4, at 405.

139. *Id.* at 407.

140. *Id.* at 412.

141. *Id.* at 419.

A. Federal Level Changes - Policy Drivers

For federal policy changes, Berg suggests that the most significant requirement for any reform is a determination of the hospital community's "need" of those services offered by the hospital to fulfill its community benefit requirements.¹⁴² In her article, writing pre-ACA and the new reform to community benefit under §501(r), Professor Berg argued that "[r]ather than creating a comprehensive and exclusive list of exactly what the community benefit requirement entails, the IRS should provide guidance on the range of activities that would fall into this category."¹⁴³ She further argued that the agency could partially accomplish this goal through rearranging Form 990 and moving the "community health services" section above charity care, decreasing the historical, judicial, and agency emphasis on the latter.¹⁴⁴ Her ultimate goal in her article is to facilitate a discernible message from the IRS to tax-exempt hospitals that a transition from policies focusing on the individual (i.e., charity care) to the community is the ultimate goal of any meaningful reform at the federal level for community benefit. To a large extent, the CHNA achieves this goal.

Analyzing § 501(r)'s new requirements for charitable hospitals under Berg's framework, "community benefit *redux*" fulfills the need for additional "guidance" from the IRS to communicate the message that community benefit should be more focused on community outcomes as opposed to individual initiatives. Although the FAP, limitation on charges, and prohibition against ECAs are aimed at controlling community benefit actions by hospitals that are aimed at curbing undesirable practices at the individual patient level,¹⁴⁵ going against Berg's suggestions for meaningful change, § 501(r)(3)'s CHNA is a drastic shift toward a focus on the health system's community impact. Her suggestion was to rearrange Form 990's hierarchy of community benefit activities to place "community health improvement services" evaluation above the hospital's charity care activities,¹⁴⁶ communicating the message that a community focus is much more important than an individual focus. The ACA's changes fulfill this suggestion for meaningful reform and then some.

Both IRS Notice 2011-52 and the April 2013 proposed regulations provide prescriptive guidance for all health systems in conducting and documenting its CHNA process,¹⁴⁷ but it is the latter's incorporation of

142. *Id.* at 404.

143. Berg, *supra* note 4, at 403.

144. *Id.*

145. *Id.* at 405.

146. *Id.* at 403.

147. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. at 20524.

public feedback from the former that encompasses its fulfillment of Berg's pre-ACA reform suggestions. The IRS's CHNA guidance encapsulates a true focus on *community* benefit by requiring feedback from community members, the local public health department, in addition to underserved and minority populations.¹⁴⁸ Incorporation of this feedback into the CHNA process fulfills her suggestion that "the services are needed and would actually benefit the community in which the hospital is located."¹⁴⁹ Participation by community stakeholders help ensure that the services are those needed by the immediate community, and the April 2013 proposed regulation's new requirements that the impact of those programs be identified and evaluated will likely help determine whether these programs are "actually benefiting the community."¹⁵⁰

Therefore, if Revenue Ruling 69-545's original goal was to provide an additional outlet for hospitals concerned about the reduction in charity care as a result of Medicare and Medicaid with a focus on *community* standards, and, as Colombo argues, that this *community* focus was almost immediately undermined by a return to charity care as a substantial element, Berg's pre-ACA suggestion for meaningful reform to persuade the IRS to require an actual focus on community efforts to improve health¹⁵¹ makes the ACA's community benefit *redux* an overwhelming success. Community involvement is required by both the proposed regulations and 2011-52,¹⁵² although the actual impact on the community was not included until the April 2013 proposed regulations.¹⁵³ This addition helps round out Berg's suggestions for policy changes at the federal level for meaningful community benefit reform.

B. Federal Level Changes - Intermediate Sanctions

Next, Professor Berg posited that any framework for change under pre-ACA community benefit requirements needed to implement some sort of "intermediate sanction" as a stick to change behavior, instead of revocation of tax-exempt status' nuclear solution.¹⁵⁴ She noted:

[i]t may be useful to consider imposing intermediate sanctions for violations of the other IRS requirements, including the community benefit standard; but

148. *Id.* at 20541.

149. Berg, *supra* note 4, at 404.

150. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. at 20534.

151. Colombo, *supra* note 2, at 31-32. See Berg, *supra* note 4, at 403-05.

152. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. at 20524.

153. *Id.* at 20534.

154. Berg, *supra* note 4, at 405.

specific penalties, such as the excise taxes for excess benefit transactions, could only be applicable if there were a set level of community benefit required against which a hospital's efforts could be measured.¹⁵⁵

Furthermore, she proposed that intermediate sanctions should not be immediately imposed, and should trigger IRS oversight in order to "ensure hospital compliance,"¹⁵⁶ a practice largely followed as acknowledged by IRS Commissioner Everson in the mid-2000s in front of the House Ways and Means Committee.¹⁵⁷

The "intermediate sanctions" argument is a familiar weapon in the arsenal of community benefit opponents,¹⁵⁸ and § 501(r) largely provides them with an answer to Professor Berg's proposal for pre-ACA reform.¹⁵⁹ The ACA notes in § 4959, "[i]f a hospital organization which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to \$50,000."¹⁶⁰ Community benefit proponents have the \$50,000 intermediate sanction in their arsenal, yet, the ACA limits it to noncompliance with the CHNA and leaves §§ 501(r)(4)-(6) untouched by any intermediate sanctions.¹⁶¹ Although the CHNA is arguably the most time-consuming and important component of the new requirements, hospital facilities will not be penalized with a \$50,000 excise tax if they fail to adopt FAP/EMC policies, fail to

155. *Id.* at 406.

