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California's Nonprofit Hospital Puzzle: Reworking The Jigsaw To Benefit Underserved Communities

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# California’s Nonprofit Hospital Puzzle: Reworking The Jigsaw To Benefit Underserved Communities

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## I. INTRODUCTION

Standards for establishing and maintaining nonprofit hospital status have become the subject of increasing scrutiny over the last decade, at both the federal and state levels.<sup>1</sup> There have been accusations that:

In the best case, the mission of a modern tax-exempt hospital is to keep their tax exemption and then provide the best health care at the lowest cost. In the worst case, a non-profit tax-exempt hospital’s mission is to keep its tax exemption in order to maximize profits and use their non-profit structure as camouflage to hide both their profit maximizing activities on behalf of doctors and administrators and/or their elitist, secretive (perhaps fraudulent) cross-subsidization of certain types of healthcare and wealth redistribution.<sup>2</sup>

This concern has only been amplified by research that has shown that the value of tax exemptions for nonprofit hospitals has doubled in the last decade<sup>3</sup> and

1. See Donna C. Folkemer et al., *Hospital Community Benefits After the ACA: The Emerging Federal Framework*, HILLTOP INST.: ISSUE BRIEF 2 (Jan. 2011), <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief-January2011.pdf> [<https://perma.cc/ZTM3-GWFH>] (discussing that in the past decade nonprofit hospital status has become the subject of increasing scrutiny in Congress); Beth Kutscher, *Growing Tax Breaks for Nonprofit Hospitals Questioned*, MODERN HEALTHCARE (June 20, 2015, 1:00 AM), <http://www.modernhealthcare.com/article/20150620/MAGAZINE/306209968> [<https://perma.cc/S78W-SLDG>] (discussing new study adding “fuel to the continuing debate over whether not-for-profit hospitals are earning their tax breaks”); Hudson Sangree, *Critics Want Nonprofit Hospitals to Account for Tax Breaks*, SACRAMENTO BEE (May 17, 2015, 2:37 PM), <http://www.sacbee.com/news/local/health-and-medicine/article21257535.html> [<http://web.archive.org/web/20181215012748/https://www.sacbee.com/news/local/health-and-medicine/article21257535.html>] (“Long-running criticism made by health care unions against nonprofit hospitals: They don’t give enough in return for their hefty tax breaks.”); Chad Terhune, *Nonprofit Hospitals Face State Hearing on Tax-Exempt Status*, L.A. TIMES (Aug. 14, 2012), <http://articles.latimes.com/2012/aug/14/business/la-fi-mo-nonprofit-hospitals-20120814> [<https://perma.cc/DN7Q-WGBZ>] (discussing that a “state Senate committee will discuss that issue and others at a hearing Wednesday as part of the debate over whether nonprofit hospitals do enough to justify their tax-exempt status”).

2. Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 125 (2015) (quoting George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals - Wolves in Sheep’s Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 180 (2010)).

3. Robert Gebelhoff, *Value of Tax Breaks for Nonprofit Hospitals Doubled in a Decade*, WASH. POST (June 17, 2015), <https://www.washingtonpost.com/national/health-science/value-of-tax-breaks-for-nonprofit-hospitals-doubled-in-a-decade/2015/06/17/4162c640-1450-11e5-9ddc->

by the recent rise in mergers and acquisitions among nonprofit hospital systems around the country.<sup>4</sup> While the Affordable Care Act (ACA) has made great strides in increasing accountability of nonprofit hospitals across the country, it has also created concerns about existing charity care requirements. The reduction in the rate of uninsured due to the ACA has opened the door to some nonprofit hospitals challenging the necessity of maintaining their current levels of charity care.<sup>5</sup>

The federal requirements are only one component of nonprofit hospital taxation status.<sup>6</sup> State tax exemptions, particularly those reducing property tax revenue in a state like California with nonprofit hospitals clustered in many of the highest rent districts, means substantial tax dollars are in effect going to support nonprofit hospitals.<sup>7</sup> While this may benefit some communities, it may contribute to significant health disparities across geographic, socioeconomic, gender, racial, and ethnic lines throughout California and across the United States.<sup>8</sup> A prime example is the health disparity between individuals in rural and urban areas.<sup>9</sup> This

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e3353542100c\_story.html [https://perma.cc/2GK4-PUH8] (“In 2002, nonprofit hospitals received about \$12.6 billion in exemptions at federal, state and local levels. That number jumped to \$24.6 billion in 2011, the latest data available, according to a study released Wednesday by the journal *Health Affairs*.”).

