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Putting the Community Back into the 'Community Benefit' Standard

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PUTTING THE COMMUNITY BACK INTO THE “COMMUNITY BENEFIT” STANDARD

Jessica Berg*

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I. INTRODUCTION

The responsibility of hospitals to provide charity care raises fundamental questions about the structure of the United States' health care system. Congress, state legislatures, and courts have all begun to scrutinize hospital charity care.¹ The Congressional Budget Office, Governmental Accountability Office, and Internal Revenue Service are engaged in national studies of nonprofit hospitals and community benefits.² Local governments are scrutinizing hospitals' community benefit claims.³ State governments are considering whether to legislate minimum amounts of charity care.⁴ Congress is debating whether hospitals should remain a part of the nonprofit sector at all.⁵ At the same time, uninsured individuals are suing hospitals for unfair billing and collection practices.⁶ Despite this flurry of activity, there has been little concrete effort to reassess the obligations of hospitals. This Article seeks to fill that gap by proposing a novel framework for analyzing hospitals' community obligations. This new framework challenges traditional notions of individual charity care and provides a normative basis for encouraging a shift toward public health benefits.

¹ See, e.g., Steve Teske & Peyton M. Sturges, *Grassley Considering Legislation to Establish Charity Care Standards for Exempt Hospitals*, 17 Health L. Rep. (BNA) 1657, 1657 (Dec. 25, 2008) (noting Senate Finance Committee ranking minority member Senator Grassley's continued investigation of services that nonprofit hospitals provide to justify tax-exempt status).

² See CONG. BUDGET OFFICE, PUB. NO. 2707, *NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 2-3* (2006), available at <http://www.cbo.gov/ftpdocs/76XX/doc7695/12-06-Nonprofit.pdf> [hereinafter CBO PUB. NO. 2707] (discussing data from the Government Accountability Office that served as basis for expanded Congressional Budget Office study on uncompensated care); *id.* at 5 (noting questionnaire that Internal Revenue Service issued to nonprofit hospitals to evaluate how they met community benefit standard).

³ See, e.g., Julie Appleby, *Scales Tipping Against Tax-Exempt Hospitals: Critics Challenge Bill Collection, Charity Care, Salaries at Non-profits*, USA TODAY, Aug. 24, 2004, at 2B ("State[] and local property tax authorities are renewing their interest in hospital tax exemptions.").

⁴ See *id.* (discussing state and local efforts).

⁵ See *id.* (noting House Ways and Means Committee's analysis of value of tax exemption compared with benefits provided).

⁶ See *id.* (discussing class action lawsuits that "take issue with the way hospitals treat the bills of the uninsured").

I start from the assumption that there is value in continuing with the current system, which distinguishes between for-profit and nonprofit hospitals, although I recognize this may be a controversial claim.⁷ Nonetheless, some empirical evidence suggests nonprofit hospitals provide different types and amounts of services than for-profit hospitals—services crucial to the health care system.⁸ In addition, nonprofit hospitals play an important role in academic medical centers, as they can function as recipients of both federal research grants and grants from private foundations.⁹ Whether there is a viable alternative system is a question for another article.

Part II of this Article will describe the current community benefit requirements and consider some problems that have arisen. Part III will explain how creative accounting practices and expansive definitions of free care have led hospitals to engage in a variety of nonideal practices to protect the bottom line, while at the same time maintaining tax-exempt status. Against this backdrop, I suggest an alternative understanding of community benefit, specifically that the concept should be interpreted to require that hospitals provide “population health care benefits.” In making this point, I draw from public health literature to understand what constitutes population—as opposed to individual—health benefits. In Part IV, I consider the conceptual and practical arguments for encouraging hospitals to provide population health benefits as part of their community benefit obligation. Both history and political theory regarding the role of hospitals and government support the notion that community benefit should be interpreted on a population,

⁷ See generally John Simon, Harvey Dale & Laura Chisolm, *The Federal Tax Treatment of Charitable Organizations*, in THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 267 (2d ed. 2006), for a discussion of the potential public policy goals pursued through the federal tax treatment of charities. There are strong arguments that the tax system should not be used to achieve social policy goals, but such discussion is beyond the scope of this Article.

⁸ See, e.g., CBO PUB. NO. 2707, *supra* note 2, at 3 (finding nonprofit hospitals more likely than for-profit hospitals to provide “intensive care for burn victims, emergency room care, high-level trauma care, and labor and delivery services”); Mark Schlesinger & Bradford H. Gray, *How Nonprofits Matter in American Medicine, and What to Do About It*, 25 HEALTH AFF. w287, w290 (2006), <http://content.healthaffairs.org/cgi/reprint/25/4/W287> (describing differences between for-profit and nonprofit hospitals and nursing homes).

⁹ See M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1046 (1992) (noting expansion of academic medical centers due to federal support and third-party payment).

rather than individual, level. Thus, the provision of individual charity care should comprise only a part of a hospital's community benefit obligation. Part V explores implementing the new standard and provides a framework for quantifying community benefit that hospital administrators, as well as local, state, and federal tax authorities can use. Part VI describes current state community benefit programs that incorporate some of these proposals. The suggestions set forth in this Article should result in better, more expansive benefits for communities; clearer guidance for health care institutions and government authorities; and fewer problematic incentives for hospitals attempting to meet their community benefit obligations.

II. HOSPITALS' COMMUNITY BENEFIT OBLIGATIONS

The following section provides a brief background on tax-exempt hospitals and the current community benefit standard, which is used to determine tax-exempt status.

A. INTERNAL REVENUE CODE § 501(C)(3)

Internal Revenue Code § 501(c)(3) creates a special status for "[c]orporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes" as long as "no part of the net earnings . . . inures to the benefit of any private shareholder or individual."¹⁰ 501(c)(3) status is the most common nonprofit status under the IRS requirements.¹¹ Although other types of organizations are eligible for tax-exempt status,¹² corporations incorporated under § 501(c)(3) are both tax-exempt and can accept charitable contributions that will be tax-deductible to the donor.¹³ Tax-exempt status allows corporations to avoid paying

¹⁰ 26 U.S.C. § 501(c)(3) (2006).

¹¹ See, e.g., Peter J. Johnston, *The Kansas Spirit of Cooperation and Rural Kansas Hospitals: Surviving Looming Medicare Cuts by Organizing into Tax Exempt Health Consortiums*, 6 KAN. J.L. & PUB. POL'Y 227, 228 (1996) (describing § 501(c)(3) as primary vehicle for tax exemption).

¹² See 26 U.S.C. § 501(c)(4)-(27) (describing other organizations exempt from taxation).

¹³ The tax status of charitable contributions is handled in 26 U.S.C. § 170(a), but as a

federal corporate income taxes, offers some reduction in postal rates, and may also make the organization exempt from federal price discrimination law.¹⁴ In some states, corporations that hold 501(c)(3) status under federal tax law are also exempt from paying local and state property and sales taxes, and are subject to higher thresholds for unemployment taxes.¹⁵ For hospitals, § 501(c)(3) provides the added benefit of eligibility for both federal research grants and private grants from foundations, which restrict their allocations to nonprofit¹⁶ organizations. Finally, there is a potential benefit in the positive public image that flows from being a nonprofit, rather than for-profit, health care provider.

Tax-exempt status is unquestionably beneficial to hospitals, but it comes with a price. The hospital must operate to benefit public, not private, interests—a condition usually referred to as the charitable purpose or public benefit requirement.¹⁷ In 1956, the IRS issued the “financial ability” standard, which required a tax-exempt hospital to operate “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.”¹⁸ In other words, a tax-exempt hospital had to operate as a charitable institution, providing charitable (free) care to the best of its financial ability; charging some patients was permitted, but free or reduced-fee care for other patients was required.¹⁹ There was a great deal of concern that this

practical matter, 501(c)(3) corporations meet the charitable deduction requirements. See, e.g., Johnny Rex Buckles, *When Charitable Gifts Soar Above Twin Towers: A Federal Income Tax Solution to the Problem of Publicly Solicited Surplus Donations Raised for a Designated Charitable Purpose*, 71 *FORDHAM L. REV.* 1827, 1849 (2003) (explaining relationship between charitable contributions and organizations described in § 501(c)(3)).

¹⁴ THOMAS K. HYATT & BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS* 21–23 (2d ed. 2001).

¹⁵ See Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 *B.C. L. REV.* 1, 8 n.19 (1995) (“[M]any jurisdictions continue to exempt § 501(c)(3) organizations from state and local sales, income, and property taxes.”).

¹⁶ Nonprofit status is actually a matter of state law separate from tax-exempt status. HYATT & HOPKINS, *supra* note 14, at 4–5. While some nonprofits may not be tax-exempt, almost all tax-exempt organizations are also nonprofit. *Id.* at 5. For purposes of this Article, the terms may be used interchangeably.

¹⁷ See 26 U.S.C. § 501(c)(3) (requiring that “no part of the net earnings . . . inures to the benefit of any private shareholder or individual”).

¹⁸ Rev. Rul. 56-185, 1956-1 C.B. 202, 203, *modified by* Rev. Rul. 69-545, 1969-2 C.B. 117.

¹⁹ See *id.* (explaining that exempt hospitals could not refuse to accept patients in need of

standard was too imprecise, as it did not quantify the charity care requirement.²⁰ In addition, hospital administrators worried that the passage of Medicare and Medicaid in 1965 and the burgeoning private insurance market would obviate the need for charity care, making it impossible for them to maintain tax-exempt status.²¹ In 1969, the IRS issued Revenue Ruling 69-545, setting forth the new community benefit standard, which is currently applicable to tax-exempt hospitals.²² The IRS essentially ruled that providing health care is a charitable purpose generally beneficial to a community as a whole, even if the actual care is not exclusively provided to indigent patients.²³ Through illustrative examples, the ruling set forth six criteria the IRS would consider for hospitals seeking tax-exempt status:

- (1) Operating an active, generally accessible emergency room;²⁴
- (2) Providing hospital care for anyone who is able to pay;²⁵
- (3) Participating in public aid programs like Medicare;²⁶
- (4) Creating a governing board of trustees composed of independent civic leaders;²⁷

hospital care who could not pay).

²⁰ See, e.g., John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 30 (2005) (“[T]he IRS never took an official position regarding how much charity care was ‘enough’ or even how to define charity care . . .”).

²¹ See, e.g., *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways & Means*, 109th Cong. 87 (2005) (statement of John Colombo, Professor, University of Illinois College of Law, Champaign, Illinois) (“[T]he common complaint . . . 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 . . .”).

²² Rev. Rul. 69-545, 1969-2 C.B. 117.

²³ See *id.* at 118 (“The promotion of health . . . is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole . . .”).

²⁴ *Id.* However, under IRS Revenue Ruling 83-157, a nonprofit hospital may be exempt from the emergency room requirement if a “state health planning agency has made an independent determination that this operation would be unnecessary and duplicative.” Rev. Rul. 83-157, 1983-2 C.B. 94.

²⁵ Rev. Rul. 69-545, *supra* note 22, at 118.

²⁶ *Id.* at 117.

²⁷ *Id.* at 118.

- (5) Making medical staff privileges available to all qualified professionals who apply;²⁸ and
- (6) Re-investing surplus funds in operations.²⁹

Although these criteria are initially considered in allocating tax-exempt status, the IRS historically took little action against hospitals failing to meet the criteria in their continued operations, except in cases of egregious violations.³⁰ The IRS's reluctance to revoke tax-exempt status was due in large part to the draconian result of taking such a drastic step.³¹ Not only would the revocation of 501(c)(3) status create hardships via new tax liabilities for the hospital (potentially impacting patient care), but it could also have repercussions for donors who anticipate individual tax benefits for donating to a nonprofit institution,³² and for ongoing federal or private grants.³³ In 1996, the Taxpayer Bill of Rights authorized "intermediate sanctions," allowing the IRS to impose more moderate penalties for more moderate violations of the sixth requirement listed above, avoiding private gains or excess benefits in favor of reinvesting surplus profits.³⁴ However, the IRS has rarely applied these intermediate sanctions to hospitals,³⁵ and they do not directly address community benefit violations.

²⁸ *Id.*

²⁹ *Id.* The Ruling uses the example of a hypothetical hospital to illustrate these factors. *Id.* at 117–18.

³⁰ See David M. Studdert et al., *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 *NEW ENG. J. MED.* 625, 626 (2007) ("Historically, regulatory problems also extended to the enforcement tools available. The IRS was limited to two options: it could permit the conduct under scrutiny or revoke the hospital's tax-exempt status.").

³¹ See *id.* ("The severity of [revoking tax-exempt status] has tended to discourage its use.").

³² See *supra* note 13 and accompanying text.

³³ See *supra* note 9 and accompanying text.

³⁴ See 26 U.S.C. § 4958(a) (2006) (providing for imposition of penalties on excess benefit transactions); Studdert et al., *supra* note 30 (discussing function of intermediate sanctions).

³⁵ See Lawrence E. Singer, *Leveraging Tax-Exempt Status of Hospitals*, 29 *J. LEGAL MED.*, Jan.–Mar. 2008, at 41, 50–51 (discussing a 2007 IRS analysis identifying twenty-five organizations that received notices of intermediate sanctions); Studdert et al., *supra* note 30 ("To the best of our knowledge, intermediate sanctions have been applied only once in health care." (footnote omitted)).

Over the past decade or so, the IRS and members of Congress³⁶ have applied more scrutiny to hospitals' tax-exempt status, focusing on whether the community benefit standard actually serves to benefit the communities in question, or whether a quantifiable charity care requirement is necessary.³⁷ State legislatures have also become more active in this area.³⁸ Some states have gone after tax-exempt hospitals for failure to meet the community benefit standard,³⁹ prompting the institutions to make voluntary payments or provide services in lieu of property taxes.⁴⁰ Other states have attempted to set explicit and quantifiable charity care requirements that must be met under the community benefit standard.⁴¹

³⁶ See Diane Freda & Peyton M. Sturges, *Grassley Issues Minority Staff Proposal, Sets Charity Care Benchmarks for Hospitals*, 16 Health L. Rep. (BNA) 909, 909 (July 26, 2007) (noting that Senator Grassley's discussion draft of tax-exempt hospital policy recommendations "proposes that hospitals must attain a 5 percent minimum charity care benchmark"); Teske & Sturges, *supra* note 1, at 1657 (discussing IRS initiatives and Senator Grassley's aggressive stance regarding standards for exempt health care organizations).

³⁷ Senator Grassley and others favor quantifiable standards and benchmarks. Teske & Sturges, *supra* note 1, at 1657.

³⁸ See Alice A. Noble, Andrew L. Hyams & Nancy M. Kane, *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. MED. & ETHICS 116, 116 (1998) (discussing survey of states undertaken "to assess the progress and known impact of measures recently taken to hold non-profit hospitals accountable for community benefits").