156. *Id.*

157. *Tax-Exempt Hospital Sector*, *supra* note 1, at 14-15 (statement of Hon. Mark Everson, Comm'r, IRS). The Commissioner also notes that out of the 375 audits of health care organizations, 79 of them occurred as part of the agency's "Team Examination Program" which is a team of tax professionals dedicated to auditing "large, complex organizations" that are "exceptionally resource intensive." *Id.* (emphasis added). "In more than one quarter of our TEP health care cases we found tax exemption issues. In these cases, we can revoke the tax status of the organization. We have done so in only a few instances because traditionally we attempt to get a tax-exempt organization back on the right track." *Id.* (emphasis added). "(We have generally reserved revocation for cases in which we believe the organization is incapable of furthering exempt purposes in the future.) We attempt to resolve exemption issues with the taxpayer short of revocation, often through the use of a closing agreement. Almost half of the health care TEP cases ended in this fashion." *Id.* As of 2012, as a partial response to § 9007 of the ACA, the IRS has instituted reviews of 1,700 healthcare organizations to ensure compliance with the additional requirements for charitable hospitals detailed in IRC § 1.501(r). See DEP'T OF TREASURY, 2012-13-070, AFFORDABLE CARE ACT: WHILE MUCH HAS BEEN ACCOMPLISHED, THE EXTENT OF ADDITIONAL CONTROLS NEEDED TO IMPLEMENT TAX-EXEMPT HOSPITALS PROVISIONS IS UNCERTAIN (2012), available at <http://www.treasury.gov/tigta/audit-reports/2012reports/201213070fr.pdf>.

158. See Berg, *supra* note 4, at 405-07.

159. See ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

160. *Id.* (emphasis added).

161. *Id.*

impose limitations on charges, and fail to follow acceptable billings and collections practices.¹⁶² Thus, much like Berg's suggestion that any reform must avoid definitive list of actions required for community benefit compliance,¹⁶³ § 501(r) is also deficient for "intermediate sanctions" because it is limited to enforcement for noncompliance *only* with the CHNA.¹⁶⁴

Not only is §501(r) deficient under Professor Berg's framework in reference to "intermediate sanctions" and the \$50,000 excise tax limited to the CHNA, but the \$50,000 has a disproportionate impact in widely disparate hospital systems. For example, Mercy's corporate headquarters are located in St. Louis, Missouri and the health system has healthcare facilities in Arkansas, Kansas, Missouri, and Oklahoma.¹⁶⁵ Overall, the system has 38 facilities in which it will likely need to conduct a CHNA.¹⁶⁶ Mercy is the overarching parent corporation for these 38 facilities, and reported \$358.7 million in net income on \$4.1 billion of revenue for 2012.¹⁶⁷ All of Mercy's 38 hospitals are potentially subject to the \$50,000 excise tax, for a hypothetical one-year penalty of \$1.6 million, or 0.45% of net income for not complying with the CHNA requirements.¹⁶⁸ In contrast, Spencer Hospital — a community hospital in Spencer, Iowa reported \$6.9 million in net income on just over \$67.7 million in operating revenue.¹⁶⁹ Spencer Hospital's potential adverse impact of a \$50,000 excise tax is 0.73% of net income.¹⁷⁰ Although these figures of 0.45% and 0.73% for Mercy and Spencer Hospital, respectively, are relatively small, they also underscore the fact the excise tax may have a disproportionate impact on smaller community hospitals.¹⁷¹

162. See *id.* (noting that a facility is not subject to an excise tax for noncompliance with §§ 501(r)(4)-(6)).

163. Berg, *supra* note 4, at 403.

164. See ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

165. About Mercy, MERCY, <http://www.mercy.net/about> (last visited Nov. 25, 2013).

166. *Id.*

167. See MERCY, MOMENTUM: ANNUAL REPORT 2012 (2012), available at <http://www.mercy.net/sites/default/files/wb/2012mercyannual/>.

168. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38151 (discussing the \$50,000 excise tax).

169. *Spencer Hospital Audit Shows Solid Financial Performance*, SPENCER DAILY REPORTER (Nov. 13, 2012), <http://www.spencerdailyreporter.com/story/1913962.html>.

170. *Id.* Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38151 (discussing the \$50,000 excise tax).

171. See John Colombo, *The Role of Access in Charitable Tax Exemption*, 82 J. WASH. U. L.Q. 343, 344-45 (2004) (citing Edward C. Norton & Douglas O. Staiger, *How Hospital Ownership Affects Access to Care for the Uninsured*, 25 RAND J. ECON. 171, 172 (1994)) (discussing the potential importance of rural community hospitals to the surrounding area).

Moreover, the two hospital examples used in the hypothetical are financially solvent healthcare organizations¹⁷² and most likely able to conduct a CHNA pursuant to the IRS Notice 2011-52 and the proposed regulations.¹⁷³ Yet, community hospitals often struggle financially and are thus likely unable to afford to conduct a CHNA, and as a result may be out of compliance.¹⁷⁴ To truly illustrate the potential disproportionate impact on community hospitals, consider two hospitals within a 40 mile radius of Spencer Hospital in Northwest Iowa — Osceola Community Hospital and Lakes Regional Hospital, located in Sibley and Spirit Lake, Iowa, respectively.¹⁷⁵ For 2011, Osceola had exactly \$51,256 net income on \$13,789,501 gross revenues.¹⁷⁶ But Osceola's \$51,000 in net income illustrates the point that the \$50,000 "intermediate sanction" introduced by Berg and implemented in §501(r) is miniscule for some, and overly burdensome for others.¹⁷⁷ Furthermore, if one considers Lakes Regional Hospital's negative \$535,596 net income on \$44,282,136 in gross revenue, §501(r)'s CHNA penalty is truly undermined as a legitimate option to encourage enforcement across the spectrum of hospitals from Mercy to rural community hospitals. This disproportionate impact is only exacerbated by the fact that these community hospitals are some of the few healthcare services in the area for emergencies, and thus integral components of their community,¹⁷⁸ perhaps even more so than the hospitals that can afford a \$50,000 hit.¹⁷⁹ Again, Professor Berg's framework for pre-ACA changes to the community benefit standard do not introduce a viable tool to promote compliance¹⁸⁰ because a small stick in one instance is proportionally large

172. See SPENCER DAILY REPORTER, *supra* note 169. See MERCY, *supra* note 167.

173. See I.R.S. Notice 2011-52, 2011-30 I.R.B. 60.

174. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38151 (discussing the \$50,000 excise tax).