4. As we see an increase in mergers and buy-outs among large nonprofit hospital systems, having effective charity care and community benefits standards in place is critical to protecting access to care for the country’s most vulnerable populations. For a discussion of a recent hospital system merger impacting California, see, e.g., Hayley Penan, *Pending Catholic Hospital Mergers Threaten Health Care Access in California*, NAT’L HEALTH L. PROGRAM (Aug. 17, 2018), <https://healthlaw.org/pending-catholic-hospital-mergers-threaten-health-care-access-in-california-communities/> [https://perma.cc/Q54Q-W6BZ].

5. For example, in California a number of nonprofit hospitals submitted a request to the Attorney General for a reduction in their required charity care obligations, citing in part the reduction in uninsured in the state from 17% in 2013 to 6.8% in 2016. Pauline Bartolone, *SoCal Nonprofit Hospitals Propose Reduced Charity Care Requirement*, CAL. HEALTHLINE (Mar. 4, 2018), <https://comptonherald.org/socal-nonprofit-hospitals-propose-reduced-charity-care-requirement/> [https://perma.cc/RP75-389G].

6. Corbett, *supra* note 2, at 103; Julia James, *Health Policy Brief: Nonprofit Hospitals’ Community Benefit Requirements*, HEALTH AFF. 2 (Feb. 25, 2016), [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_153.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_153.pdf) [https://perma.cc/2EP3-6ZGG] (discussing variations on state requirements and that states generally condition receipt of sales, property, and corporate tax benefits on nonprofit status).

7. See *infra* notes 152–54 (showing the groupings of nonprofit hospitals in California are in major urban areas, which have the highest property values); see also Susannah Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 33 (Sept. 5, 2014) (discussing how community benefit and financial policies “vary systematically in relation to their different notions of ‘community’ and the characteristics of the communities where the hospitals are located.”).

8. See OFF. STATEWIDE HEALTH PLAN. & DEV., RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE IN CALIFORNIA 1 (2010), [http://www.oshpd.ca.gov/hid/Products/PatDischargeData/ResearchReports/EthnicRacialDisp/RacialEthnicFactBook\\_2010.pdf](http://www.oshpd.ca.gov/hid/Products/PatDischargeData/ResearchReports/EthnicRacialDisp/RacialEthnicFactBook_2010.pdf) [https://perma.cc/24KC-XTEV]; Ctr. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report—United States, 2013*, 62 CDC MORBIDITY & MORTALITY WKLY REP. 1 (2013), <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf> [https://perma.cc/DZK7-EUKB].

9. *California Rural Healthcare Facilities*, RURAL HEALTH INFO. HUB (formerly the Rural Assistance Center), <https://www.ruralhealthinfo.org/states/california> [https://perma.cc/HA75-

persisting difference should lead us to scrutinize whether the current tax exemptions for nonprofit hospitals are the most efficient use of states' tax dollars.

In a time when we are debating women's access to the fields of science, technology, engineering, and math (STEM), universal basic income, and new life-saving technologies, what chance do we have to address these complex issues if we cannot find ways to get the fundamentals right? Access to basic health care services is critical to reducing health disparities and social inequity in our society, and we must make sure that our limited resources are used in the most effective ways to reduce health disparities and increase the overall public health.<sup>10</sup> Access to

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Q5HN] (last visited June 2, 2019) [hereinafter *California Rural Healthcare Facilities*].