³⁹ See *Provena Covenant Med. Ctr. v. Dep't of Revenue of Ill.*, 894 N.E.2d 452, 456 (Ill. App. Ct. 2008) (reversing circuit court and finding that Illinois could revoke hospital's property tax exemption); *Menno Haven, Inc. v. Franklin County Bd. of Assessment & Revision of Taxes*, 919 A.2d 333, 335 (Pa. Commw. Ct., 2007) (affirming local Pennsylvania decision to revoke tax-exempt status for two skilled nursing facilities); *Another Nonprofit Hospitals [sic] in Illinois Denied Exemption by State Tax Officials*, 16 Health L. Rep. (BNA) 263, 263 (Mar. 1, 2007) (describing refusal to grant exemption to Carle Foundation Hospital); *Illinois Revenue Department Again Denies Exemption Sought by Rural Hospital in State*, 16 Health L. Rep. (BNA) 289, 289 (Mar. 8, 2007) (describing denial of property tax exemption for Richland Memorial Hospital).

⁴⁰ See ROBERT I. FIELD, *HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE* 191 (2007) ("To avoid such challenges [from losing tax-exempt status], hospitals in many localities make voluntary payments in lieu of property taxes . . . includ[ing] free services in addition to monetary payments." (footnote omitted)).

⁴¹ See, e.g., Laura Mahoney, *Tax-Exempt Bonds for California System Tied to Charitable Donations for First Time*, 16 Health L. Rep. (BNA) 442, 442 (Apr. 5, 2007) (noting new California requirement that hospital systems make specific charitable contributions in order to receive bond funding); Peyton M. Sturges, *Legislation Proposed in Minnesota House Sets 'Community Care' Bar for Tax Exemption*, 16 Health L. Rep. (BNA) 301, 301 (Apr. 5, 2007) (discussing proposed floor for amount of community care that exempt hospitals must provide in Minnesota).

B. THE INTERNAL REVENUE CODE AND COMMUNITY BENEFIT

Evaluations of tax-exempt status generally focus on finding sufficient “community benefit,” although there are some other areas prompting scrutiny, such as executive compensation, which will not be addressed in this Article. If tax exemption is a mechanism for a community to provide a benefit to the hospital, it is reasonable to expect the hospital to provide something back to the community in turn. Previously, in the absence of any medical center, the mere creation of a hospital was viewed as a benefit. For example, the Hill-Burton Act, designed to spur the creation of new hospitals, resulted in major federal spending on new hospitals during the middle of the twentieth century, on the assumption that significant community benefits existed in creating hospitals, thus justifying the use of public tax funds.⁴² Even though the Act was based on the idea that creating or expanding a hospital was itself beneficial to the community, it still required hospitals receiving funds to provide a reasonable amount of free care, although this amount was not initially quantified.⁴³ Currently, with the proliferation of for-profit institutions,⁴⁴ community benefit can no longer be defined as simply

⁴² See FIELD, *supra* note 40, at 56–57 (noting that the Hill-Burton Act “approved major new spending to fund the creation of new hospitals and the expansion of existing ones”). The Hill-Burton Act worked, at least in the sense that it vastly increased spending for hospitals. *See id.* (noting that funding reached \$3.7 billion by 1971). However, the growth led to such high costs that the government began requiring state certificate-of-need (CON) programs to limit spending based on identified needs. *See id.* at 57–58 (explaining that, under the CON program, hospitals were permitted to spend funds on services, facilities, and equipment only if regional planning agency identified a need). These changes are somewhat ironic, in that Hill-Burton funds successfully increased access to health care but increased costs so much that restriction in the form of CON programs was taken as a countermeasure. *Id.* at 58.

⁴³ The original requirement was to provide twenty years of a reasonable volume of free care from the initial point of funding. *See* Karen I. Treiger, Note, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1198 (1986) (noting requirement to “provide, for a twenty-year period, a reasonable volume of free or below-cost care to any person unable to pay”). In 1975, the Hill-Burton Act became Title XVI of the Public Health Security Act and required all hospitals that receive or received the funding to provide a certain amount of free care without any time limit. *See* 42 C.F.R. § 124.501 (1979) (noting provisions applying to recipients of federal assistance that gave assurance they would provide “reasonable volume of services to persons unable to pay for the services”).

⁴⁴ Some prominent for-profit hospital chains are Tenet, HealthSouth, and Hospital Corporation of America (HCA). *See* Elizabeth A. Weeks, *Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era*, 40 WAKE FOREST L. REV. 1215, 1226 (2005) (noting that Tenet is second largest hospital holding company after

the presence of a hospital or access to a hospital. Rather, the question becomes whether there are substantial and additional benefits from having a *nonprofit* hospital, rather than a *for-profit* hospital, functioning in the community.

One of the unique benefits nonprofit hospitals provide may be free care; yet recently, the amount and sufficiency of the charity care provided by tax-exempt hospitals has been a point of contention. For example, a 2005 report from the Government Accountability Office (GAO) found that the burden of uncompensated care falls disproportionately on a small number of nonprofit hospitals, rather than being spread among all nonprofit hospitals.⁴⁵ For any given nonprofit hospital system, only one or two institutions may offer the bulk of the entire system's uncompensated care.⁴⁶ A 2006 paper from the Congressional Budget Office (CBO) found that "[i]ndividual hospitals varied widely in their uncompensated-care shares," and specifically that government hospitals provided more uncompensated care than nonprofit hospitals, and nonprofit hospitals provided more than for-profit hospitals.⁴⁷

On the other hand, one study suggests the benefit nonprofit hospitals provide stems not only from free care, but from the type of care.⁴⁸ Jill Horowitz gathered empirical data to show "nonprofit hospitals act in the public interest by providing services that are unlikely to be offered by the other types of hospitals."⁴⁹ Specifically,

HCA). Although there are many for-profit hospitals, most hospitals are still nonprofit. See Field, *supra* note 40, at 190 ("Most American hospitals continue to function on a nonprofit basis . . ."). There are also for-profit health maintenance organizations (HMOs), which tend to be more controversial than for-profit hospitals. See, e.g., David U. Himmelstein et al., *Quality of Care in Investor-Owned vs Not-for-Profit HMOs*, 281 JAMA 159, 163 (1999) (discussing dissatisfaction with HMO care).

⁴⁵ See GOV'T ACCOUNTABILITY OFFICE, GAO-05-743T, NONPROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS: UNCOMPENSATED CARE AND OTHER COMMUNITY BENEFITS 8 (2005), available at <http://www.gao.gov/new.items/d05743t.pdf> ("[U]ncompensated care cost burden was not evenly distributed within each hospital group but instead was concentrated in a small number of hospitals.").

⁴⁶ See *id.* at 12 (discussing the concentration of uncompensated care costs).

⁴⁷ CBO PUB. NO. 2707, *supra* note 2, at 2.

⁴⁸ See Jill R. Horowitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139, 139 (2007) (offering evidence that whether a hospital is "for-profit, nonprofit, or government owned" affects mix of medical services offered). But other studies have been more equivocal. See Colombo, *supra* note 20, at 51 (concluding that sufficient differences do not exist between nonprofit and for-profit hospitals to justify tax exemption).

⁴⁹ Horowitz, *supra* note 48, at 139; see also *supra* note 8 and accompanying text.

data showed these institutions may be more likely than for-profit hospitals to offer services with low profit potential, such as emergency room services.⁵⁰

There is no explicit IRS ruling that hospitals must provide free care to meet the community benefit standard. In fact, Revenue Ruling 69-545 explicitly states that hospitals *can* charge for nonemergent care, and can even refuse to provide nonemergent care based on ability to pay.⁵¹ The emergent care requirement merely states that a hospital cannot refuse emergent care based on ability to pay; it does not say that hospitals have to provide all emergent care free of charge.⁵² Rather, the charity care requirement comes from a variety of other governmental policy signals. For example, IRS Form 13790, a questionnaire mailed out to approximately 600 nonprofit hospitals in May 2006 to evaluate compliance with the community benefit standard, included a number of questions regarding charity care.⁵³ Although the Form is not itself a directive from the IRS, it “provides valuable guidance to all tax-exempt hospitals as to the types of information that the IRS finds to be particularly relevant.”⁵⁴ Among other things, the form asks hospitals to provide very specific information on uncompensated care.⁵⁵ Perhaps reflecting the Form’s potential impact, large law firms immediately issued guidance documents for their hospital clients on issues of concern, the majority of which focused on charity care requirements.⁵⁶

⁵⁰ See Horowitz, *supra* note 48, at 200 (listing emergency services as unprofitable).

⁵¹ Rev. Rul. 69-545, *supra* note 22, at 118 (stating that a hypothetical hospital provides community benefit “by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement”).

⁵² See *id.* (stating that hypothetical hospital emergency room must be “generally accessible”).

⁵³ Francis J. Serbaroli, *IRS ‘Community Benefit’ Standard, Tax-Exempt Hospitals*, 236 N.Y.L.J. 4 (2006) (noting IRS Form 13790’s specific and detailed questions about how hospitals calculate charity care).

⁵⁴ *Id.*

⁵⁵ I.R.S. Form 13790, Part II (May 2006), available at http://www.irs.gov/pub/irs_tege/exhibit_1_form13790.pdf. The Form also asks about the presence of an emergency room, membership on the board of directors, medical staff privileges, medical research, professional medical education, billing practices, community programs, and compensation practices. *Id.* at Parts II–III.

⁵⁶ For examples of such law firm guidance documents, see Gerald M. Griffith, James R. King & David S. Boyce, Partners, *IRS Mails Community Benefit Questionnaires (May 2006)*, http://www.jonesday.com/pubs/pubs_detail.aspx?pubID=3449 (from Jones Day); Allen R.

III. WHAT COUNTS AS COMMUNITY BENEFIT?

The American Hospital Association (AHA) issued guidelines hospitals can use to state the value of their community benefits, including: (a) charity care costs, (b) bad debt costs, (c) unpaid costs of government programs like Medicare and Medicaid, and (d) net expenses of research, education, community health services, subsidized health services, community building, philanthropic donations, and community benefit operations.⁵⁷ Many hospitals follow this checklist approach, primarily emphasizing the first categories.⁵⁸ However, a 2008 GAO report found that hospitals retain broad discretion in determining and measuring community benefit services.⁵⁹ The following Subparts of this Article focus initially on the problems that arise from the incentives to provide and quantify primarily individual charity care in order to meet the community benefit requirement. This Article then considers an alternative focus for community benefit: population health care.

A. INDIVIDUAL CHARITY CARE

Charity care is a simple idea but involves significant complexities when implemented. Although charity care is a basic service of many hospitals, there are a number of problems with using charity care to measure community benefit. Not all charity care is free, or even offered at a reduced fee.⁶⁰

Killworth, Partner, IRS Begins "Community Benefit" Inquiries – Hospitals Contacted (June 2006), <http://www.bricker.com/publications/articles/955.asp> (from Bricker & Eckler); Squire, Sanders & Dempsey, IRS Form 13790 Questionnaire Review (July 2006), <http://www.ssd.com/publications/Detail.aspx?pub=3340> (from Squire, Sanders & Dempsey).

⁵⁷ AM. HOSP. ASS'N, AHA GUIDANCE ON REPORTING OF COMMUNITY BENEFIT (2006), available at <http://www.aha.org/aha/content/2006/pdf/061113message-framework.pdf>.

⁵⁸ See Lisa Kinny Helvin, Note, *Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 459 (2008) ("AHA's guidelines have been adopted by 3000 of its member hospitals.").

⁵⁹ GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 14 (2008), available at <http://www.gao.gov/new.items/d08880.pdf> ("[The] IRS's community benefit standard allows nonprofit hospitals broad latitude to determine services and activities that constitute community benefit.").

⁶⁰ See Joel S. Weissman, *The Trouble with Uncompensated Hospital Care*, 352 NEW ENG. J. MED., 1171, 1171 (2005) ("[U]ncompensated care is not free. A small portion is covered by

The biggest problems are the accounting practices used to quantify what is referred to as "uncompensated" care.⁶¹ A 2007 interim report from the IRS's Hospital Compliance Project indicated that "there is considerable variation in how hospitals report uncompensated care . . . how they measure and incorporate bad debt expense and shortfalls between actual costs and Medicare or Medicaid reimbursements into their measures, and whether they use charges or costs in their measures."⁶² For many institutions, "[u]ncompensated care is defined as the sum of free care, for which the hospital does not expect payment, and bad debt, for which it attempts to collect payment."⁶³ The care provided under this framework is not technically free. Tax-exempt hospitals may receive charitable donations, and these funds can be used to offset previously uncompensated care.⁶⁴ Some hospitals are applying to state uncompensated care funds for reimbursement for charity care.⁶⁵ It is not clear why hospitals should be allowed to count the care reimbursed in this manner to meet their community benefit obligation.

Additionally, hospitals can set the costs of procedures for private insurers and individuals who pay out of pocket at levels that take into account that some individuals will be unable to pay.⁶⁶ These payments may be used to make up shortfalls. This has been a significant problem for uninsured individuals who may be charged rates significantly above the rates paid by public and private

in-kind donations, and the rest is paid for by parties other than the patients or their public or private insurance.").

⁶¹ 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) (noting that, for determining cost, "[t]here is no where it is more controversial than in determining community benefit from uncompensated care").

⁶² INTERNAL REVENUE SERV., HOSPITAL COMPLIANCE PROJECT: INTERIM REPORT 1 (2007), available at http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf.

⁶³ Weissman, *supra* note 60, at 1171.

⁶⁴ Silvers, *supra* note 61, at 5-6 (discussing cash inflows from donations).

⁶⁵ See Jean M. Mitchell & Stephen A. Norton, *Provider Assessments, the Uninsured, and Uncompensated Care: Florida's Public Medical Assistance Trust Fund*, 74 MILBANK Q. 545, 549 (1996) (discussing state uncompensated care funds used "solely to reimburse hospitals providing high levels of charity care").

⁶⁶ See David Dranove, *Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting*, 7 J. HEALTH ECON. 47, 48 (1988) (explaining conventional notion of cost shifting). But see Weissman, *supra* note 60, at 1171 (noting market competition has limited hospitals' ability to cost shift).

insurers.⁶⁷ In fact, concerns about these unreasonably high fees and unscrupulous debt-collection practices have led to both a congressional investigation into tax-exempt hospitals and a series of class-action lawsuits on behalf of uninsured patients against nonprofit health care institutions.⁶⁸

Not only do private parties “pay” for uncompensated care, but so do public programs. For example, the Medicare program explicitly adjusts reimbursement rates for hospitals based on whether they serve a disproportionate share of poor patients through Disproportionate Share Hospital (DSH) adjustments, a proxy for unreimbursed or under-reimbursed care.⁶⁹ Thus, hospitals providing more free care get additional Medicare dollars for each procedure they provide to a beneficiary over and above the reimbursement amount given to hospitals that do not provide the same level of free care services. The Healthcare Financial Management Association addressed some, but not all, of these concerns in a December 2006 report, stating that bad debt and Medicare shortfalls should not be identified as charity care;⁷⁰ the Association’s recommendations, however, are not binding.