175. *Identification and Characteristics: Lakes Regional Hospital*, AMERICAN HOSPITAL DIRECTORY, http://www.ahd.com/free_profile/160124/Lakes_Regional_Hospital/Spirit_Lake/Iowa/ (last updated Oct. 8, 2013) [hereinafter *Lakes Regional Hospital*]; *Identification and Characteristics: Osceola Community Hospital*, AMERICAN HOSPITAL DIRECTORY, http://www.ahd.com/free_profile.php?hcf_id=ceee5868fcd38a80916f5f159d1dfe03&ek=96aadca2fe9ad4278271b52377db3f18 (last updated Sept. 11, 2013) [hereinafter *Osceola Community Hospital*].

176. *Osceola Community Hospital*, *supra* note 175.

177. Berg, *supra* note 4, at 402. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38151 (discussing the \$50,000 excise tax). See also *Osceola Community Hospital*, *supra* note 175 (noting Osceola Community Hospital's 2011 net income of a little over \$50,000).

178. Colombo, *supra* note 171, at 344.

179. See *id.*

180. Berg, *supra* note 4, at 406.

on the other end of the tax-exempt spectrum,¹⁸¹ and §501(r) fails under her framework for meaningful reform.

Thus, although we do have the intermediate sanctions under § 501(r) as envisioned by Professor Berg,¹⁸² they are largely ineffective at evenly distributing penalties across the sector and are severely limited by their inability to account for differences in the \$50,000 penalty's proportional impact on the diverse revenues of the charitable hospitals. This penalty could ultimately undermine the community outreach/health goals posited by Professor Berg and embodied in the CHNA on small, community hospitals. The IRS cannot overcome these limitations, as the \$50,000 penalty is written into the law.¹⁸³ Furthermore, the "intermediate sanctions" argument for meaningful reform is undermined by the fact that at least some commentators have noted "for many hospitals, it will be far more cost-effective to shell out \$50,000 than to comply with Section 501(r),"¹⁸⁴ but this argument is largely undermined by the fact tax-exempt charitable hospitals are often unwilling to compromise the status of their federal tax-exemption.¹⁸⁵

C. *Creating a Community Benefit Board*

Professor Berg's third component of meaningful reform under her pre-ACA suggestions focuses on the need of a Community Benefit Board (CBB) to oversee compliance with her suggested standards.¹⁸⁶ The CBB's goal in her suggested framework is to "ensure that the services offered are, in fact, beneficial to the specific community in which the hospital operates."¹⁸⁷ Among other suggestions, the board would be responsible to align the hospital's community benefit requirements under § 501(c)(3), very similar to the ACA's CHNA.¹⁸⁸ Interestingly, writing pre-ACA, Professor Berg highlights that "some federal congressional health reform proposals have included

181. See *infra* Part V.B. (discussing the potential adverse impact on community hospitals of a \$50,000 excise tax).

182. Berg, *supra* note 4, at 406.

183. ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

184. Katie Stewart & Darren Azman, *Section 501(r) and Nonprofit Hospital Joint Ventures*, TAX'N OF EXEMPTS, September/October 2010, at 9, 18.

185. See Douglas Mancino, *Section 501(r) Requirements for Section 501(c)(3) Hospitals*, TAX'N OF EXEMPTS, January/February 2013, at 3, 3-4 (the author submitted a copy of the article with his comments submitted in response to the IRS proposed regulations for § 501(r) implementation).

186. Berg, *supra* note 4, at 407, 409.

187. *Id.* at 407.

188. *Id.* at 407-12; ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

community-needs-assessment requirements for tax-exempt hospitals.”¹⁸⁹ Overall, the suggestions of a CBB in potential pre-ACA meaningful reform framework embody the community health focus of the CHNA, and the § 501(r)(3)’s relatively straightforward requirements¹⁹⁰ are an improvement over Berg’s overly complicated suggestions.¹⁹¹ Here, there are few criticisms of the CHNA, in that it identifies a relationship with the tax-exempt hospital’s community in order to address the community health needs to fulfill the community benefit standard.¹⁹² The CHNA, as proposed, fulfills Berg’s suggestions and is the first victory for § 501(r) under Professor Berg’s meaningful reform framework to address public health needs.¹⁹³

D. Evaluating and Quantifying the Benefit

In the final section of Professor Berg’s framework for meaningful reform to address the complications of the pre-ACA community benefit standard, she asks how population benefits should be measured under her CBB, which parallels § 501(r)’s CHNA.¹⁹⁴ She proposes measuring a hospital’s “monetary outlay” as it relates to charity care under the standard, but acknowledges this approach is limited.¹⁹⁵ To overcome this limitation, she suggests “institutions should be encouraged to measure the actual effects or outcome of their efforts,”¹⁹⁶ which is superior to fiscal measurement because “it should discourage creative accounting similar to what currently occurs regarding individual charity care, and also because the goal of the community benefit standard is to benefit the community, not merely to promote hospital spending on interventions of uncertain value.”¹⁹⁷

To the extent which Professor Berg’s argument emphasizes the reporting of outcomes to measure community benefit compliance, § 501(r)’s CHNA fulfills these variables as defined under her suggested framework. Specifically, the changes to Form 990, Schedule H will permit a quantifiable reporting mechanism to aid the Secretary of the Department of Health and Human Services report to both Houses of Congress after five years on

189. Berg, *supra* note 4, at 408-09 (citing Diane Freda, *Exempt Hospital Proposals for Health Reform Launch New Debate on Change in Standards*, 18 HEALTH L. REP. (BNA) 651, 652 (2009)) (emphasis added).

190. See I.R.S. Notice 2011-52, 2011-30 I.R.B. 60.

191. Berg, *supra* note 4, at 409.

192. *Id.*

193. See *id.* at 407-12, 431.

194. *Id.* at 412-13.