10. It is clear that the people who will be the hardest hit without access to needed health care services are poor women, and, in particular, poor women of color. Women are more likely than men to postpone needed care due to costs. *Women's Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women's Health Survey*, KAISER FAM. FOUND. (Mar. 13, 2018), <https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/> [https://perma.cc/TQ4Z-UT9P]. Women also face logistical barriers to obtaining care, such as transportation and child care concerns, which are experienced most frequently by poor women of color, particularly those in poor health. *Id.* For women of color, these barriers are substantial and are compounded by the fact that women of color experience health disparities separate and apart from those linked to socioeconomic status. For example, black women die in pregnancy or childbirth at three to four times the rate of white women, and black women die from cervical cancer at more than double the rate of white women. *Addressing Disparities in Reproductive and Sexual Health Care in the U.S.*, CTR. FOR REPROD. RTS., <https://reproductiverights.org/addressing-disparities-reproductive-and-sexual-health-care-us> [https://perma.cc/6E3Q-NL65] (last visited June 2, 2019); Anna Beavis et al., *Hysterectomy-Corrected Cervical Cancer Mortality Rates Reveal a Larger Racial Disparity in the United States*, 123 *CANCER* 1044 (2017), <https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.30507> [https://perma.cc/8ZN3-55JV]; Domenica Ghanem, *For Women of Color, the 'Healthcare Gap' Is Real and Deadly*, HILL (Mar. 8, 2017, 7:40 AM), <https://thehill.com/blogs/pundits-blog/healthcare/322874-for-women-of-color-the-healthcare-gap-is-real-and-deadly> [https://perma.cc/L8BM-LF57]. Women in rural communities experience additional health disparities. For example, rural women have a 64% higher rate of pregnancy-related death than women in urban settings. Betsy McKay & Paul Overberg, *Rural America's High Childbirth Crisis: The Fight to Save Whitney Brown*, WALL ST. J. (Aug. 11, 2017, 10:42 AM), <https://www.wsj.com/articles/rural-americas-childbirth-crisis-the-fight-to-save-whitney-brown-1502462523> [https://perma.cc/V7HC-F4Z4]. The way these intersect is that when care is limited or reduced, poor women of color from rural areas suffer greatest. An example of this can be seen in Texas with respect to access to reproductive health services. Texas has taken a number of actions aimed at reducing access to reproductive health services, especially abortion and contraception. The state cut its family planning budget by 66% and changed the way it delegated its Title X funds to put nonprofits and community organizations last in line for funds. Alicia Gallegos, *Trump Overturns Title X Family Planning Rule*, OB.GYN. NEWS (Apr. 18, 2017), <https://www.mdedge.com/obgyn/article/135954/health-policy/trump-overturns-title-x-family-planning-rule> [https://perma.cc/TCE5-LF7M]; Akiba Solomon, *Collateral Damage in the War on Women*, COLOR LINES (Oct. 11, 2012, 9:54 AM), <https://www.colorlines.com/articles/collateral-damage-war-women> [https://perma.cc/86HN-EW2Y]. It then gutted its Women's Health Program, which had extended care to a wide range of poor women who could not meet the state's narrow definition for Medicaid eligibility (especially given it is a non-expansion state). Solomon, *supra*. The legislature then passed additional restrictions on clinics that provide abortions. While some of these were rejected by the Supreme Court in *Whole Women's Health v. Hellerstedt*, these collective state actions have forced more than half of the state's clinics to close, leaving wide swaths of the state without access to reproductive health care within

health care is a matter of life and death impacting civil liberties and privacy concerns; it serves as a window into the fundamental values of our society. How we choose to allocate precious resources within our health care system speaks volumes about our values around human life, and most importantly, sheds light on who in our society benefits from existing legal and social structures and at whose expense this benefit is achieved.

This Article focuses on a case study of California. California matters significantly in discussions about health care access for a number of reasons. First, it is one of the most populous states in the country. Second, it is the largest recipient of Title X funds. Third, it is regarded as a thought leader in ensuring health care access and protecting the rights of its citizens; a clear example of which is California's protection of reproductive privacy through the state constitution.<sup>11</sup> Finally, California is a vibrant place to examine nonprofit hospital status in the context of several recent attempts by the state's legislators to amend the current standards for nonprofit hospital status.<sup>12</sup>

California's mandatory hospital data reporting through the state's Office of Statewide Health Planning and Development (OSHDP) facilitates a comparison between the charity care and community benefits provided by nonprofit hospitals and for-profit hospitals in the state.<sup>13</sup> Researchers at the University of California, San Francisco (UCSF) conducted a survey in 2015 of nonprofit and for-profit

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100 miles. *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, PLOS ONE (Oct. 26, 2016), <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0165048> [<https://perma.cc/9UPZ-S68Z>]; Daniel Grossman et al., *How Greater Travel Distance Due to Clinic Closures Reduced Access to Abortion in Texas*, POPULATION RES. CTR. (Feb. 2017), <https://liberalarts.utexas.edu/prc/research/research-brief-series/2017-research-briefs/txpep-distance-reduced-abortion-access.php> [<https://perma.cc/83KW-A5CX>]. These clinic closures have resulted in a decrease by more than a third in the number of claims for long-acting contraception and a simultaneous 27% increase in births paid for by Medicaid, which were likely in large part from unintended pregnancies. Maggie Fox, *When Texas Defunded Planned Parenthood*, NBC NEWS (Feb. 3, 2016), <https://www.nbcnews.com/health/health-care/contraception-fell-medicaid-births-went-when-texas-defunded-planned-parenthood-n510736> [<https://perma.cc/VU2N-SV6G>]. These restrictions not only impact women's access to reproductive health care services, but also impede their access to other basic health care. Six out of ten women in the United States who access care from a family planning clinic consider it their primary source of health care. *Publicly Funded Family Planning Services in the United States*, GUTTMACHER INST. (Sept. 2016), <https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states> [<https://perma.cc/LB4-5PPQ>]. The communities most impacted by these closures and reductions in access to essential health care services are rural, poor, and predominantly Latinx. Solomon, *supra*.