⁶⁷ See Gerard F. Anderson, *From ‘Soak the Rich’ to ‘Soak the Poor’: Recent Trends in Hospital Pricing*, 26 HEALTH AFF. 780, 780 (2007) (“[U]ninsured and other ‘self-pay’ patients are often presented with bills . . . with charges that are 2.5 times what most public and private health insurers actually pay.”); Weissman, *supra* note 60, at 1172 (“[S]ome low-income, uninsured patients are being overcharged for services.”). A related problem is that in most teaching hospitals—which is where the bulk of uninsured patients are seen—uninsured patients may only have access to residents or other physicians-in-training, rather than attending physicians—since the cost of the trainees’ time is less than that of attending physicians. See, e.g., David L. Coleman, *The Impact of the Lack of Health Insurance: How Should Academic Medical Centers and Medical Schools Respond?*, 81 ACAD. MED. 728, 730 (2006) (“[The] care of indigent or uninsured patients often occurs in residents’ clinics. These clinics typically have a lower ratio of faculty to trainees and a lower level of faculty involvement in patient care than other sites of faculty practice.”). This situation raises additional questions about the level of uncompensated care costs that these hospitals claim.

⁶⁸ Weissman, *supra* note 60, at 1172.

⁶⁹ See 42 C.F.R. § 412.106 (2008) (listing factors used to determine whether hospital gets payment adjustment); Ctrs. for Medicare & Medicaid Servs., *Disproportionate Share Hospital (DHS)*, http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp (last visited Sept. 10, 2009) (explaining how DSH is calculated).

⁷⁰ HEALTHCARE FIN. MGMT. ASS’N, P&P BOARD STATEMENT 15: VALUATION AND FINANCIAL STATEMENT PRESENTATION OF CHARITY CARE AND BAD DEBTS BY INSTITUTIONAL HEALTHCARE PROVIDERS 9, 11 (2006), available at <http://www.hfma.org/NR/rdonlyres/B32E0CB5-9AE5-4127-83A3-02FFDE0054D5/0/400530Statement15.pdf>.

In addition to concerns about defining free care and including bad debt and shortfalls—which raise questions about whether hospitals are truly providing the uncompensated care they say they are—there are problems with including these activities as part of the community benefit used to justify tax-exempt status. For-profit hospitals also provide charity care, assume some bad debt, and may have shortfalls in compensation from government programs; thus, there are serious questions about whether these categories function as an appropriate gauge of community benefit to justify tax-exempt status. In response to some of these concerns, the IRS recently issued a revised Form 990, which is a required reporting form for nonprofit tax-exempt organizations.⁷¹ According to the background documents issued with Schedule H of Form 990—which applies to institutions providing hospital or medical care—the changes are designed to “quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals.”⁷² The redesigned form attempts to address a number of issues, including executive compensation, but its primary focus is on community benefit.⁷³ While Form 990 responds to some of the concerns identified above, it does not go far enough in emphasizing a shift away from individual charity care.

Determining whether and how charity care should be quantified is beyond the scope of the Article. For my purpose, it is important only to note that this is an area subject to a great deal of controversy.⁷⁴ Given that controversy, we may be uneasy about continuing to incentivize hospitals to provide primarily individual charity care under their community benefit obligations in order to maintain tax-exempt status. Charity care is undoubtedly an important service that both nonprofit and for-profit hospitals offer. I do not mean to suggest the provision of individual charity care should be abandoned.

⁷¹ See I.R.S. Form 990, Schedule H (2008), available at <http://www.irs.gov/pub/irs-tege/f990rschh.pdf> (asking questions about charity care in hospitals).

⁷² INTERNAL REVENUE SERV., TAX-EXEMPT & GOV'T ENTITIES DIV., OFFICE OF EXEMPT ORGS., DRAFT FORM 990 REDESIGN PROJECT – SCHEDULE H (2007) [hereinafter FORM 990 REDESIGN], available at http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf.

⁷³ See I.R.S. Form 990, Schedule H, *supra* note 71 (focusing on community benefits).

⁷⁴ See, e.g., Teske & Sturges, *supra* note 1, at 1657 (discussing political controversy surrounding charity care).

At the same time, perhaps it would be better for the system as a whole if we did not continue to rely on nonprofit hospitals to provide services to the vast number of uninsured and underinsured members of our society. If nonprofit hospitals stop acting as a safety net, we might be more likely to see comprehensive health care reform passed on a national level.⁷⁵ On the other hand, development of a universal coverage system will not happen overnight, and it is not clear that the harms to individuals who would lack access to needed care during the intervening period would be worth the potential benefit to the system as a whole.⁷⁶ There may be other ways to accomplish comprehensive reform without harming those in our society who are already most vulnerable. Moreover, even with reform, nonprofit hospitals may still be required to provide some uncompensated care.⁷⁷ In the current situation, creative accounting and concerns about what exactly qualifies as free care have led to a variety of nonideal practices. Thus, although charity care may continue to be a part of hospitals' obligations, the standards should focus less on individual services and more on true *community* benefits. I argue below that we should refocus our attention on population health benefits rather than individual care services. The following subpart seeks to define and expand the notion of population health in this context.

B. POPULATION HEALTH CARE AND PUBLIC HEALTH BENEFITS

The concept of community benefit is necessarily broader than the definition of public health. Many organizations provide community benefits without focusing on public health. Consider the examples of fire and police departments, both of which focus on public safety, a close cousin of public health. Furthermore, public ice skating rinks and swimming pools create community benefits, as do private businesses providing shopping, services, employment, and tax revenues. In one sense, the notion of community benefit is broad

⁷⁵ See Bruce Siegel, Marsha Regenstien & Peter Shin, *Health Reform and the Big Safety Net: Big Opportunities, Major Risks*, 32 J.L. MED. & ETHICS 426, 431 (2004) ("Large-scale coverage expansions might indeed relieve many pressures on the safety net.").

⁷⁶ See *id.* (discussing difficulties of reform).

⁷⁷ See *id.* ("[U]ncompensated care might persist . . .").

enough to encompass almost any activity.⁷⁸ If this statement is accurate, however, then critics of hospitals' tax-exempt status may be correct in asserting that there is little difference between the community benefits offered by nonprofit and for-profit health care institutions.⁷⁹ Rather than resolve this issue, I propose applying a narrower definition of community benefit in this context. Specifically, *nonprofit hospitals should be required to provide population health benefits to the communities in which they operate.*⁸⁰

What are population health benefits? Since population health benefits are part of public health benefits, perhaps the first question is, "What is public health?" Public health scholars have long debated the scope of public health, as opposed to individual medical care.⁸¹ For example, according to a report from the Institute of Medicine (IOM), "[p]ublic health is what we, as a society, do collectively to assure the conditions for people to be healthy"⁸²—a definition seeming to include everything but individuals' actions to promote their own health. Professor Gostin distinguishes individual health from public health, stating "health care is devoted to personal medical diagnosis, clinical prevention, and treatment, while public health is devoted to strategies to identify health risks and improve behavioral, environmental, social, and economic conditions that

⁷⁸ The idea of public health can also be defined so broadly (and thus less usefully) as to include almost any activity. See *infra* note 82 and accompanying text.

⁷⁹ See *supra* note 1 and accompanying text. Notably, even if both types of institutions provide community benefit, there could be differences in the type and amount of benefit provided. See *supra* note 8 and accompanying text.

⁸⁰ Others have suggested alternative approaches to revising the community benefit standard. See, e.g., John D. Colombo, *The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L. REV. 343, 345 (2004) (suggesting standard for evaluating exempt status should be whether the organization enhances access to health care services); Crimm, *supra* note 15, at 103 (recommending tax regime granting beneficial tax treatment to both nonprofit and for-profit organizations that engage in charitable activities and socially valuable programs); Sean Nicholson et al., *Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals*, 19 HEALTH AFF. 168, 168–69 (2000) (relying on distinction between public and private goods to measure community benefit standard); Singer, *supra* note 35, at 44 (arguing for broad-base community benefit test as opposed to limited focus on charity care); Julie Trocchio, *What Are True Community Benefits?*, 77 HEALTH PROGRESS Sept.–Oct. 1996, at 34, 34 (defining community benefit as activity that responds to a particular health problem in the community).

⁸¹ See, e.g., LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 3–22 (2000) (defining public health law and describing its characteristics).

⁸² *Id.* at 13 (citing COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, INST. OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 19 (1988)).

affect the health of wider populations.”⁸³ Without resolving the oft-debated issue of the scope of public health, we can draw from work done in this area to provide a useful basis for thinking about the types of activities in which a hospital could engage to meet its community benefit requirement.⁸⁴ Thus, population health might include “efforts to improve access to health care as well as more general measures to prevent injury and illness and reduce morbidity and mortality, such as advice to use sunscreen and eat healthy foods”⁸⁵ Specifically, population health focuses on the health of the group as a whole.⁸⁶

Population health—and, likewise, most definitions of public health—includes some notion of individual health care. Certainly the health of a population is in part measured by access to individual health care benefits. However, I argue that the understanding of population health in the context of community benefit should include services and interventions that primarily provide benefit to the population as a whole, even though that benefit may then have a secondary positive effect on any one individual’s health care. In this

⁸³ GOSTIN, *supra* note 81, at 17–18.

⁸⁴ For example, Professor Mark Rothstein explores the scope of public health and identifies three approaches: human rights, population health, and government intervention. Mark A. Rothstein, *Rethinking the Meaning of Public Health*, in PUBLIC HEALTH ETHICS: THEORY, POLICY, AND PRACTICE 71, 71–76 (Ronald Bayer et al. eds., 2007). Rothstein supports the narrow definition of public health as government intervention. *Id.* at 74, 76. A full analysis of this argument is beyond the scope of this Article. For my purposes, the important issue is that there is a group of activities that can be categorized as geared towards population health, separate from individual health.

⁸⁵ *Id.* at 73. Rothstein rejects the use of the concept of population health as a definition for public health for a number of reasons, including: the overlap between public and private roles, the blurring of individual and public health, and the lack of justification for coercive measures. *Id.* at 73–74. Although these may be good reasons not to equate population health with public health, they do not affect the use of a population health focus for community benefit.

⁸⁶ David Kindig and Greg Stoddart promote as their definition of population health “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” David Kindig & Greg Stoddart, *What is Population Health?*, 93 AM. J. PUB. HEALTH 380, 381 (2003). They further stress that the hallmark of population health “is significant attention to the multiple determinants of . . . health outcomes . . . includ[ing] medical care, public health interventions, aspects of the social environment (income, education, employment, social support, culture) and of the physical environment (urban design, clean air and water), genetics, and individual behavior.” *Id.* They note that the shift to population health will not be a stretch for most public health workers, who already think of public health in broad terms. *See id.* at 382 (“Those in public health or health promotion may legitimately feel that population health is simply a renaming of what has been their work or legacy.”).

sense, population health benefits the group, and these group benefits may, but do not have to, entail individual benefits.

Geoffrey Rose draws attention to this concept in his description of the “prevention paradox,” noting that “a measure that brings large benefits to the community offers little to each participating individual.”⁸⁷ Consider the traditional example of vaccination. Vaccinating enough members of the population to prevent the spread of illnesses results in herd immunity.⁸⁸ In some cases, individuals may not be appropriate targets for vaccination, even though they are at high risk of contracting the illness.⁸⁹ These individuals benefit from the vaccination of the group as a whole, even though they themselves are not vaccinated.⁹⁰ For example, the elderly population is at high risk of death from influenza.⁹¹ School-aged children are most likely to spread influenza, but are generally at a lower risk of dying from it.⁹² At one point, Japan decided to vaccinate all schoolchildren to prevent the spread of the flu to high-risk populations.⁹³ The benefits of the policy were directed at the population as a whole, not at any one individual who was

⁸⁷ Geoffrey Rose, *Strategy of Prevention: Lessons from Cardiovascular Disease*, 282 BRIT. MED. J. 1847, 1850 (1981).

⁸⁸ LEON GORDIS, EPIDEMIOLOGY 20–21 (3d ed. 2004) (“Once a certain proportion of people in the community are immune, the likelihood is small that an infected person will encounter a susceptible person . . .”)

⁸⁹ See Anthony Ciolli, *Religious & Philosophical Exemptions to Mandatory School Vaccinations: Who Shall Bear the Costs to Society*, 74 MO. L. REV. 287, 288 (2009) (emphasizing that extremely young children or individuals with diseases such as AIDS cannot be immunized).

⁹⁰ See GORDIS, *supra* note 88, at 21 (“[B]y immunizing a large part of the population the remaining part will be protected because of herd immunity.”).

⁹¹ See JOHN M. BARRY, THE GREAT INFLUENZA: THE EPIC STORY OF THE DEADLIEST PLAGUE IN HISTORY 238 (2004) (“Influenza almost always selects the weakest in society to kill . . . [such as] the very old.”). Similarly at risk are very young children and people with compromised immune systems. See *id.* (noting that influenza kills opportunistically). Interestingly—and perhaps tragically—in at least one case of pandemic flu, those who are the healthiest, such as adults between the ages of twenty and forty, may be especially vulnerable. *Id.* at 238–39. During the 1918 pandemic, many adults in their prime died because their immune systems responded so strongly that the response itself caused irreparable damage to the lungs and, thus, death. See *id.* at 247 (discussing massive immune response).

⁹² See Lone Simonsen et al., *Pandemic Versus Epidemic Influenza Mortality: A Pattern of Changing Age Distribution*, 178 J. INFECTIOUS DISEASES 53, 55 (1998) (discussing decline in percentage of deaths accounted for by young people).

⁹³ Thomas A. Reichert et al., *The Japanese Experience with Vaccinating Schoolchildren Against Influenza*, 344 NEW ENG. J. MED. 889, 889 (2001).

vaccinated.⁹⁴ In fact, from the perspective of a specific schoolchild, the vaccination entailed individual risks justified (or not) by the benefit to others.⁹⁵ Thus, whether each child individually benefited from the vaccination was not deemed as important as the group benefits.

The vaccination program described above provides one example of a group (or population) benefit, in contrast to an individual benefit. The key to my proposal is defining what types of activities would fall under the definition of community benefit for tax-exempt status. I want to stress that my purpose here is not to *supplant* the responsibilities of public health departments, but rather to use hospitals' community benefit requirements to fill in some of the gaps and *supplement* the role of traditional public health departments. As a result, some activities may be more appropriate as hospital services than others. For example, maternal and well-baby care seem well suited to hospitals, whereas traditional public health surveillance and monitoring of infectious diseases might better remain with public health departments, which have the required epidemiological skills.⁹⁶ Ideally, some of the responsibilities of public health departments, however, could shift to hospital community services, enabling the health departments to focus on other areas.

IV. WHY MOVE AWAY FROM A PRIMARY EMPHASIS ON INDIVIDUAL CHARITY CARE?

Although shifting the focus from individual health benefits to population health benefits has the practical advantage of reallocating much-needed resources into the public health field, there are a variety of other reasons to choose this route. First, as noted above, an emphasis on individual charity care leads nonprofit hospitals to engage in a variety of nonideal practices seeking to

⁹⁴ See *id.* at 893 (noting that aim of program was to reduce transmission of infection within community).