195. *Id.* at 412.

196. Berg, *supra* note 4, at 412-13. See also Rubin et al., *supra* note 24, at 614.

197. Berg, *supra* note 4, at 413 (citing R. Scott MacStravic, *Demonstrating Value: Healthcare Organizations Can Document Positive Outcomes from Their Community-Benefit Services*, 80 HEALTH PROGRESS 54, 57 (Jan.-Feb. 1999)).

community benefit trends.¹⁹⁸ In short, the CHNA's relationship to Schedule H will finally provide the coveted quantifiable information so desired by proponents and opponents of the community benefit standard. Thus, § 501(r) certainly fulfills the requirement of comparing apples to apples.

Yet, despite the coveted status bestowed upon *quantifiable activities* in the community benefit realm¹⁹⁹ and in Professor Berg's framework, in practice, Schedule H's quantifiable data for CHNAs may ultimately be ill-suited for analysis.²⁰⁰ Granted, *anything* is better than the current comparison data, which is zilch, zippo, and nada, but Professor Berg almost immediately undermines her own argument shortly after introducing the idea of quantifiable activities for meaningful reform.²⁰¹ She notes that "[i]t may be even *more difficult* to quantify population health benefits than it currently is to quantify individual health benefits,"²⁰² and further notes that "population health benefits may take longer to become evident and thus may be hard to measure for yearly tax reporting."²⁰³ Professor Berg acknowledges the difficulty inherently associated with measuring public health benefits, noting that successful public health initiatives, which the CHNA is designed to be,²⁰⁴ are measured by their "lack of illness and, thus, a lack of apparent benefit."²⁰⁵ And even if certain public health outcomes are traceable, some commentators suggest it will prove difficult attributing responsibility in urban areas.²⁰⁶

Thus, notwithstanding § 501(r)'s CHNA providing quantifiable, ergo comparable data, Professor Berg illustrates the inherent limitations in applying measurements to public health initiatives,²⁰⁷ which the *community health needs assessment* is under the ACA.²⁰⁸ Tax-exempt hospitals

198. See ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.).

199. See Colombo, *supra* note 2, at 41-42.

200. See I.R.S. Notice 2011-52, 2011-30 I.R.B. 65 (stating the IRS has added new questions to Schedule H, Hospitals, of the Form 990 to reflect the new reporting requirements for hospital organizations under section 6033(b)(15)(A)).

201. Berg, *supra* note 4, at 420.

202. *Id.* (emphasis added).

203. *Id.*

204. See I.R.S. Notice 2011-52, 2011-30 I.R.B. 60 (stating that hospital organizations will be allowed to base a CHNA on information collected by a public health agency).

205. Berg, *supra* note 4, at 414 (citing ANN ASCHENGRAU & GEORGE R. SEAGE III, *ESSENTIALS OF EPIDEMIOLOGY IN PUBLIC HEALTH* 3 (2003)).

206. Rubin et al., *supra* note 21, at 614.

207. Berg, *supra* note 4, at 420.

208. ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.). See I.R.S. Notice 2011-52, 2011-30 I.R.B. 60 (focusing on the relationship of the hospital to its surrounding community in order to effectively perform the CHNA).

conducting CHNAs may collect baseline data in order to track health outcomes as a result of their § 501(r) compliance programs, but even in this best-case-baseline-data scenario, the IRS and HHS will not be comparing apples to apples through Schedule H comparisons, but will be comparing apples, kiwis, oranges, and bananas. All are fruits, yet they are all different. For example, a diabetes education and outreach program in rural Nebraska is drastically different from a smoking cessation program in urban St. Louis. Both are designed to improve health outcomes, but which program did more for its community, and how do you determine what constitutes “more worth” or “better outcomes?”²⁰⁹

Furthermore, under Form 990, CHNA reporting has no reportable outcome measures in Part V, Section B for Schedule H for hospitals.²¹⁰ Arguably, the closest “outcomes” reporting is line six where the hospital facility must identify how it addressed the needs identified under the CHNA.²¹¹ The following nine lines have action-oriented verbiage like “adoption,” “execution,” “participation,” “inclusion,” and “prioritization,”²¹² but little for the IRS to report outcomes measures as proposed in Professor Berg’s framework,²¹³ and arguably virtually no meaningful data for the IRS/HHS report to Congress²¹⁴ that is any different from the existing community benefit efforts from tax-exempt hospitals.²¹⁵ The only comparable reportable data under Schedule H for actions to address the needs identified in the CHNA is an “[a]doption of a budget for provision of services that

209. See Rubin et al., *supra* note 21, at 614 (noting that “[d]espite the inherent difficulties, attributing outcomes to specific community-benefit interventions is possible in well-defined circumstances” (emphasis added)). The authors continue to recount “well-defined” instances where outcomes measures are easily quantifiable, including a targeted initiative to educate mothers on the care of newborns. *Id.* The authors next recount instances of “population health” in certain hospitals, including a farmers market, and eventually draw a parallel to the ACA’s CHNA, and a potential opportunity for implement outcomes measures. *Id.* at 615. However, the lofty and unsupported assertions are largely undermined by Professor Berg’s acknowledgement of the severe limitations associated with measuring outcomes in public health initiatives. Berg, *supra* note 4, at 420.

210. I.R.S. Form 990, Schedule H-Hospitals, available at <http://www.irs.gov/pub/irs-pdf/f990sh.pdf> (last visited Feb. 18, 2013) (hereinafter “Form 990 Schedule H”). See also Rubin et al., *supra* note 21, at 614 (arguing that “Form 990 Schedule H, as it exists currently, focuses on inputs to assess the adequacy of a hospital’s community-benefit activities. Inputs, both monetary and non-monetary, play a crucial role in improving community health. In addition, from the perspective of the IRS, inputs are easy to measure and, more importantly, do not require risk adjustment and are thus less susceptible to gaming.”) (citing Peter A. Gross, M.D., *Editorial Process Versus Outcome Measures*, 50 MEDICAL CARE 200, 200-02 (2012)).