⁹⁵ See *id.* at 890 (noting lawsuits alleging adverse side effects of vaccination).

⁹⁶ I will not address the current problems that public health departments face, including the lack of well-trained professionals in a number of important areas. See, e.g., Kristine M. Gebbie & Bernard J. Turnock, *The Public Health Workforce, 2006: New Challenges*, 25 HEALTH AFF. 923, 923-24 (2006) (noting concerns with size, composition, distribution, skills, and performance among public health workforce).

inflate their charity care “numbers,” such as creating artificially high charges for uninsured patients.⁹⁷

Second, such a shift is in line with the IRS’s current community benefit standard. Ironically, in contrast to hospitals’ almost single-minded attention to individual free care to maintain tax-exempt status,⁹⁸ the history of the creation of the community benefit standard suggests its primary purpose was to *broaden* the financial ability standard⁹⁹ to take into account hospital expenditures beyond charity care.¹⁰⁰ Thus, in a sense, I am simply suggesting one interpretation of a previously articulated standard for tax-exempt status.

Third, a shift from emphasizing individual care to considering population care is conceptually appealing given the role of the government in providing for the welfare of the people.¹⁰¹ To quote Joseph Tussman, “the government’s concern for the individual is not to be understood as special concern for *this* or *that* individual but rather as concern for all individuals. Government, that is to say, serves the welfare of the community.”¹⁰² Likewise, governmental tax policy should encourage practices that return the benefits of tax-exempt status to the community, not simply to an individual member of the community.

Fourth, in some sense, the role of hospitals in providing individual charity care, as opposed to public health care, is a historical artifact. The earliest health care institutions in America

⁹⁷ See *supra* notes 66–67 and accompanying text.

⁹⁸ Diane Freda & Peyton M. Sturges, *Uncompensated Care Biggest Expense For Tax-Exempt Hospitals, IRS Says in Study*, 16 Health L. Rep. (BNA) 932, 932 (July 26, 2007) (discussing IRS survey finding that “uncompensated care made up the largest reported charitable expenditure and was the most frequently reported type of community benefit”).

⁹⁹ See *supra* note 18 and accompanying text.

¹⁰⁰ See Colombo, *supra* note 20, at 30–31 (discussing IRS’s abandonment of charity care requirement in favor of community benefit standard).

¹⁰¹ This conception of the role of government may be even more appropriate in the context of health care. See William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 519–22 (2008) (exploring importance of collective health policy goals and regulatory governance frameworks—as opposed to current focus on individual or relational health law—and noting particular importance of a community approach for public health law).

¹⁰² JOSEPH TUSSMAN, OBLIGATION AND THE BODY POLITIC 28 (1960). For a more detailed discussion of the concept of community, see generally Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 HASTINGS CENTER REP. 28 (1985) (exploring relationship between community and public health).

were the late-eighteenth-century and early-nineteenth-century dispensaries.¹⁰³ The dispensaries were free-standing institutions designed to provide medical services, and they played an important role in educating medical professionals.¹⁰⁴ One of their primary functions was to provide public health care, such as “vaccination for the poor and vaccine matter for the use of private practitioners.”¹⁰⁵ Dispensaries were often viewed as the first line of defense against epidemic diseases, particularly since they could address infectious diseases in poor populations.¹⁰⁶ At the same time, the lack of resources elsewhere often meant dispensaries also acted as social welfare institutions, providing shelter, clothing, and food to poor people.¹⁰⁷ Today, other social welfare organizations are charged with these responsibilities, although health care organizations still may play an important role in connecting patients with available social services. One of the initial arguments for creating community-based dispensaries was that “maintaining the health of the poor would not only save the tax dollars implied by the almshouse or hospital care of chronically ill workers, but would aid the economy more generally by helping maintain the labor force at optimum efficiency.”¹⁰⁸ In other words, society as a whole benefits from providing public health services to the population, and dispensaries played an important historic role in achieving this aim. It became clear, however, that in the absence of broader social welfare services, a dispensary could do little to address public health if it focused solely on medical care and ignored other basic needs, such as food, clothing, and shelter.¹⁰⁹

In the late nineteenth and early twentieth century, more modern hospitals took over the role of educating medical professionals, and

¹⁰³ See Charles E. Rosenberg, *Social Class and Medical Care in 19th-Century America: The Rise and Fall of the Dispensary*, in *SICKNESS AND HEALTH IN AMERICA* 309 (Judith Walzer Leavitt & Ronald L. Numbers eds., 3d ed. 1997) (tracing the founding of American dispensaries).

¹⁰⁴ See *id.* (describing dispensaries as “both the primary means for providing the urban poor with medical care and a vital link in the prevailing system of medical education”).

¹⁰⁵ *Id.* at 310.

¹⁰⁶ *Id.* at 312.

¹⁰⁷ See *id.* at 311 (asserting that dispensary physicians were, in a sense, “*de facto* social workers”).

¹⁰⁸ *Id.* at 312.

¹⁰⁹ See *id.* at 311 (discussing dispensaries’ other philanthropic endeavors).

the dispensaries gradually lost favor as a source of acute care.¹¹⁰ This, combined with the unwillingness of physicians to refer patients to dispensaries because they feared the lost revenue, and the general backlash against providing charity care to perceived undeserving individuals, gradually undermined the dispensary system.¹¹¹ However, while hospitals took over the role of educating professionals, much of the public health function of the dispensaries was lost.¹¹² Individual charity cases involving specific illnesses or injuries provided valuable learning opportunities, and thus hospitals sought these cases.¹¹³ Vaccination and other general public health responsibilities not only failed to provide any source of income to individual physicians, but provided little educational value and thus were not part of hospital care.¹¹⁴ Additionally, individual charity care may have been more in line with the professional ideal of the physician at the bedside, healing and saving the ill patient with the grateful family looking on.¹¹⁵

The role of hospitals as charity care institutions was well established by the beginning of the twentieth century.¹¹⁶ There was a perception (and reality) that hospitals were essentially almshouses for the poor.¹¹⁷ They served mostly lower economic classes and often a large proportion of immigrants.¹¹⁸ The care hospitals provided to poor people created learning experiences for physicians-in-training and also provided an outlet for wealthy individuals to meet their religious charity obligations.¹¹⁹ Many hospitals were affiliated with

¹¹⁰ See *id.* at 317 (acknowledging that dispensaries had become marginal to needs of medical profession by 1920s).

¹¹¹ See *id.* at 318 (noting reasons why dispensaries lost their appeal).

¹¹² See *id.* at 319 (“[T]he death of the dispensary and the transfer of its functions and client constituency to general hospitals has not been an unqualified success.”).

¹¹³ See *id.* at 314 (noting rivalry between hospitals and dispensaries).

¹¹⁴ See *id.* at 317 (discussing economic and intellectual pressures facing hospitals and dispensaries).

¹¹⁵ See *id.* at 315 (discussing social bond between doctors and individual charity care cases).

¹¹⁶ Morris J. Vogel, *Patrons, Practitioners, and Patients: The Voluntary Hospital in Mid-Victorian Boston*, in *SICKNESS AND HEALTH IN AMERICA* 323, 323 (Judith Walzer Leavitt & Ronald L. Numbers eds., 3d ed. 1997) (“[Victorian hospitals] treated the same socially marginal constituency that American hospitals had always served.”).

¹¹⁷ See *id.* at 326 (discussing society’s negative image of Boston City Hospital).

¹¹⁸ See *id.* (describing the patients at Boston City Hospital as mostly poor and foreign-born).

¹¹⁹ See *id.* at 328 (“The poor provided their economic betters the opportunity, the privilege actually, of spending God’s wealth . . .”).

specific religions and often provided spiritual care and teaching as well as medical services.¹²⁰ Charity care was, thus, a fundamental part of the creation of the hospital system, although the system was not necessarily the best way to provide health services, even to poor people.¹²¹ During the initial years, those with money still greatly preferred home health care, or even care through a dispensary, over care in a hospital.¹²² Being forced to use a hospital could be seen as degrading.¹²³ Perhaps because the patient population largely consisted of people from lower socioeconomic classes and the care was provided without compensation, hospital care was often supplied in a routine manner that emphasized ease of administration, rather than "the human component of caring."¹²⁴

As insurance systems and government health care programs such as Medicaid and Medicare developed in the middle of the twentieth century, hospitals began admitting a wider clientele, and their services no longer focused solely on poor populations.¹²⁵ At this time, the push came to move from the traditional financial ability standard to the community benefit standard in tax exemption law,¹²⁶ but the residual notion of hospitals as charity-care providers has lingered, due in part to the historical forces that created the institutions in the first place.¹²⁷ Many of these forces, however, are no longer prevalent. The creation of hospitals focusing on individual charity care and the disappearance of dispensaries having a clearer public health and social welfare role were not the results of some inherent ideal of either medical organization or provision of health

¹²⁰ See *id.* (discussing Boston hospitals' religious connections and spiritual roles in community).

¹²¹ See *id.* at 331 (discussing stigma of receiving charity care).

¹²² See *id.* at 324 (explaining general preference for home care).

¹²³ See *id.* at 325 ("Even the sick poor would avoid the hospital if possible.").

¹²⁴ *Cf. id.* at 331 (indicating that evolution of hospitals suppresses "human component" of medical practice, even today).

¹²⁵ See Richard Kronick, *Valuing Charity*, 26 J. HEALTH POL. POL'Y & L. 993, 998 (2001) (noting shift in clientele from indigent to well-paying patients and attributing shift to rise of Medicare and private insurance).

¹²⁶ See *supra* note 21 and accompanying text.

¹²⁷ See *supra* notes 103–24 and accompanying text.

care.¹²⁸ To the contrary, the educational and monetary needs of the medical profession shaped much of hospitals' history.¹²⁹

Finally, while individual charity care is certainly important, we cannot continue to use nonprofit hospitals as a health care safety net without making additional changes in the system. With the continued push towards health care reform, the need to provide uncompensated care may decrease.¹³⁰ But even if such charity care remains a part of the system, the provision of individual care requires coordination and follow-up, services hospitals may not be well-suited to provide.¹³¹ Simply providing free acute care or a rotating door to treat acute episodes of chronic patients is insufficient. We desperately need a basic system of health care coverage in this country. Various authors have already pointed out the limitations of hospital emergency departments as surrogate primary care providers or chronic disease managers.¹³² Inpatient hospital units are generally not well-suited for either delivery of primary care or overall coordination of care outside the context of an acute episode.¹³³ Even outpatient hospital clinics may have limited ability to take on these functions.¹³⁴ Primary care and coordination

¹²⁸ See Vogel, *supra* note 116, at 331 (“[T]he hospital has not evolved toward any foreordained perfection. It is no more the ideal form of medical organization today than it was of social consideration for the poor in the second half of the 19th century.”).

¹²⁹ See Rosenberg, *supra* note 103, at 317 (asserting that changing intellectual, institutional, and economic pressures in health care led to “centralized and capital-intensive logic of the hospital”).

¹³⁰ See Siegel, *supra* note 75, at 431 (“Large-scale coverage expansion might indeed relieve many pressures on the safety net.”).

¹³¹ There is some question as to whether hospitals are even the best providers of acute emergency care in certain contexts. See, e.g., Mark J. Alberts et al., *Recommendations for the Establishment of Primary Stroke Centers*, 283 JAMA 3102, 3102 (2000) (“[M]any hospitals do not have the necessary infrastructure (personnel and equipment) and organization required to triage and treat patients with stroke rapidly and efficiently.”).

¹³² See, e.g., Doris F. Glick & Karen MacDonald Thompson, *Analysis of Emergency Room Use for Primary Care Needs*, 15 NURSING ECON. 42, 42 (1997) (“[E]mergency rooms are overused for non-urgent health needs that could be more appropriately addressed in a primary care setting.”).

¹³³ See *id.* (discussing overuse of emergency rooms for nonurgent care and reasons why emergency services are used inappropriately).

¹³⁴ See, e.g., Christopher B. Forrest & Ellen-Marie Whelan, *Primary Care Safety-Net Delivery Sites in the United States: A Comparison of Community Health Centers, Hospital Outpatient Departments, and Physicians' Offices*, 284 JAMA 2077, 2083 (2000) (“Greater service intensity and poorer continuity for primary care in hospital outpatient clinics . . . raise the concern over the suitability of these clinics as primary care delivery sites.”).

are the services needed most in the system today, particularly for those individuals who have few health resources or chronic health problems.¹³⁵ If hospitals are not well-suited to provide these services, their community obligations should be met through means other than the provision of individual charity care.

Encouraging hospitals to provide population health benefits, rather than only individual charity care, should present a more cogent basis for continuing tax exemption on federal, state, and local levels. The community benefit given up in lost tax revenues would be returned via community health benefits. A shift from emphasizing individual charity care to emphasizing population health benefits would also spread benefits over a larger proportion of the population. It may also be more politically palatable because population health impacts all socioeconomic classes. Additionally, hospitals are not designed to function as social welfare institutions and may be particularly ill-suited to provide the comprehensive individual health services needed by the poor.¹³⁶ This may be one role government cannot pass on to a private institution in exchange for tax exemption. Better, more comprehensive, and more coordinated coverage through government health care programs like Medicaid may be necessary to provide home health care and long-term nursing care. Hospitals may provide initial charity services, but they lack the resources and structure to provide adequate follow-up care.¹³⁷ Relying on hospitals to provide comprehensive uncompensated health care is both a disservice to those who need the care and a waste of the potential community benefits that could be obtained from hospitals. Shifting the community benefit requirement to encourage population health services will enable hospitals to serve a much needed public health role, will make better

¹³⁵ See Kevin Grumbach & Thomas Bodenheimer, *A Primary Care Home for Americans: Putting the House in Order*, 288 JAMA 889, 890 (2002) ("Nations with primary care-oriented systems tend to have better health outcomes and lower health care costs.").

¹³⁶ Cf. Vogel, *supra* note 116, at 331 (noting that hospitals, as institutions, have "often remained unresponsive to the mass of [their] patients").

¹³⁷ See, e.g., Arlene Luu & Bryan A. Liang, *Case Management: Lessons from Integrated Delivery to Promote Quality Care to the Elderly*, 9 J. MED. & L. 257, 266 (2005) (noting that the fragmentation in care under the current Medicare structure results in lack of planning and follow-up for elderly).

use of their unique resources,¹³⁸ and may help spur the development of a better system of health care for the poor. In Part V, I suggest an approach to achieve this shift.

V. IMPLEMENTING THE CHANGE: A NEW FRAMEWORK FOR COMMUNITY BENEFIT

*[E]ach community is unique and its particular health care problems and needs should be examined and the community benefits provided by health care charitable trusts which serve it should be directed toward addressing the issues and concerns of that community.*¹³⁹

Implementation of the change I have proposed above requires at least five steps. The first concerns the signals and incentives that IRS policies and reporting forms have created, and the authority of the IRS to impose intermediate sanctions for noncompliance. The second involves creating an oversight mechanism to ensure that hospitals provide appropriate benefits for the communities in which they operate. The third requires a shift away from measuring monetary outlays to measuring beneficial effects of services that tax-exempt hospitals offer; this step requires developing both a framework of standard measurements and tools to quantify the benefit. Fourth, some changes in the timeline for evaluating community benefit may be necessary to accommodate the shift to measuring outcomes. Each of these four steps is discussed in more detail in the subparts below. The final aspect of my proposal addresses legislative changes needed at the state level; this step is explored in Part VI.

¹³⁸ See David A. Hyman & William M. Sage, *Subsidizing Health Care Providers Through the Tax Code: Status or Conduct?*, 25 HEALTH AFF. w312, w314 (2006), <http://content.healthaffairs.org/cgi/reprint/25/4/W312> (suggesting broad community benefit standard may increase efficiency and encourage nonprofit hospitals to engage in promoting overall community or public health).

¹³⁹ N.H. REV. STAT. ANN. § 7:32-c (LexisNexis 2008).

A. FEDERAL LEVEL CHANGES

1. *Policy Drivers.* Rather 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. In testimony before Congress in the early 1990s, the Treasury Department resisted calls for specific guidelines on community benefit and pointed out that crafting a specific charity care standard would create an “incentive to divert . . . services to the form of care that best protects [hospitals] tax-exempt status,”¹⁴⁰ rather than allow for a range of useful efforts focused on the needs of specific communities. An exclusive list of specific population services could result in the same diversion of resources. Ideally, tax documents would provide broad guidelines and perhaps general examples to shift hospitals’ behaviors in appropriate directions.

The redesigned Form 990 has made some initial progress on this front. For example, it includes “community health improvement services” as part of its accounting of community benefit.¹⁴¹ However, it does not provide enough of an incentive for hospitals to focus on providing true community benefits. A change as simple as moving the community health services worksheet to the top of the list—from its current location after traditional charity care, uncompensated individual care, bad debt, and unreimbursed costs under government programs¹⁴²—could send a message about the importance of this type of community benefit compared to that of the others.

Without providing an exclusive list, the IRS—through Form 990 or some other means—could provide additional guidance as to what types of activities count as community health improvement services.¹⁴³ The IRS currently defines those activities broadly as

¹⁴⁰ Hyatt & Hopkins, *supra* note 14, at 35.

¹⁴¹ I.R.S. Form 990, Schedule H, *supra* note 71. Public health benefits may also fall into the category of “subsidized health services,” recounted on worksheet 6 of Form 990. *See id.* at Part I (listed under “Other Benefits”).

¹⁴² *Id.* at Part I.

¹⁴³ It may be worth considering whether hospitals should receive community benefit credit for making efforts to improve environmental health, including efforts within their own buildings and infrastructure. While these efforts can be beneficial to a community, my goal is not to allow a hospital to divert all of its community benefit funds to internal projects.

“activities carried out or supported for the express purpose of improving community health.”¹⁴⁴ IRS Form 13790, for example, includes questions about community screening, immunization, educational seminars, and studies of unmet health needs.¹⁴⁵ The IRS could emphasize certain areas, such as maternal and well-baby care; for example, a hospital might institute a postpartum depression screening program.¹⁴⁶ Mental health care is another long-underfunded area that fits nicely under the heading of population care, given its potentially broad community impact. Additionally, in light of the current aging trends in our populations, elder care services could easily be part of a community benefit package. The key inquiry is whether the services are needed and would actually benefit the community in which the hospital is located.

Research activity presents a different issue. One author has suggested there should be a categorical tax exemption for hospitals based on their involvement in research.¹⁴⁷ Research activities funded by outside sources, however, should not count towards a hospital's community benefit obligation. The IRS includes questions about medical research efforts in both Form 13790¹⁴⁸ and Form 990.¹⁴⁹ While I have no doubt that research efforts are important, my focus here is more on benefits to the specific community populations each hospital serves. Under this framework, research studies focused on identifying the health care needs of the

¹⁴⁴ FORM 990 REDESIGN, *supra* note 72, at 2.

¹⁴⁵ I.R.S. Form 13790, *supra* note 55, at Part II.

¹⁴⁶ See Nada Stotland, Letter to the Editor, *There is a Strong Case to be Made for Postpartum Depression Screening*, AM. MED. NEWS, Apr. 28, 2008, at 22 (noting the convenience and public health benefits of this service).

¹⁴⁷ In order to get the exemption, hospitals would document:

research grants they have received, the results of that research, surgical or medical breakthroughs pioneered at the hospital, and any other relevant information demonstrating innovation on the part of the hospital and/or its medical staff, the ways in which that innovation has benefited the national community, and the percentage of the hospital's budget dedicated to this purpose.

Helena G. Rubinstein, Note, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381, 426 (1997). Although I will not evaluate this argument, it may be that research efforts should be counted as a population health benefit.

¹⁴⁸ I.R.S. Form 13790, *supra* note 55, at Part II.

¹⁴⁹ I.R.S. Form 990, Schedule H, *supra* note 71.

particular community, certain types of public health research, and efforts to engage in community disaster response planning¹⁵⁰ all could count as population health benefits,¹⁵¹ as long as they received no outside funding. In fact, disaster relief planning may already be incorporated under community benefit operations in IRS Form 990.¹⁵²

Listing some or all of these suggestions as part of a compliance checklist or guidance document will send clear signals to hospitals. IRS Forms 13790 and 990 already do this to some extent, but the categories of population health benefits should be more prominent and explicit, and questions about individual charity care should be de-emphasized. Given the detailed attention that hospitals pay to IRS tax forms, something as simple as placing the community-benefit-operations questions before the charity-care questions may have an impact. These measures, coupled with IRS guidance documents emphasizing a preference for population benefits over individual benefits, should encourage a change in hospitals' approaches to providing community benefits.

2. *Intermediate Sanctions.* In 1996, Congress amended the tax laws to allow the IRS to impose more moderate sanctions on nonprofit institutions, instead of presenting the IRS with a harsh choice between allowing noncompliance and withdrawing tax-exempt status.¹⁵³ However, the change is specific to excess benefit transactions,¹⁵⁴ and permits the imposition of excise taxes based on

¹⁵⁰ It is not clear, however, that hospitals should coordinate such efforts or that hospitals will be the appropriate locations for providing health care in disasters. See, e.g., Kenneth Kipnis, *Overwhelming Casualties: Medical Ethics in a Time of Terror*, in *IN THE WAKE OF TERROR* 95, 105 (Jonathan D. Moreno ed., 2003) (“[D]uring a catastrophe, hospitals cannot serve as the primary locus of health care.”).

¹⁵¹ Consider, for example, recent regional health information organization (RHIO) efforts to obtain tax-exempt status. See Diane Freda & Peyton M. Sturges, *IRS Considering Exemption Applications of RHIOs Seeking to Operate as Nonprofits*, 16 Health L. Rep. (BNA) 337, 337 (Mar. 22, 2007) (“[The] Internal Revenue Service has been asked to grant tax-exempt status to regional health information organizations . . .”).

¹⁵² See I.R.S. Form 990, *supra* note 71, at 3 (defining community benefit operations to include “costs associated with community benefit strategy and planning”).

¹⁵³ See *supra* note 34 and accompanying text.

¹⁵⁴ Excess benefit transactions are “transaction[s] in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person if the value of the economic benefit provided exceeds the value of the consideration. . . .” 26 U.S.C. § 4958(c)(1)(A) (2006). Disqualified persons include anyone in a position to exert substantial influence over the affairs of the organization during the five-

the amount of the excess benefit.¹⁵⁵ It may be useful to consider imposing intermediate sanctions for violations of the other IRS requirements, including the community benefit standard; but 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. This is not currently the case, at least at the federal level.¹⁵⁶ Moreover, the difficulties and complexities of applying 26 U.S.C. § 4958, even in the area of excessive compensation—where the standards are clearer than in the area of community benefit—indicate that the creation of intermediate sanctions may not be ideal.¹⁵⁷

Alternatively, failure to meet community benefit requirements might trigger additional IRS oversight, review, and reporting obligations—rather than specific monetary penalties—in order to ensure hospital compliance. In this situation, fear of revocation of federal tax-exempt status would remain the primary impetus to provide community benefit. This fear, along with the fear of losing local and state tax exemption, should provide a significant motivation to implement the changes I propose below. While federal changes allowing additional IRS oversight and the imposition of intermediate sanctions may be appropriate, this Article focuses on changes that should be made at the state level.¹⁵⁸ Future legislation that allows greater flexibility in the application of federal sanctions

year period ending on the date of the transaction, a family member of such a person, or an entity of which such a person controls more than thirty-five percent. *Id.* § 4958(f)(1)(A)–(C).

¹⁵⁵ *Id.* § 4958(a)(1).

¹⁵⁶ Senator Grassley and his staff have proposed a system of intermediate sanctions specifically aimed at enforcing the community benefit standard, though no such system has yet been implemented. See STAFF OF S. COMM. ON FIN., 109TH CONG., TAX-EXEMPT HOSPITALS: DISCUSSION DRAFT 15 (2007), available at <http://grassley.senate.gov/releases/2007/07182007.pdf> (recommending excise tax on hospitals that fail to meet quantitative requirements). The proposal suggests nonprofit hospitals should be required to dedicate at least five percent of their annual patient operating expenses or revenues to community benefit. *Id.* at 12. According to the draft, failure to do so would result in excise taxes of at least twice the amount of the hospital's shortfall. *Id.* at 15.

¹⁵⁷ See, e.g., Bernadette M. Broccolo et al., *The Price is Right!—Taxpayers Prevail in the First Case to Review IRS Imposition of Intermediate Sanctions*, 19 HEALTH LAW., Oct. 2006, at 1, 1 (describing Fifth Circuit case determining that IRS could not impose excise taxes because it could not prove value of excess).

¹⁵⁸ See *infra* Part VI.

could provide a further basis for encouraging the changes described below.

B. CREATING A COMMUNITY BENEFIT BOARD

Sending signals that emphasize the importance of population health benefits over individual charity care is only a first step. In addition, an oversight mechanism must be created, aside from the current IRS reporting, to ensure that the services offered are, in fact, beneficial to the specific community in which the hospital operates. I suggest the creation of a special committee—a community benefit board—to evaluate and recommend appropriate population health efforts under the community benefit requirement.¹⁵⁹ Despite the requirement in IRS Revenue Ruling 69-545 that a hospital's governing board should be representative of the community,¹⁶⁰ using the existing governing board to oversee community benefit is not adequate. Like other governing boards of prominent institutions, hospital board members may have been chosen for their financial or social connections, rather than their ability to ensure community benefit.¹⁶¹ Additionally, hospital governing boards will owe their primary loyalty to the institution, rather than to the community. Instead of revamping the general governing structure of hospitals, we should create a separate committee to oversee community benefit. Each community benefit board (CBB) could have multiple nonprofit hospitals within its jurisdiction.

The idea of creating a board with responsibility for determining community benefit is not new. A similar model was used when a

¹⁵⁹ One author has suggested a tax-exempt compliance committee to oversee a hospital's community benefit care. Nancy M. Kane, *Tax-Exempt Hospitals: What is Their Charitable Responsibility and How Should it Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 472 (2007). Another suggested a community certification panel that would create a community medical needs plan to access the community health care needs. See Crimm, *supra* note 15, at 107; see also Hyman & Sage, *supra* note 138, at w315 (stressing that individual communities have taken significant role in determining activities that suffice for tax exemption).

¹⁶⁰ See *supra* note 27 and accompanying text.

¹⁶¹ See *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways & Means*, 109th Cong. 117 (2006) (statement of Nancy M. Kane, Professor, Department of Health Policy and Management, Harvard School of Public Health) (suggesting boards are chosen for wealth, social connections, or compatibility with hospital management).

nonprofit hospital converted to for-profit status, and a foundation was created to oversee the distribution of charitable funds after the conversion and ensure that the funds continued to benefit the community.¹⁶² The idea of evaluating benefits for each specific community is also not new. For example, the Community Reinvestment Act (CRA) is designed to “encourage [financial] institutions to help meet the credit needs of the local communities in which they are chartered”¹⁶³ Under the CRA, federal agencies view records of banks’ efforts in their home communities in making determinations about applications for deposit facilities, including applications for mergers and acquisitions.¹⁶⁴ Similarly, health care facilities have long been required to obtain certificates of need (CONs) before building new structures,¹⁶⁵ and state public health councils are charged with evaluating the community needs before issuing the certificates.¹⁶⁶ Thus, creating a board to evaluate community needs and benefits has precedent in a number of areas. In fact, some federal congressional health reform proposals have

¹⁶² See Christopher W. Frost, *Financing Public Health Through Nonprofit Conversion Foundations*, 90 KY. L.J. 935, 968–71 (2001–2002) (discussing creation of The Foundation for a Healthy Kentucky using settlement funds).

¹⁶³ 12 U.S.C. § 2901(b) (2006).

¹⁶⁴ *Id.* §§ 2902, 2903.

¹⁶⁵ See Josephine Gittler, *Hospital Cost Containment in Iowa: A Guide for State Public Policymakers*, 69 IOWA L. REV. 1263, 1314 (1984) (noting federal act mandating CON laws in all states to control hospital expenditures); see also *supra* note 42 and accompanying text.

¹⁶⁶ Initially, federal law required CON programs, and all states had an agency that would evaluate the need for a new hospital or hospital service. See Gittler, *supra* note 165, at 1314 (noting that Iowa enacted CON legislation in accordance with federal law). By many accounts, the CON requirement failed to control costs, and there was still significant duplication of health care services. See *id.* at 1315 (explaining general disillusionment after CON programs failed to control costs). Although the federal requirement was repealed in 1987, a majority of states still have state legislation requiring community review and the issuance of a CON before opening new facilities. See generally The National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs, <http://www.ncsl.org/programs/health/cert-need.htm> (last visited Sept. 10, 2009) (analyzing state CON programs). Some particular concerns about the federal CON program were that community committees rarely refused to issue a CON or were co-opted by various business interests. See Gittler, *supra* note 165, at 315–16 (discussing criticism of CON programs). These concerns are not applicable to the community benefit board that I suggest. Here, the committees do not decide whether their community needs a new health facility—a question often answered in the affirmative—but instead engage in a zero-sum game of determining which health care services the community is most likely to need. Thus, while there was no limit on the number of CONs that could be issued, there is a limit on the amount of money that community benefit programs can spend.

included community-needs-assessment requirements for tax-exempt hospitals.¹⁶⁷

The community benefit board suggested here would be comprised of a variety of local community members. Although the concept of “community” is subject to a number of interpretations—geographic communities, religious communities, or communities defined by specific illnesses¹⁶⁸—the composition of the board conceived of here is likely to be defined using geographic parameters, reflecting the community of persons who use and benefit from the hospital health care services within the jurisdiction of the local taxing authority. Thus, the community that would otherwise receive the local or property taxes determines which community benefits it will accept in lieu of tax revenues. This does not mean the board that makes the tax determination should be the same as the CBB, it merely means that the community from which the CBB representatives should be drawn is determined by the local tax jurisdiction. Representation from the local health department will be essential, as may representation from other social services agencies. Given that the hospital’s community may be broader than the jurisdiction of municipal health departments, representatives from multiple departments may be appropriate. In addition, there should be multiple community representatives—lay health care consumers, community leaders, and other appropriate individuals. The CBB should be independent of any hospital’s administration, although a CBB member may be drawn from the staff of each institution within the board’s jurisdiction.