211. Form 990 Schedule H, *supra* note 210.

212. *Id.*

213. Berg, *supra* note 4, at 405-18. See also Rubin et al., *supra* note 21, at 612.

214. ACA § 9007.

215. See Form 990 Schedule H, *supra* note 210 (focusing on Parts I-III).

address the needs identified in the CHNA,²¹⁶ which may be ultimately undermined by the acknowledgement that some hospitals may find it less of a hassle to incur the \$50,000 excise tax.²¹⁷

Furthermore, Professor Berg points out another severe limitation in that public health initiatives, which focus on preventative measures, likely will not manifest their worth for years and that it will be difficult to attribute results in year five to the program started in year one.²¹⁸ Professor Berg rightly acknowledged these limitations in her framework, and they are ultimately another severe limitation of § 501(r)'s strongest component – the community health needs assessment, and as the next section illustrates, § 501(r)'s superficial reform is demonstrated in other areas of the new regulations.

V. LIMITATIONS OF THE ADDITIONAL SUBSECTIONS OF §501(R)

Although the CHNA is the most substantial change for new federal tax-exempt requirements, the IRS's proposed regulations for the FAP and EMC policies, limitations on charges, and limitations on billing and collections practices also severely impact hospital operations.²¹⁹ Professor Berg's suggested reform framework pre-ACA highlighted meaningful elements in order to focus on population health within the community impacted by the tax-exempt charitable hospitals. As the previous section illustrates, her framework solely considering the most pivotal § 501(r) component – the CHNA – underscores the point that the additions to § 501(c)(3) charitable hospitals are likely similar to existing requirements for tax-exempt hospitals and existing actions usually performed by hospitals.²²⁰ Even if additional requirements for charitable hospitals prove workable under Professor Berg's suggested framework,²²¹ considering the history of the community benefit standard,²²² existing obligations under federal law, and prevalent characteristics of the healthcare industry, §§ 501(r)(4)-(6) are independently deficient. Below, each of the additional sections will be discussed.

216. *Id.*

217. Stewart & Azman, *supra* note 184, at 18.

218. Berg, *supra* note 4, at 418-19. Professor Berg suggests borrowing concepts from "accrual accounting" where organizations calculate the costs of borrowing debt capital over the life of the loan, and not during the first year. *Id.*

219. See *infra* Parts V.A-C.

220. See *supra* Parts IV.A-D.

221. See *supra* Parts IV.A-D.

222. See *supra* Parts II.C-E.

A. *Financial Assistance Policy and Emergency Medical Care Policy, § 501(r)(4)*

Charitable tax-exempt hospitals are required to implement a FAP in accordance with §501(r)(4) of the new regulations.²²³ Minimally, each hospital facility within an organization, or alternatively, the only hospital within a single hospital organization, must adopt a “written FAP that applies to . . . all emergency and other medically necessary care provided by the hospital facility.”²²⁴ The Code section also requires healthcare systems to establish a written policy pertaining to emergency medical care to all patients, whether or not they are eligible under the facility’s self-defined FAP.²²⁵

Again, the § 501(r) requirements for the FAP and EMC policy are similar to existing requirements for charitable hospitals.²²⁶ As the proposed regulations illustrate, “an [EMC] policy will generally satisfy this standard if it requires [the hospital] to provide the care for any emergency medical condition that [the hospital] is required to provide” for Centers for Medicare and Medicaid Services (CMS) “standards and certifications and including the regulations under the Emergency Medical Treatment and Active Labor Act

223. ACA, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 865 (2010) (codified in scattered sections of 26 U.S.C.); Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38151-53.

224. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38151. The regulations highlight the components of an FAP that a hospital must have, including: “(1) Eligibility criteria for financial assistance, and whether such assistance includes free or discounted care; (2) the basis for calculating amounts charged to patients; (3) the method for applying for financial assistance; (4) in the case of an organization that does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment; and (5) measures to widely publicize the FAP within the community served by the hospital facility.” *Id.* Interestingly, in the discussion of the FAP in the proposed regulations, the Internal Revenue Service requested comments on the potential interrelationships between different sections of § 501(r), requesting comments on how the “community” defined by the CHNA may inform facilities’ FAP. *Id.*

225. *Id.* at 38153. The proposed regulations clarified that the new EMC must establish that the hospital will “provide, without discrimination, care for emergency medical conditions (within the meaning of EMTALA) to individuals, regardless of whether they are FAP-eligible.” *Id.* For this section, the IRS made clear that the only new requirement for hospitals in the EMC is to explicitly prohibit the act of immediately collecting on payments from the patient while they are still present in the emergency department. *Id.*

226. See Colombo, *supra* note 2, at 33-36 (discussing how community benefit reverted back to something similar to the “charity standard,” which Colombo classifies as “community benefit plus something else,” which he argues is a significant amount of charity care). See also Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2012) (discussing the “examination and treatment for emergency medical conditions and women in labor” under existing federal law).

(EMTALA).²²⁷ Thus, the EMC forces charitable hospitals to codify CMS and EMTALA requirements in their rules and regulations,²²⁸ when it is highly likely that hospitals are already complying with these federal regulations due to the important role of federal reimbursement to operations.²²⁹ Medicare payments may account for approximately 31% of hospital revenues,²³⁰ underscoring the importance of compliance with CMS and EMTALA requirements, which § 501(r)(4)'s EMC requires hospitals to codify.²³¹

Even if § 501(r)(4)'s superficial change to the community benefit standard is not highlighted by the redundancy of the EMC, the facility's FAP drives the point home. Professor Colombo aptly illustrated that almost immediately after introduction of the community benefit standard post Rev. Rul. 69-545, the IRS undermined the standard's strength by essentially reverting back to the old charity care standard,²³² noting that it was essentially a "community benefit *plus*" something else, the "plus" being charity care.²³³ As Colombo argued, the importance of the "plus" for tax-exempt charitable hospitals was supported by the Tenth Circuit in *IHC Health Plans, Inc. v. Commissioner*.²³⁴ In his analysis, Colombo borrows language from the Tenth Circuit in the *IHC Health Plans* case, and notes that the court acknowledged activities such as research and medical training as complying with the community benefit standard,²³⁵ but first listed "free or below cost services" as a factor in the "plus" analysis.²³⁶ Therefore, it is arguable existing judicial precedent already forced hospitals to offer "free or below cost services," as the Tenth Circuit identified it as an important factor.²³⁷ Similar to the EMC policy's impact on existing behavior for tax-

227. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153 (emphasis added).