Many large hospital organizations are likely to have institutions located in multiple taxing authorities. This situation is at the root of some current tax battles in which a local tax authority claims that the facility within its borders does not provide any charity care, even

¹⁶⁷ See, e.g., Diane Freda, *Exempt Hospital Proposals for Health Reform Launch New Debate on Change in Standards*, 18 Health L. Rep. (BNA) 651, 652 (May 21, 2009) (“[A] 1993 White House Task Force on health reform included a community needs assessment proposal in its final report that ended up in the Health Security Act but was not enacted.”).

¹⁶⁸ See Patricia A. Marshall & Jessica W. Berg, *Protecting Communities in Biomedical Research*, 6 AM. J. BIOETHICS, May/June 2006, at 28, 28–29 (describing fluid nature of notion of community).

though another facility within the same health care organization provides significant community benefits.¹⁶⁹

The CBB might evaluate whether a reasonable portion of the hospital's efforts to comply with the community benefit requirement create actual population health benefits, or the CBB may simply set priorities for public health benefits within their community.¹⁷⁰ In either case, the CBB should provide initial guidance as to the range of community benefit services deemed important in the particular community, perhaps creating a list of possible needs, or even a hierarchy of priorities. Additionally, the CBB might evaluate a proposal for a community benefit program for a specific hospital. The CBB should document its recommendations, as well as the hospital's responses, and this information should be available to the IRS for evaluating community benefit, or to local tax authorities for determining property and local tax exemptions. In the event of a disagreement between the hospital and the CBB regarding the most appropriate community benefit funds, the taxing authorities will have the final say. While this system gives the CBB significant power to indicate priorities for community benefit activities in its locale, it also ensures that hospitals can make different choices and show that their choices resulted in community benefit sufficient to retain tax-exempt status. Additionally, the limitation on a CBB's power to mandate a specific community benefit program reflects the reality that tax exemption determinations happen at multiple levels. Thus, a state or federal taxing authority may be interested in the combined evaluations of different local CBBs in making the decision as to whether a hospital is exempt from state or federal taxes. It is

¹⁶⁹ See *infra* notes 171-72 and accompanying text.

¹⁷⁰ One possibility would be to have the CBB create a weighted ranking system, incentivizing desired types of community benefit programs. Thus, an informational marketing program to promote recommended screening for certain populations might be given a "weight" of .75 for each dollar spent, individual charity care given a weight of 1.0 per dollar spent, and money spent on prioritized public health programs given a weight of 1.5 per dollar spent. On the other hand, this system might give too much authority to the CBB in specifically directing hospital resources. Moreover, I believe more emphasis should be placed on outcomes assessment than money spent. See *infra* notes 175-77 and accompanying text. I recognize, however, that there may be a variety of creative ways to quantify community benefits, and any system will likely have to take into account both the hospital's initial monetary outlays and the outcomes assessments. Perhaps a system that simply incentivizes outcomes measurement will be developed. See *infra* Part V.C.

certainly possible—as it is under the current system—that a hospital will have provided sufficient community benefit at a state or federal level, but not with respect to a specific community.

A final interesting question is whether a hospital system,¹⁷¹ with the assent and approval of the CBB, can delegate to another of its facilities—or even to another institution's facilities—its community benefit obligations. One option is to create a type of community benefit “credit system”—similar to carbon emissions credits, for example. A hospital that is well-positioned to provide significant community benefits may have excess credits it could either distribute among multiple facilities or sell to institutions that provide fewer benefits. In either situation, the alternative facility or institution would likely still have to be located within the community in question, as convincing a CBB to allow benefits to flow to another community in exchange for tax exemption in the other community may be difficult. Such restrictions may be short-sighted, however, as health care facilities may serve overlapping tax communities beyond those in which they are physically located;¹⁷² a health care community is not necessarily coterminous with a tax community. One response to this criticism is to note that state and federal tax authorities have the ability to look across multiple communities, so a hospital that chose not to provide a benefit in one community would only risk losing local tax exemption.

Perhaps this is exactly what should happen. If local tax exemption means the local community foregoes tax revenues it would otherwise receive, then the local community should benefit; in the absence of those benefits, the local community should gain the tax revenues. Hospitals may still present the benefit programs other facilities undertake as benefits to the specific community in question, as there is no reason to think—merely because the facility coordinating the program is not physically located in a

¹⁷¹ Throughout this Article I refer to “hospitals,” but the reality is that most hospitals are really part of health care systems with multiple facilities, scattered throughout a city, region, state, or even country. See Thomas L. Greaney & Kathleen M. Boozang, *Mission, Margin, and Trust in the Nonprofit Health Care Enterprise*, 5 YALE J. HEALTH POL'Y L. & ETHICS 1, 26 (2005).

¹⁷² See, e.g., Richard D. Pomp, *State Tax-Reform: Proposals for Wisconsin*, 88 MARQ. L. REV. 45, 85 (2004) (giving example of hospitals in Connecticut with less than half of their patients living in city where hospital is located).

community—that the community does not benefit. In fact, unlike individual charity care services, population health services are more likely to benefit multiple communities. Thus, CBBs should be free to consider creative approaches to community benefit programs, including potentially allowing a type of credit system to function between and among hospitals and facilities.

C. EVALUATING AND QUANTIFYING THE BENEFIT

Assuming agreement is possible regarding what constitutes a public health benefit in contrast to an individual health benefit, and the CBB can identify community priorities, the next most difficult aspect of the above proposal will be quantifying the benefit.¹⁷³ As stated previously, one of the primary reasons for the revision of Form 990 was to provide a more standardized mechanism for quantifying community benefit, although it still focused a great deal on individual charity care.¹⁷⁴ How should we quantify population health benefits?

One possibility is to measure the expenses for providing population health services, similar to the ways in which individual charity care costs are calculated. Any charges for the services or reimbursements from public or private benefit programs would be deducted. However, an accurate measure of population health benefit may not be gained from simply measuring the hospital's monetary outlay. Instead, institutions should be encouraged to

¹⁷³ Many commentators have suggested benchmarks to judge the sufficiency of total community benefit expenditures. Some authors have suggested the tax exemption benefit be quantified and used as a standard against which to evaluate community benefit. See, e.g., Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 URB. LAW. 143, 169–70 (1994) (discussing formula in which tax benefit from tax-exempt status must be calculated to test nonprofit's exempt status); Jack Hanson, *Are We Getting Our Money's Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals*, 17 LOY. CONSUMER L. REV. 395, 398–400 (2005) (suggesting hospital community benefit programs should equal or exceed value of preferential tax treatment). But see Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 396 (1991) (suggesting benchmark be percentage of operating budget that comes from donations); Sean Nicholson et al., *supra* note 80, at 172 (suggesting benchmark be sum of similarly situated for-profit hospital's tax payments, community benefits, and after-tax profits, adjusted for asset and equity differences between institutions). Review of suggested standards is beyond the scope of this Article.

¹⁷⁴ See *supra* note 72 and accompanying text.

measure the actual effects or outcome of their efforts.¹⁷⁵ Measuring effect is advantageous both because it should discourage creative accounting similar to what currently occurs regarding individual charity care,¹⁷⁶ 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.

This is not to imply that shifting to an evaluation measuring effect is simple. To the contrary, determining how to measure health benefits has long plagued both the individual and public health fields.¹⁷⁷ In order to measure health benefits, one must first define what constitutes "health"—a term that can be defined so broadly as to include almost every aspect of life. Consider, for example, the definition of health in the World Health Organization's 1946 Constitution: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹⁷⁸

In addition to determining what aspects of life should fall into the health category (as opposed to, say, a happiness category), we must also identify qualitative and quantitative standards and develop valid and reliable measurement tools. These tools must accommodate the fact that while health is subjectively "experienced by an individual," it must be measured with an "external instrument."¹⁷⁹ One author explains that "measures for gauging outcomes fall into seven basic categories: participation, mind states, behavior, health status, sickness care utilization, sickness care expenditures, and community value."¹⁸⁰ Except for sickness care

¹⁷⁵ R. Scott MacStravic argues that hospitals should demonstrate effect for all community benefit activities, even uncompensated care. See R. Scott MacStravic, *Demonstrating Value: Healthcare Organizations Can Document Positive Outcomes from Their Community-Benefit Services*, 80 HEALTH PROGRESS, Jan.-Feb. 1999, at 54, 57 (arguing hospitals should document "complete set of effects of contributions to the community").

¹⁷⁶ See *supra* notes 61-65 and accompanying text.

¹⁷⁷ See, e.g., JOHN BRAZIER ET AL., MEASURING AND VALUING HEALTH BENEFITS FOR ECONOMIC EVALUATION 8 (2007) ("One of the things that make[s] health consequences difficult to assess is that they are multidimensional, uncertain and disparate.").

¹⁷⁸ WORLD HEALTH ORG. CONST. pmbl. (1946), available at http://www.searo.who.int/LinkFiles/About_SEARO_const.pdf.

¹⁷⁹ BRAZIER ET AL., *supra* note 177, at 15.

¹⁸⁰ MacStravic, *supra* note 175, at 54.

expenditures, these measurements do not translate directly into dollar amounts.¹⁸¹

Measuring may prove especially difficult for public health benefits.¹⁸² As many authors adroitly point out, when public health interventions work well, the result is a lack of illness and, thus, a lack of apparent benefit.¹⁸³ Moreover, even when one can identify the benefit (for example, lack of harm), there are different mechanisms used to value statistical lives saved, lack of pain and suffering, gains in productivity, and risk reductions. There are, however, a number of traditional public health tools that might be used to measure the impact of a particular intervention. The tools may vary depending on the intervention, and the key may be to ensure that the hospital—ideally via the community benefit board described above—identifies at the outset what the measures of benefit will be for any particular intervention. Interventions may have short-term (one-to-three-year), mid-range (three-to-five-year) and long-term (ten-year or longer) measures of benefit, and for each measure, specific standards should be identified.

A few rough examples may help demonstrate how this measuring could work. First, suppose a hospital offered free flu shots for a community. A hospital could gather the following data:

- (1) Number (or proportion) of people immunized;
- (2) Number (or proportion) of people at (high) risk who are immunized;
- (3) Number (or proportion) of people immunized who show serologic response;
- (4) Number (or proportion) of people immunized and later exposed in whom clinical disease does not develop;

¹⁸¹ *Id.* at 57.

¹⁸² See NAT'L RESEARCH COUNCIL, ASSESSMENT OF PERFORMANCE MEASURES FOR PUBLIC HEALTH, SUBSTANCE ABUSE, AND MENTAL HEALTH 2 (Edward B. Perrin & Jeffrey J. Koshel eds., 1997) (discussing lack of data sources for performance monitoring of health statistics).

¹⁸³ See, e.g., ANN ASCHENGRAU & GEORGE R. SEAGE III, ESSENTIALS OF EPIDEMIOLOGY IN PUBLIC HEALTH 3 (2003) ("Unfortunately, public health achievements are difficult to recognize because it is hard to identify people who have been spared illness." (footnote omitted)).

- (5) And number (or proportion) of people immunized and later exposed in whom clinical or subclinical disease does not develop.¹⁸⁴

Immunization of a certain percentage of the population will lead to herd immunity,¹⁸⁵ but even vaccination programs that do not achieve herd immunity can reduce the incidence disease in a population. The value of that reduction can be stated in terms of the monetary value of fewer physician visits, fewer days of work lost due to sick employees, and even deaths avoided. Likewise, an infectious disease screening program can be evaluated based on:

- (1) Number of cultures taken (symptomatic or asymptomatic);
- (2) Number (or proportion) of cultures positive for infection;
- (3) Number (or proportion) of persons with positive cultures for whom medical care is obtained;
- (4) Number (or proportion) of persons with positive cultures for whom proper treatment is prescribed and taken;
- (5) And number (or proportion) of positive cultures followed by a relapse.¹⁸⁶

Second, a hospital might, for example, institute an emergency room screening program for domestic violence¹⁸⁷ or a community screening program for diabetes. Benefits of screening programs may be estimated through calculation of the incremental cost effectiveness ratio: cost per years of life saved or cost per injuries avoided. A screening program for an infectious disease, for example, could have the benefit of preventing the spread of infection, thereby

¹⁸⁴ See GORDIS, *supra* note 88, at 267 (providing end points for measuring success of vaccine program).

¹⁸⁵ See *supra* note 88 and accompanying text.

¹⁸⁶ See GORDIS, *supra* note 88, at 267 (providing end points for measuring success of culture program).

¹⁸⁷ See Harriet L. MacMillan et al., *Approaches to Screening for Intimate Partner Violence in Health Care Settings*, 296 JAMA 530, 530-33 (2006) (describing study of screening procedures for "intimate partner violence" in various health care settings).

preventing additional physician visits. The quantifiable benefit to the community of a particular screening program would depend on a number of factors, including: the prevalence of the disease or problem in the specific community; the sensitivity (ability to pick up a true positive) and specificity (ability to pick up a true negative) of the test; and the possibilities for treatment or intervention.¹⁸⁸ These measurements are based on statistical models that can provide at least general estimates of benefits in monetary terms.¹⁸⁹

Similarly, for any given exposure or causal factor, we can calculate the etiologic fraction (or “attributable risk”), which represents the proportion of the disease or disability that will be eliminated if the exposure or causal factor in question is eliminated.¹⁹⁰ For example, if a certain percent of diabetes cases are a result of obesity, then lowering obesity in the population should lower the diabetes disease burden on the population. Conversely, if something protects against disease, a prevented fraction (or “avoidable mortality”) can be calculated to estimate the impact of instituting the protective measure.¹⁹¹ For example, public health officials often calculate the percentage of dental caries prevented by the implementation of drinking water fluoridation.¹⁹² Like estimates of vaccine effectiveness, the attributable risk and prevented fraction can be calculated mathematically to provide another basis for quantitative determinations of hospitals’ efforts to provide community benefits.

Finally, hospitals could use measures of general health indicators to get an overall picture of community health benefits subsequent to either a specific intervention or a series of interventions. Under this

¹⁸⁸ See, e.g., Alexandra Barratt et al., *Users' Guides to the Medical Literature: XVII. How to Use Guidelines and Recommendations About Screening*, 281 JAMA 2029, 2029–34 (1999) (analyzing guidelines used to measure effectiveness of screening programs).

¹⁸⁹ See GORDIS, *supra* note 88, at 267 (noting measures must be quantifiable and lend themselves to standardization for study).

¹⁹⁰ $AR_i = [(R_e - R_u) / R_u] \times 100$; Attributable Risk = [(Incidence of disease in population – Incidence of disease in unexposed individuals in population) ÷ Incidence of disease in unexposed individuals in population] x 100.