228. *Id.*

229. Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 59 (2006). See also Mark Taylor, *New Medicare Cuts Will Force Hospitals to Plug Major Revenue Leak: Traditional Economizing Strategies Unlikely to be Efficient*, HOSP. & HEALTH NETWORKS, Sept. 2010, at 12 (estimating that anywhere from 35 to 55% of hospital revenues are attributable to Medicare).

230. Reinhardt, *supra* note 229, at 59; Taylor, *supra* note 229, at 12.

231. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153.

232. Colombo, *supra* note 2, at 35.

233. *Id.*

234. *Id.* at 37 (citing *IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188 (10th Cir. 2003)).

235. *Id.*

236. *Id.*

237. See *id.* at 37 (noting how despite the community benefit's broad standard introduced in Rev. Rul. 69-545, subsequent cases relied on charity care as a "significant factor" in determining an entity's compliance with community benefit) (citing *IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188 (10th Cir. 2003)).

exempt hospitals,²³⁸ § 501(r)(4)'s FAP simply forces the tax-exempt entities to codify an activity they were likely already performing prior to the ACA.²³⁹

B. *Limitation on Charges, § 501(r)(5)*

Section 501(r)(5) of the additional requirements for charitable hospitals will perhaps provide the most pivotal decision for tax-exempt healthcare entities²⁴⁰ as it determines *how much* FAP-eligible individuals will pay for emergency and medically necessary services.²⁴¹ Facilities must choose either a “look-back” or “prospective” method for determining the amounts generally billed (AGB).²⁴² Although the amendments to the Code and the proposed regulations limit charges to FAP-eligible patients, hospitals are, in practice, limited to charges to patients unable to pay because, by definition, they are unable to fulfill the financial obligation.²⁴³ So, the hospital previously may have billed poor patients its gross charges, fully understanding that it would eventually sell the inflated price to a debt collection agency, and receive a relatively high amount compared to what

238. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153.

239. *Id.*

240. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153-54 (discussing the differences between the “look-back” and “prospective” method for determining which technique to use to calculate the “amounts generally billed”).

241. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153. Comments for industry stakeholders suggested that “widely publicizing” the FAP include utilizing “one or a combination” of these measures: “(1) posting information on the hospital facility’s Website; (2) distributing information at the hospital facility’s patient access points; (3) notifying patients upon admission; (4) posting information conspicuously in public areas of the hospital facility (including admissions areas, emergency rooms, waiting rooms, billing offices, outpatient reception areas, etc.); (5) including information with or on billing statements; (6) mentioning the FAP when discussing an individual’s bill over the telephone; (7) making the FAP available for public inspection and/or copying without charge at the hospital facility’s principal, regional, and district offices during regular business hours; (8) publicizing the FAP to physicians and community health centers in the community; (9) including information regarding the FAP in hospital newsletters or magazines; (10) including information regarding the FAP in appropriate reports filed with state governments; (11) publicizing the FAP through local news media and/or (12) publicizing the FAP through social service agencies.” *Id.* at 38152.

242. *Id.* at 38154.

243. See Lucette Lagnado, *Anatomy of a Hospital Bill: Uninsured Patients Often Face Big Markups on Small Items; ‘Rules Are Completely Crazy’*, WALL ST. J., September 21, 2004, at B.1 (chronicling the financial difficulties of an uninsured patient with high hospital bills who was unable to pay, highlighting the fact that patients who cannot pay the high medical bills initially will be unable to pay them in the future).

the indigent patient could afford.²⁴⁴ Thus, it was in the hospital's interest to charge indigent patients the gross charges for services.

Hospital chargemasters are the gross charges for medical services,²⁴⁵ and are often set high with the understanding that private insurers will negotiate rates below the chargemaster rates.²⁴⁶ Thus, hospitals set these prices intentionally high understanding they will receive an amount somewhere below this set amount for the majority of their target customers – patients covered under health insurance.²⁴⁷ Under new § 501(r)(5), hospitals are limited to charging FAP-eligibles the AGB, which is an aggregate calculation of all private insurance rates negotiated at the facility and Medicare Part A payments.²⁴⁸ Section 501(r)(5) certainly brings change to this area in that hospitals are no longer able to bill FAP-eligible patients the chargemaster rate,²⁴⁹ but FAP-eligible patients are potentially subject to be charged the “AGB percentage,”²⁵⁰ which is an amount that neither privately insured patients nor Medicare patients actually pay out-of-pocket once their deductible is met.²⁵¹ Privately insured and Medicare patients will pay some percentage below the amounts billed to their insurers,²⁵² yet § 501(r) still permits hospitals to charge FAP-eligibles the whole amount of the AGB,²⁵³ potentially placing them above all patients in terms of the amount responsible for payment.²⁵⁴

244. See Jenny Gold, *New Rules Will Ban Debt Collections at Charitable Hospitals*, KAISER HEALTH NEWS (Jun. 27, 2012), <http://www.kaiserhealthnews.org/stories/2012/june/27/er-debt-charity-hospitals.aspx>.

245. Reinhardt, *supra* note 229, at 58, 59.

246. *Id.* at 61. See also Gerard F. Anderson, *From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 784 (2007).

247. Reinhardt, *supra* note 229, at 61.

248. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153-55. This is assuming hospitals will opt for the “look-back” method, which permits higher patients under the facility's FAP. *Id.* at 38154-55.

249. *Id.* at 38155.

250. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153. This is assuming hospitals will opt for the “look-back” method, which most certainly will as it allows them to charge higher amounts to FAP-eligible patients.

251. Christopher P. Tompkins et al., *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45, 52 (2006).

252. KAISER FAMILY FOUNDATION, *MEDICARE: A PRIMER* 1, 12 (2010), available at <http://www.kff.org/medicare/upload/7615-03.pdf>. See also Lagnado, *supra* note 243.

253. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38153-55.

254. See generally *id.* at 38154-55 (discussing the “look-back” method for determining amounts generally billed). See also Reinhardt, *supra* note 229, at 62. Consider an example where a hospital chooses the “look-back” method to calculate its “amounts generally billed” to calculate the charges to FAP-eligible patients. Prior to the § 501(r)(5) limitations on charges, hospitals would have been able to charge their “gross charges,” and let us assume this figure is \$1,000 for this procedure. However, under the “look-back” method, the hospital

The above analysis undermines the assertion that § 501(r) brings meaningful change to limitations on charges, and this is supported by the legislative history of ACA § 9007. As amended in December 2009, the term “amounts generally billed” replaced “the lowest amounts charged” language in § 501(r)(5) as originally introduced by the Senate version of healthcare reform.²⁵⁵ The “lowest amounts charged” language would have forced hospitals to charge FAP-eligibles the lowermost negotiated rates for health insurance companies,²⁵⁶ and would have supported a stronger argument that § 501(r) brings meaningful change to the community benefit standard, as envisioned by Professors Berg and Colombo in their writings on the topic.²⁵⁷ However, by replacing the relatively strong language with “amounts generally billed,” Congress introduced a standard more open to interpretation by hospitals setting AGB-percentages for FAP-eligibles,²⁵⁸ and introducing another somewhat cloudy variable. Again, the immediately preceding analysis points to the fact that § 501(r)(5), similar to the CHNA analyzed under Professor Berg’s framework and the FAP/EMC requirements, are truly nothing more than hollow requirements for charitable hospitals.

C. *Billing and Collections & Extraordinary Collection Actions, § 501(r)(6)*

The last portion of §501(r) of the Code relates to the ultimate step for tax-exempt healthcare entities attempting to collect nonpayment from a FAP-eligible individual in §501(r)(6) for billings and collections.²⁵⁹ It embodies guidance for “reasonable efforts” to determine whether a patient is FAP-eligible and a prohibition from engaging in ECAs against the patient,²⁶⁰ any

determines that it charges Health Insurers A, B and C, \$500, \$540, and \$450, respectively, under the negotiated rates. In addition, the charge under Medicare is \$400. Thus, the AGB would be calculated as $(\$500 + \$540 + \$450 + \$400) / 4 = \$472.50$, which is the amount charged to FAP-eligible individuals. Therefore, under the limitations on charges to the “amounts generally billed” hospitals are permitted to charge FAP-eligible individuals \$472.50 under the above example, which is far below the \$1,000 charge prior to reform, yet it would still place FAP eligible patients above Medicare and privately insured patients in terms of actual out-of-pocket costs. See *Additional Requirements for Charitable Hospitals*, 77 Fed. Reg. at 38153 (providing examples of how hospitals may comply with the limitations on charges). However, it should also be noted that hospitals are permitted to provide discounts larger than the “amounts generally billed.” See *id.* at 38162 (proposing a hypothetical hospital’s FAP under the look-back method).

255. 111 CONG. REC. S13,527 (daily ed. Dec. 19, 2009).

256. 111 CONG. REC. S11,808 (daily ed. Nov. 19, 2009).

257. See Berg, *supra* note 4, at 412; Colombo, *supra* note 2, at 58.

258. See *Additional Requirements for Charitable Hospitals*, 77 Fed. Reg. at 38165 (noting that hospitals are permitted to calculate the limitations on charges by utilizing the “amounts generally billed”).

259. *Id.* at 38152.

260. *Id.*

individual responsible for payment of the patient's debt, and imposes liability on any hospital whose third-party collection agency engages in ECAs.²⁶¹

Considering the previous analysis, the prohibitions on billings and collections is likely the most beneficial component of § 501(r) for patients, as it severely limits the ability of hospitals to pursue outstanding bad debts against certain patients.²⁶² Under closer scrutiny, the limitations of §

261. *Id.* at 38158-59. Under the proposed regulations, ECAs are any action that "require[s] a legal or judicial process" and include, but are not limited to "(1) plac[ing] a lien on an individual's property; (2) foreclos[ing] on an individual's real property; (3) commenc[ing] a civil action against an individual; (4) caus[ing] an individual's arrest; (5) caus[ing] an individual to be subject to a writ of body attachment; and (6) garnish[ing] an individual's wages." *Id.* at 38156. In addition to the steps, which require legal or judicial processes, the IRS also proposed that reporting adverse information to a credit agency is also considered an ECA. *Id.* The common practice of selling a patient's debt to a collections agency is classified as an ECA under the proposed rules, but they specifically note *assigning* a patient's debt to a third party is not considered an ECA. *Id.* The proposed regulations note that the hospital may maintain greater control over a third-party agent and contractually prohibit the agent from engaging in ECAs against the patient, or potentially subject the hospital to liability. *Id.*