¹⁹¹ $PF = [(R_u - R_e) / R_u] \times 100$; Prevented Fraction = [(Incidence of disease in unexposed group – Incidence of disease in exposed group) ÷ Incidence of disease in population] x 100.

¹⁹² See Edwin Pratt, Jr., Raymond D. Rawson & Mark Rubin, *Fluoridation at Fifty: What Have We Learned?*, 30 J.L. MED. & ETHICS 117, 117 (2002) (noting that studies have shown decline in dental caries since introduction of drinking water fluoridation).

approach, hospitals could measure and plot the incidence of certain conditions over time or compare them to incidence and prevalence data for other populations.¹⁹³ However, evaluating general health indicators may be more problematic than the other measurement options described above for several reasons. First, it can be difficult to identify key conditions that can be used as markers for general community health. Second, the comparisons require identifying equivalent communities or having a period of time over which to plot the data for an internal comparison. Third, the comparisons assume a somewhat static population in the communities compared. Nonetheless, this typical public health measurement, along with the others identified above, can be used to quantify community benefit.

In summary, hospitals should be encouraged, if not required, to identify short-, medium- and long-range goals for community benefit interventions and upon which their impact will be evaluated. While all community benefits will ideally be evaluated on outcomes rather than the amount spent, there may be resistance to the idea that a hospital could spend a significant amount of money on a program and gain little or no credit because the outcomes are not as expected. One way to address this concern would be to acknowledge the monetary outlay at a discounted rate or, alternatively, to weight the outcome benefits at twice the value of the money spent, thus providing an incentive to measure end results.

Not only is quantifying population health benefits possible, but it is likely that hospitals already gather some of the necessary data for their own purposes.¹⁹⁴ For example, one hospital created a database to “track individuals from point of contact such as a community screening through clinic experience . . . [to measure] community benefit by identifying the number of individuals reached, those at

¹⁹³ These measurements are already gathered in some areas, such as environmental toxins, on which the Agency for Toxic Substances & Disease Registry (ATSDR) gathers data. ATSDR is part of the Centers for Disease Control (CDC), which falls under the Department of Health and Human Services. See generally Agency for Toxic Substances & Disease Registry, <http://www.atsdr.cdc.gov/> (last visited Sept. 10, 2009).

¹⁹⁴ A recent trend has also encouraged hospitals to gather outcome data for individual health care under the rubric of “evidence based medicine.” See, e.g., David L. Sackett et al., *Evidence Based Medicine: What It Is and What It Isn't*, 312 BRIT. MED. J. 71, 71 (1996) (explaining that evidence based medicine “is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients”).

risk, and the subsequent care and improved health status through services at the hospital.”¹⁹⁵ Increasing incentives to gather such data by linking it with tax exemption should motivate hospitals to do more evaluations of their interventions, resulting in more public health services overall, more services targeted to the specific needs of the community, and possibly also a source of data on the benefits or lack of benefits of specific public health interventions. The need, however, to gather this data—and the potentially lengthy period of time needed to evaluate the data—create one final problem associated with the current annual tax-reporting structure.

D. COMMUNITY BENEFIT TAX REPORTING AND EVALUATION

One of the few disadvantages of tax-exempt status is the extensive annual reporting requirements.¹⁹⁶ While annual reporting may be necessary, some changes, at least initially,¹⁹⁷ must be put into place to accommodate the shift from expense accounting to impact evaluation. Here, there are two concerns. First, population health benefits may take longer to become apparent than individual health care benefits. Second, while monetary outlays can easily be identified in a specific tax year, the effect of those outlays may not occur until many years later. As such, there must be a mechanism for tax-exempt hospitals to quantify community benefit over multiple years.

Multi-year accounting is used in other areas. For example, many businesses use accrual methods of accounting for tax purposes, matching the income earned under a contract to the expenses paid under the contract.¹⁹⁸ In such a model, any contract that is

¹⁹⁵ Arthur C. Sturm, Jr., *Take Your Community Benefit Reporting to the Next Level*, HEALTHCARE FIN. MGMT., Jan. 2007, at 118, 120.

¹⁹⁶ See Hyatt & Hopkins, *supra* note 14, at 24 (discussing annual tax return requirements for tax-exempt organizations, which can be more extensive than reporting requirements for for-profit organizations).

¹⁹⁷ There will be an initial time lag during which community benefit will be hard to calculate during a year, because the institution will move from evaluating the monetary outlay during that year to measuring the benefits in the community from a specific outlay.

¹⁹⁸ See 26 U.S.C. § 446(c) (2006) (listing permissible methods of accounting). Alternatively, one may use a cash-basis accounting method (as most individuals do), which results in taxation only on the actual cash income received in a given tax year and allows for the deduction of expenses only when paid in a given tax year. See *id.*

considered long-term (exceeding one tax year) requires calculating the income and expenses over multiple tax years. To address this problem, a business may in some contexts calculate the percent completed under the contract and report that percent of income as taxable in the particular year.¹⁹⁹ Another example of multi-year tax reporting occurs in calculating the amount of deductions for net operating losses, which are losses that exceed income.²⁰⁰ Federal tax law allows businesses to carry these losses forward twenty years or back two years,²⁰¹ implicitly accommodating the fact that the businesses function on a continuous basis even though tax-reporting occurs annually.

For evaluating tax-exempt status, the IRS and local tax authorities should likewise think in multi-year terms because although the value of the tax exemption accrues to the hospital on an annual basis, the benefit of its community health programs may vary considerably from year to year. It may be useful for the IRS to explicitly indicate how to handle multi-year accounting, as it has done in other contexts, such as those noted above.²⁰² For example, it may be helpful to set the number of years a community benefit amount can be carried forward or backward when balanced against each year's tax exemption benefit. Likewise, states may want to explicitly identify appropriate mechanisms for multi-year accounting for purposes of state and local tax exemption. Ideally, hospitals would be responsible for determining when and how to balance various community benefits against tax exemption as part of their annual reporting obligations, as opposed to requiring tax authorities to gather and evaluate this information.

E. NOT A PANACEA, BUT A FIRST STEP

Providing regulatory incentives for hospitals to provide population health benefits and requiring the creation of community benefit boards are unlikely to address all of the concerns

¹⁹⁹ See *id.* § 460(b) (allowing percentage of completion method of calculation).

²⁰⁰ See *id.* § 172(a) (2006) (specifying net operating loss deduction).

²⁰¹ *Id.* § 172(b)(1)(A).

²⁰² See *supra* notes 198–201 and accompanying text.

surrounding hospitals' tax-exempt status.²⁰³ Moreover, the framework this Article proposes is not without its own potential problems. For example, a policy that encourages population health benefits assumes hospitals can identify and quantify these benefits. It may be even more difficult to quantify population health benefits than it currently is to quantify individual health benefits. One author suggests it is tricky to distinguish between true community benefit programs and marketing initiatives.²⁰⁴ Additionally, population health benefits may take longer to become evident and thus may be hard to measure for yearly tax reporting. Finally, one must assume that linking the population care requirement to tax-exempt status will result in an increase in hospitals' overall population care efforts. It is possible, however, that we will instead see an attempt to categorize existing efforts in the individual care realm as population benefits. Furthermore, we might see some of the same efforts to take advantage of the system with respect to population care as we see in the context of individual care, since hospital managers will continue to face pressure to hold down overall hospital costs in order to maintain economic viability. The oversight of the community benefit committees should help mitigate some of these concerns.

Despite these potential problems, refocusing community benefit on population health benefits is at least a step in the right direction, and conceptually more appealing given the government's obligations to community—as opposed to individual—welfare. Even if it proves difficult to quantify population health benefits, at least the effort will have been made to consider actual *community* benefits. Individual charity care does not necessarily lead to community benefit. Consider, for example, the extreme hypothetical case of a hospital with a fixed amount of community benefit dollars that provides a free heart transplant each year—an endeavor with

²⁰³ See J. David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 2 HEALTH MATRIX 35, 43–45 (1992) (arguing that the tax legislation cannot effectively solve health policy concerns). I do not argue that using the tax code as I have suggested will solve our societal public health problems.

²⁰⁴ See Thomas C. Buchmueller & Paul J. Feldstein, *Hospital Community Benefits Other Than Charity Care: Implications for Tax Exemption and Public Policy*, 41 HOSP. & HEALTH SERVICES ADMIN. 461, 462 (1996) (finding that the distinction between programs with charitable purposes and those that primarily serve marketing initiatives is vague).

extremely high cost outlays, but limited to a few recipients. Not only is there no guarantee that the specific recipient is a part of the community in question, as the recipient may have travelled from someplace else, but there is also no reason to think the community as a whole has benefited from these services. Thus, although it may seem simpler to measure individual charity care than population benefit, the latter is closer to the core concept of community benefit. Moreover, as demonstrated in the current efforts to revise the IRS reporting forms, it is not that simple to use charity care as a measure of community benefit.²⁰⁵ Instead, it is better to encourage health care organizations to provide population health benefits to meet their community benefit obligations. Merely refocusing attention towards populations rather than individuals may prove helpful. For example, one study found that institutions that had a higher “community orientation” provided more health promotion services.²⁰⁶ Combined with other efforts to quantify the amount of community benefit necessary to maintain tax-exempt status generally, the suggestions in this Article should create better incentives to guide hospitals.

VI. CURRENT STATE PROGRAMS

Implementation of the suggestions I have set forth above requires action at both the state and federal levels. I have suggested above that the changes needed at the federal level are likely to be minimal, and my focus here is on the role of state regulation of community benefit. The rationale for the state focus is four-fold. First, my goal in creating this framework is to shift the focus to communities, and states are better equipped to respond to communities than the federal government. Second, a major issue for many hospitals is state and local tax-exempt status, not federal tax exemption, and, thus, paying attention to state legislation is appropriate. Third, states may choose different routes to achieve community benefit programs, and there is not necessarily a one-size-fits-all standard

²⁰⁵ See *supra* notes 71–73 and accompanying text.

²⁰⁶ Gregory O. Ginn & Charles B. Moseley, *Community Health Orientation, Community-Based Quality Improvement, and Health Promotion Services in Hospitals*, 49 J. HEALTHCARE MGMT. 293, 304 (2004).

that can be applied uniformly at the federal level. States are often viewed as laboratories for innovation, and that role is as appropriate here as it is in other areas of law. Finally, states have already begun the process of developing community benefit programs,²⁰⁷ and a state lacking such a program can adopt, with or without modification, existing programs from other states.

A. BASIC STATE EFFORTS

Over the past decade, various states have created programs or passed legislation to address the need for guidance on hospital community benefit obligations. Indiana, for example, requires nonprofit hospitals to develop a community benefit mission statement and plan,²⁰⁸ based on a community needs assessment,²⁰⁹ which includes measurable objectives²¹⁰ and annual reporting to the state department of health.²¹¹ Although the statute does not provide specific standards and guidelines for community benefit, failure to file the annual report may result in a fine of up to \$1,000 per day, thus providing an incentive to comply.²¹² Illinois has an almost identical statute, but only allows for fines of up to \$100 per day.²¹³ New York has similar statutory requirements, without the fines, and requires the mission statement and community needs assessment to be reevaluated every three years.²¹⁴ Nevada has a basic statute setting forth filing requirements for hospitals that have over one hundred beds,²¹⁵ which includes a section referring to community benefit reporting to the state health department.²¹⁶ None of these states provide comprehensive guidelines.

²⁰⁷ See *infra* notes 208–22 and accompanying text.

²⁰⁸ IND. CODE ANN. § 16-21-9-4 (LexisNexis 2008).

²⁰⁹ *Id.* § 16-21-9-5.

²¹⁰ *Id.* § 16-21-9-6(2).

²¹¹ *Id.* § 16-21-9-7.

²¹² *Id.* § 16-21-9-8.

²¹³ 210 ILL. COMP. STAT. ANN. 76/25 (West 2008).

²¹⁴ N.Y. PUB. HEALTH LAW § 2803-1 (McKinney 2007). There is a bill pending in the New York Senate to amend the requirement for review every three to four years. S.B. 8186, 230th Leg. Sess. (N.Y. 2008).

²¹⁵ NEV. REV. STAT. § 449.490(2) (2007).

²¹⁶ See *id.* § 449.490(3)(b) (2007) (requiring hospitals with one hundred or more beds to file expenses incurred in providing community benefits).

New Hampshire provides slightly more detail in its community benefit statute,²¹⁷ requiring needs assessments every five years,²¹⁸ potential fines of up to \$1,000 per day plus attorney's fees for violation of the statutory provisions,²¹⁹ and oversight by the director of charitable trusts in the Attorney General's Office.²²⁰ New Hampshire, however, exempts hospitals whose fund balance of their health care charitable trust is below \$100,000 and those whose petition claiming hardship in complying has been granted.²²¹ Connecticut also provides a more detailed statute, but it only applies if a hospital voluntarily decides to create a community benefit program.²²² While it does not have any oversight authority, the Connecticut Department of Health prepares aggregate reports for the state general assembly describing the types of community benefits provided in previous years.²²³

B. COMPREHENSIVE EFFORTS

Although no state has implemented all of the elements described in Part V, Massachusetts comes closest with its "Community Benefits Program," established as the statutory oversight authority for charitable organizations by the Office of the State Attorney General in 1994.²²⁴ The voluntary program is designed to facilitate and encourage hospitals (and HMOs²²⁵) to collaborate with their constituent communities in developing a community benefit

²¹⁷ See N.H. REV. STAT. ANN. § 7:32-c (LexisNexis 2008) (stating purpose of statute).

²¹⁸ *Id.* § 7:32-f.

²¹⁹ *Id.* § 7:32-g.

²²⁰ *Id.*

²²¹ *Id.* § 7:32-j.

²²² CONN. GEN. STAT. ANN. § 19a-127k (West Supp. 2008).

²²³ See, e.g., CONN. DEPT OF HEALTH, REPORTING OF COMMUNITY BENEFITS PROGRAMS BY HOSPITALS AND HEALTH PLANS IN CONNECTICUT CALENDAR YEARS 2001, 2004 & 2006: REPORT TO THE GENERAL ASSEMBLY, STATE OF CONNECTICUT (2007), available at http://www.ct.gov/dph/lib/dph/state_health_planning/community_benefits/community_benefits_2001_2004_2006.pdf (survey of information reported under section 19a-127k).

²²⁴ See OFFICE OF ATT'Y GEN., THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR NON PROFIT HOSPITALS 2 (2007), available at http://www.mass.gov/Cago/docs/healthcare/hospital_guidelines.pdf [hereinafter GUIDELINES] (describing history and progress of program).

²²⁵ There is a separate, but similar set of guidelines for HMOs. See generally OFFICE OF ATT'Y GEN., THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR HEALTH MAINTENANCE ORGANIZATIONS (2007), available at http://www.mass.gov/Cago/docs/healthcare/hmo_guidlines.pdf.

program.²²⁶ The impetus to participate comes from the inclination to maintain a position of good standing with the Attorney General's Office and avoid investigations and accusations of failure to meet charitable obligations. Although the program was prompted in part by the concerns raised in the context of tax exemption, it is not geared specifically towards evaluations of tax-exempt status.²²⁷ Nonetheless, the Massachusetts program provides an initial template that might be used to implement my suggestions.