262. See *id.* at 38155 (discussing traditional actions taken by hospitals in order to collect debts, and the limitations on these actions by the new regulations). This practice elicited a scathing comment from Minnesota Attorney General Lori Swanson in response to the proposed regulations highlighting the collection practices of a Chicago-based company hired to manage "revenue cycles" of some Minnesota hospitals. Letter from Lori Swanson, Minnesota Attorney General, to the Dept. of Treas. 4 (Sept. 24, 2012), available at <http://www.regulations.gov/#!documentDetail;D=IRS-2012-0036-0211>. Ms. Swanson's comment in response to the proposed regulations highlighted egregious actions from the Chicago-based company where they elicited payments from individuals in vulnerable situations. "Patients were asked to pay money in the emergency room while suffering from chest pain, strokes, blood clots, labored breathing, suicide attempts, diabetic attacks, elevated heart rates, elevated blood pressure, acute pain, kidney stone attacks, disorientation, mental confusion, and while hemorrhaging blood. Some patients were asked to pay money while in so much pain they thought they were dying. Others were asked to pay money while dazed and disoriented. Some were asked to pay money while hooked up to morphine drips, heart monitors, IVs, or with tubes down their throat. Many were laying undressed on a gurney when the collector visited their bedside. Some had not yet seen a doctor. Some had not been treated. Some were forced to haggle in their ER bed over their ability or need to pay the bill." *Id.* Ms. Swanson's comment continued to highlight specific instances of the "revenue cycle" management company: "(1) A woman suffering a stroke caused by a blood clot in her brain was asked to pay money at her bedside in the ER before she had been stabilized. (2) The mother of a teenage daughter who had tried to overdose on a bottle of pills was made to pay \$500 in the middle of the night before she could return to her daughter's bedside. (3) A pregnant mother was made to pay money while she was bleeding and in the midst of miscarrying her first baby." *Id.* The Attorney General's Office filed a lawsuit against the Chicago-based company in January 2012. *Id.* at 3. The lawsuit was filed as a result of some rather unusual circumstances. See also Press Release, The Office of the Attorney General Lori

501(r)(6) are revealed when considering its relationship to a facility's FAP.²⁶³ As revealed in the FAP/EMC section above, a hospital is permitted to create its own FAP, as long as it meets certain requirements set forth in the proposed regulations,²⁶⁴ and ECAs defined in the footnotes are prohibited if it is revealed that the patient qualifies for the facility's FAP.²⁶⁵ But a glaring criticism of this standard is that ECAs are prohibited against FAP-eligibles,²⁶⁶ and the definition of a FAP-eligible patient is defined by the hospital.²⁶⁷ Thus, the potential volume of ECAs pursued by a facility will be largely determined by that facility,²⁶⁸ again undermining what could have been meaningful community benefit reform under § 501(r).

VI. DISCUSSION & SOLUTION

Under Professor Berg's framework and the additional analysis of § 501(r), the community benefit reform under the ACA's changes to community benefit are somewhat lacking in their long awaited change in this arena of healthcare.²⁶⁹ CHNA outcome comparisons based on Schedule H information will likely prove difficult to quantify and compare, as illustrated by Professor Berg's acknowledgement of the difficulty measuring outcomes for public health initiatives.²⁷⁰ And perhaps the most inefficient provision of the additions is the \$50,000 excise tax imposed on healthcare organizations who fail to comply with CHNA requirements and its impact on

Swanson, Attorney General Swanson Sues Accretive Health for Patient Privacy Violations (Jan. 19, 2012), available at <http://www.ag.state.mn.us/Consumer/PressRelease/120119AccretiveHealth.asp>. The Chicago Company announced in early 2013 that it would no longer pursue bad debts older than one year, but that it would still pursue collections from patients at the time of treatment. Andrew L. Wang, *Accretive Mulls Paring Back Debt Collection Practices*, CHICAGO HEALTH CARE DAILY (Jan. 17, 2013), <http://www.chicagobusiness.com/article/20130117/NEWS03/130119810/accretive-mulls-paring-back-debt-collection-practices>. The company settled the lawsuit filed by Ms. Swanson, agreeing to pay patients \$2.5 million, and agreeing to not operate in Minnesota for two years. *Id.*

263. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38155 (noting that hospitals are prohibited from engaging in ECAs against those who qualify for the facility's FAP).

264. *Id.* at 38151.

265. *Id.* at 38155.

266. *Id.*

267. See *id.* at 38151 (noting that under the proposed regulations, hospital facilities are entitled to define which patients will qualify under their FAP).

268. See Additional Requirements for Charitable Hospitals, 77 Fed. Reg. at 38155-59 (noting that hospitals may define their financial assistance policy, and the limitation of ECAs is only defined to those who qualify for the financial assistance policy, showing that the practice may have the opportunity for abuse).

269. See Berg, *supra* note 4, at 402-21 (describing the five components of Professor Berg's framework).

270. *Id.* at 387.

rural community hospitals that traditionally operate on low profit margins.²⁷¹ These shortcomings, among many others, support the assertion that § 501(r) is nothing more than a sheep in wolves clothing, masquerading as meaningful reform but simply presenting an illusion until subject to close scrutiny.

Ultimately, is our infatuation with the community benefit standard holding not-for-profit tax-exempt charitable hospitals to the lofty, albeit stale ideals of a bygone era?²⁷² Are the familiar criticisms that community benefit does not go “far enough” or that we need something more, simply a reflection on society’s unwillingness to acknowledge that the not-for-profit hospital is not what we think it is?²⁷³ Perhaps yes, but ultimately the § 501(r) changes are not the solution to the problems plaguing community benefit. However, a glimmer of hope to right the community benefit wrongs is buried in the ACA tax-exempt hospital reform, even though it misses the mark on a majority of its provisions. Collaboration between the IRS and HHS was a suggestion offered by academics in the 1990s,²⁷⁴ and it is likely that this collaboration is finally what community benefit needs to overcome its limitations and become a viable standard for federal tax-exemption. Yet, despite this much needed collaboration between IRS and other agencies, § 501(r) does not fulfill the meaningful reform under Professor Berg’s analysis and only brings superficial change to an area rife with complication. In the end, § 501(r) is just community benefit *redux* – the resurgence of a familiar standard.

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271. I.R.S. Notice 2011-52, 2011-30 I.R.B. 65.

272. See Berg, *supra* note 4, at 399 (noting that traditional not-for-profit hospitals have transformed into some sort of other institution as a result of Medicare, Medicaid, and private insurance).

273. See *id.* (noting that “[m]any of these forces . . . are no longer prevalent.”).

274. Daniel M. Fox et al., *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. OF HEALTH POL. POL’Y & L. 251, 276 (1991).

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