Under the Massachusetts program, each hospital issues a formal public Community Benefits Mission Statement after identifying the relevant community,²²⁸ assessing its needs and priorities (with significant community involvement),²²⁹ developing a plan with short-term (one-year) and long-term (three-to-five-year) goals,²³⁰ identifying measurable outcomes (including factors such as those listed in this Article),²³¹ and establishing a budget for

²²⁶ See GUIDELINES, *supra* note 224, at 2 (noting that Massachusetts program has "succeeded in encouraging and demonstrating cooperation between health care institutions and the communities they serve").

²²⁷ See *id.* at 1 (noting that the Guidelines were created to help hospitals "continue to build upon their commitment to address health and social needs in the communities they serve").

²²⁸ See *id.* at 7 (discussing form and function of Community Benefit Mission Statement). Identifying communities is not as simple as it might sound. See, e.g., Marshall & Berg, *supra* note 168, at 28-29 (discussing difficulty of identifying communities). The Massachusetts Guidelines do a rather good job of recognizing this problem and list a number of examples of ways in which a community might be identified, including geographically, demographically, based on specific underserved populations, and based on health or disease status. GUIDELINES, *supra* note 224, at 14.

²²⁹ The Guidelines state that over the course of a year, the hospital should draw from existing data to assess community needs; establish a set of priorities; inventory current programs; re-examine existing community benefit commitments; identify goals; identify additional needed resources; prepare a budget; determine time frames; take a leadership role in coordinating community benefit projects; and encourage involvement both among the hospital staff and the wider community. GUIDELINES, *supra* note 224, at 10-12, App. III. The hospitals are directed to "include community representatives from outside the hospital, including community leaders. . . ." *Id.* at 11. Moreover, the hospital should gather information directly from community groups and create a formal annual process for soliciting additional information. See *id.* (suggesting annual public hearing as appropriate mechanism to solicit views of community members and agencies).

²³⁰ See *id.* at App. III. I note above the need to consider short-, medium-, and long-term goals. See *infra* pp. 414-15.

²³¹ Similar to some of the suggestions I made in Part V.C, the Guidelines give examples such as quantifying "the number of patients treated in a particular area for a given condition . . . [and] [t]he reduction of or improvement in a particular health status indicator. . . ." See GUIDELINES, *supra* note 224, at 17. The Guidelines also include a non-exclusive list of potential community benefit programs, including: community health

expenditures.²³² The program gives primary oversight authority to the hospital's governing board and senior managers,²³³ a concern addressed above.²³⁴ Most interesting, perhaps, is the method the Massachusetts program suggests for establishing a level of expenditures. The Guidelines suggest hospitals identify a "reasonable amount of gross community benefits" after taking into consideration:

- a. Audited total patient operating expenses and audited total operating revenues;
- b. Accumulated hospital operating margins (positive or negative) and compensation structures and levels relative to industry norms; and
- c. The net value of the hospital's tax exempt benefits, if that figure is available.²³⁵

The Guidelines also describe a more specific approach that would require hospitals with operating expenses under \$200 million to spend three percent of expenses, and hospitals with operating expenses above \$200 million to spend three percent to six percent of expenses on community benefits.²³⁶ The Attorney General's Office chose not to recommend this approach without further evaluation. Currently, the entire program is under review; the Office appointed an Advisory Task Force in January 2008,²³⁷ which—in addition to

education; free preventive care or health screening; mobile health vans; low- or negative-margin services responding to an identified need; violence-reduction education and counseling; anti-smoking education; substance abuse education; domestic violence reduction education; early childhood wellness programs; expanded prescription drug programs; volunteer services; net financial assistance to community health centers and community mental health centers; and unfunded services ancillary to Medicaid or Medicare. *Id.* at 16–17.

²³² *Id.* at App. III.

²³³ *See id.* at 6 (allocating authority to board to be "responsible for overseeing the development and implementation of the Community Benefits Plan").

²³⁴ *See supra* note 161 and accompanying text.

²³⁵ **GUIDELINES**, *supra* note 224, at 18–19. Thus, the Guidelines reject the approach of determining community benefits expenditures based solely on the value of the hospital's tax-exempt benefit, taking that figure into account if it is available. *Id.*

²³⁶ *Id.* at 19.

²³⁷ *See* Press Release, Office of Attorney General, Attorney General Martha Coakley Appoints Task Force to Review Community Benefits Program (Jan. 16, 2008), available at <http://www.mass.gov/?pageID=cagopressrelease&L=1&L0=Home&sid=Cago&b=pressrelease&>

evaluating the current program—will also have to consider the implications of the new Massachusetts comprehensive health care plan.²³⁸

The Massachusetts program has an annual reporting mechanism through the Attorney General's Office.²³⁹ The Office publishes reports online, which are accessible to the public.²⁴⁰ Community members and organizations are encouraged to respond to the hospital's efforts, and their comments are also published.²⁴¹ Such a system could provide a basis for state and local tax evaluations as I describe above in Part V. While the Massachusetts program is laudable and clearly aimed at the appropriate goal of providing public health community benefits, more work is needed. Certain aspects of the program will need adjustment in light of the framework I set forth above. Specifically, I think that oversight and community input should be accomplished through a non-affiliated group, rather than the hospital governing board, and multi-year accounting should be considered. Additionally, the Massachusetts program is a voluntary program under the aegis of the Attorney General's Office. While this may be appropriate, I suggest these efforts should be more directly linked to tax-exempt status. A state that chooses to develop a similar program might explicitly direct taxing authorities to review the community benefit reports.

Texas does just that. It has a detailed community benefit statute, which lists requirements both for community benefit planning and for representation in community assessments.²⁴² Texas is the only

f=2008_01_16_advisory_task_force&csid=Cago J (stating that task force was established to determine "what[,] if any[,] changes should be made to the program for non-profit health care institutions").

²³⁸ See generally 2006 Mass. Acts Ch. 58.

²³⁹ See GUIDELINES, *supra* note 224, at 23 (asking each hospital to report annually to the Attorney General's Office).

²⁴⁰ *Id.* Even states that have minimal guidelines, as described in section A, make the annual reports public. See, e.g., 2003 Ill. Legis. Serv. 2519 (West 2006) (requiring statement to notify public of community benefit plan); IND. CODE ANN. § 16-21-9-7(c) (LexisNexis 2008) (requiring public statement); N.Y. PUB. HEALTH LAW § 2803-l(2)(iv) (McKinney 2007) (noting that hospital must prepare and make available public statement); NEV. REV. STAT. § 449.490(7) (2007) (noting that reports filed are open to public inspection).

²⁴¹ GUIDELINES, *supra* note 224, at 26.

²⁴² See TEX. HEALTH & SAFETY CODE ANN. §§ 311.041–.048 (Vernon 2001) (providing requirements, penalties, rights, and remedies). The representatives include:

(1) the local health department; (2) the public health region . . . ; (3) the

California requirements have the benefit of being legislatively promulgated, as do those in Texas. Oversight authority is given to the Office of Statewide Health Planning and Development.²⁴⁷ The statute stresses the “social obligation to provide community benefits in the public interest” in exchange for “favorable tax treatment.”²⁴⁸ Interestingly, the list of examples of services that may count as community benefit in California includes “[f]ood, shelter, clothing, education, transportation, and other goods or services that help maintain a person’s health.”²⁴⁹ Such a broad conception of community benefit may not be ideal, as hospitals are not necessarily well-suited to provide general social services. California does require that hospitals separately list different types of community benefits in a framework including medical care, benefits for vulnerable populations, benefits for the broader community, health education and research, and nonquantifiable benefits;²⁵⁰ thus, presumably, the authorities can make some determination about whether the services reported are appropriate community benefits. Like Massachusetts, California emphasizes actual benefits (not just costs)²⁵¹ and suggests hospitals should identify short-term, intermediate, and long-term goals, as well as quantifiable measurements.²⁵²

Maryland has also codified comprehensive community benefit requirements.²⁵³ It gives oversight and regulatory authority to the State Health Services Cost Review Commission,²⁵⁴ which

²⁴⁷ See *id.* § 127350(d) (requiring hospitals to annually submit community benefit plan to Office of Statewide Health Planning and Development).

²⁴⁸ *Id.* § 127340(a).

²⁴⁹ *Id.* § 127345(c)(8).

²⁵⁰ *Id.* § 127355(c).

²⁵¹ See OFFICE OF STATEWIDE HEALTH PLANNING & DEV., NOT-FOR-PROFIT HOSPITAL COMMUNITY BENEFIT LEGISLATION (SENATE BILL 697): REPORT TO THE LEGISLATURE 31 (1998), available at <http://www.oshpd.state.ca.us/HID/SubmitData/CommunityBenefit/notforprofitlegislation.pdf> (recommending California “[r]esist the temptation to measure benefits only in financial terms”).

²⁵² OFFICE OF STATEWIDE PLANNING & DEV., CALIFORNIA’S HOSPITAL COMMUNITY BENEFITS LAW: A PLANNER’S GUIDE 114 (2003), available at <http://www.oshpd.ca.gov/HID/SubmitData/CommunityBenefit/HCBPPlannersGuide.pdf> (discussing short-term, intermediate, and long-term goals).

²⁵³ See MD. CODE ANN., HEALTH-GEN. § 19-303 (LexisNexis 2005) (setting forth community benefit reporting requirements).

²⁵⁴ *Id.* § 19-303(c).

promulgated detailed guidelines in 2006 and a subsequent report in 2007. The Guidelines were revised in 2008.²⁵⁵ The Guidelines provide specific examples of aspects of programs that should or should not be counted as a community benefit. Thus, for example, health education provided to groups (such as caregiver training) may be counted, but “health education classes designed to increase market share (such as prenatal and childbirth programs for private patients)” may not.²⁵⁶ Details such as those that Maryland provides can be invaluable in directing hospitals towards appropriate community benefit activities. A recent study of nonprofit hospitals in Maryland showed the broad range of community benefit activities.²⁵⁷

Oregon recently adopted a basic statute outlining community benefit²⁵⁸ that authorizes the Administrator of the Office for Oregon Health Policy and Research to promulgate specific guidelines.²⁵⁹ That office has since created a system of community benefit reporting categories very similar to the Maryland guidelines.²⁶⁰

Each of these state efforts has value and each provides different options for implementing a community benefit plan. States considering a community benefit statute may do well to pick and choose the best options from various existing programs. To the extent that a state integrates the recommendations I provide in Part IV, it will be better able to encourage community public health benefits rather than individual charity care—a goal I suggest is laudable.

²⁵⁵ HEALTH SERV. COST REVIEW COMM’N, COMMUNITY BENEFIT REPORTING GUIDELINES AND STANDARD DEFINITIONS (2008), available at http://www.hscre.state.md.us/documents/HSCRC%20Initiatives/Community%20Benefits/Data%20collection%20Tools/CBR_ReportingGuidelinesStandardDefinitions.pdf [hereinafter MD GUIDELINES]; HEALTH SERV. COST REVIEW COMM’N, MARYLAND HOSPITAL COMMUNITY BENEFITS REPORT (2007), available at <http://www.hscre.state.md.us/documents/HSCRC%20Initiatives/Community%20Benefits/Reports/Community%20Benefits%20Report%20FY2007.pdf>.

²⁵⁶ MD GUIDELINES, *supra* note 255, at 8–9.

²⁵⁷ Bradford Gray & Mark Schlesinger, *Charitable Expectations of Nonprofit Hospitals: Lessons from Maryland*, 28 HEALTH AFF. w809 (2009).

²⁵⁸ See 2007 Or. Laws 1049 (defining community benefit).

²⁵⁹ See *id.* (allowing Administrator to “by rule adopt a cost-based community benefit reporting system for hospitals”).

²⁶⁰ See OR. ADMIN. R. 409-023-0100 (2008) (listing criteria for meeting community benefit standard).

VII. CONCLUSION

There has been a great deal of attention focused on nonprofit hospitals over the past few decades. Periodically, there are calls for a new standard of community benefit²⁶¹ or even abolition of tax-exempt status for hospitals. Given the possibility that tax-exempt hospitals provide care not offered by other parts of the health care sector, dispensing with the distinctions between nonprofit and for-profit hospitals may not be warranted. Moreover, a sudden and drastic change in the current tax framework could lead to unusual hardship since contributions would no longer be deductible, and have significant implications for the health care field as a whole—for example, with respect to medical research funding, since federal grants are limited to nonprofit institutions.²⁶² Instead, we might think creatively about how to employ the current structure in a way most beneficial to the community, since, after all, community benefit is the purpose of providing tax exemptions. Hospitals, as well as local, state, and federal authorities, are likely to welcome change—not only because of the difficulties and uncertainties in applying the current standard, but also because of the possibility of health care reform over the next few years. Some states have already taken steps towards universal health insurance coverage, and the Obama administration is leading efforts at the federal level.²⁶³ The same concern that led to the development of the

²⁶¹ As recently as February 2009, however, IRS counsel Don Spellman asserted that the community benefit standard is not outdated and is not likely to be changed. See Diane Freda, *Community Benefit Standard Here to Stay, IRS Official Tells Tax-Exempt Practitioners*, 18 Health L. Rep. (BNA) 195, 195 (Feb. 12, 2009) (claiming courts and IRS “have adapted the formula over the years and it is working as a model for how nonprofit hospitals are to serve their communities”).

²⁶² The IRS is currently considering whether the community benefit standard should be applied differently to different types of hospitals, specifically teaching and research hospitals. See Diane Freda, *IRS May Revise Community Benefit Standard, Exempt Critical Access, Teaching Hospitals* 18 Health L. Rep. (BNA) 810, 810 (June 18, 2009) (questioning whether teaching and research hospitals and sole providers “should be subject to the same facts-and-circumstances approach to determining tax exemption as other types of hospitals”).

²⁶³ Massachusetts enacted a comprehensive health care plan and California proposed one, but it did not pass. See *supra* note 238 and accompanying text; Jesse McKinley & Kevin Sack, *California Senate Panel Rejects Health Coverage Proposal*, N.Y. TIMES, Jan. 29, 2008, at A14 (noting that California State Senate committee rejected plan that would have provided insurance to millions of uninsured).

community benefit standard in 1969 (after the enactment of federal Medicare and Medicaid programs)—that there will no longer be a need for charity care—may come into play again.

I have argued here that the “community benefit” standard is not unworkable, but that it should be refocused to encourage the provision of population health care instead of primarily individual charity care. Some initial steps in this direction have already been taken, but more work needs to be done. In particular, the IRS should revise its reporting forms to stress population care over individual charity care; an oversight mechanism should be created in the form of a Community Benefit Board to further the emphasis on community public health needs; the community benefit provided should be measured in terms of outcomes of community programs with clearly defined goals; and tax exemption evaluations should incorporate multi-year reporting. A few states have taken steps in this direction.²⁶⁴ It is time for others to follow their lead and put the *community* back into the “community benefit” standard.

²⁶⁴ See *supra* Part VI.