11. CAL. CONST. art. 1, § 1; Rachel Roubein & Brianna Ehley, *HHS Awards Title X Grants, Shortens Funding Cycle*, POLITICO (Aug. 28, 2018, 3:24 PM) (Essential Access Health received \$14.3 million to administer California's Title X program, the largest recipient in the nation); *see also* CAL. HEALTH & SAFETY CODE § 123460 et seq. (West 2019) (Reproductive Privacy Act).

12. *See infra* notes 77–117 (discussing in depth recent attempts by California legislators to reform the California nonprofit hospital status standards).

13. CAL. OFF. STATEWIDE HEALTH PLAN. & DEV., <http://www.oshpd.ca.gov/> [<https://perma.cc/2YYK-JRWX>] (last visited June 2, 2019).

hospitals' expenditures on charity care in California in a first-of-its-kind study based on the OSHPD data.<sup>14</sup> The resulting report serves as a basis from which to examine whether the current nonprofit system provides enough of a public benefit to justify nonprofit hospitals receiving significant tax exemptions.<sup>15</sup>

This Article looks at the UCSF study's findings and examines the current structure of the federal and California state nonprofit taxation status standards, as well as recent efforts to reform the California statutory nonprofit hospital requirements. Review and analysis of these findings and laws ultimately leads to a conclusion that there is a problem with the current system. There is a lack of uniformity and certainty that nonprofit hospitals' charity care and community benefits are directed towards the populations that are most in need of these services.

The current system is failing to help the most vulnerable populations in the state. This Article focuses on the persisting health disparities between individuals living in urban areas and rural areas, the latter of which are generally unserved or underserved by California's nonprofit hospitals. Part II begins by providing the history, rationale behind, and standards for granting nonprofit status to hospitals. Part II also addresses in detail recent efforts by California legislators to reform the state standards for nonprofit hospital status. Part III provides an overview of what a nonprofit hospital looks like in California. This section examines the locations, operations, and self-impressions of California nonprofit hospitals, and provides a framework for how nonprofit hospitals operate in conjunction with EMTALA and the ACA requirements. Part IV looks at other state systems for determining whether to grant hospitals nonprofit status. Part V lays out potential solutions to the problematic California statutory standards, assesses the costs and benefits of each, and puts forth a proposal to improve the current system. Part VI concludes.

## II. HISTORY, RATIONALE, AND STANDARDS OF NONPROFIT HOSPITALS

Some background is helpful to understand how our current nonprofit system evolved into the system that exists today. Part A looks at the history of how nonprofit hospitals came into existence and the rationale behind the tax benefits nonprofit hospitals receive. Part B looks at the current federal standards for nonprofit status, and Part C looks at the California state standards for nonprofit taxation status, as well as detailing the benefits received by institutions with nonprofit status. Part D describes the problem with the current California statutory regime and the recent efforts by California legislators to amend existing law.

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14. Erica Valdovinos et al., *In California, Not-for-Profit Hospitals Spent More Operating Expenses on Charity Care Than For-Profit Hospitals Spent*, 34 HEALTH AFF. 1296 (2015).

15. *Id.* at 1296.

*A. History and Rationale Behind Nonprofit Hospitals*

The development of hospitals in America can be traced to industrialization and the expansion of cities.<sup>16</sup> In the nineteenth century, hospitals originated as “alms houses,” where communities and religious charities would care for the poor and sick, without expectation of payment.<sup>17</sup> In the few decades between the late nineteenth and early twentieth centuries, “the United States was transformed from a predominately rural agrarian society to an industrial economy centered in large metropolitan cities.”<sup>18</sup> During this time, children were working in sweatshops, slaughterhouses, and in prostitution, and were literally dying in the streets from illness and starvation.<sup>19</sup> The visage of these children who were sick and dying in public spaces caused the American public to begin to realize the serious public health risk posed by having the nation’s poor out on the streets spreading disease throughout cities and towns across the country.<sup>20</sup> Many of the pre-existing almshouses were transformed into hospitals.<sup>21</sup> Prime examples were Bellevue Hospital in New York City, which originated as a “six-bed ward founded in 1736”<sup>22</sup> and Pennsylvania Hospital, which originated as an almshouse in 1730–31.<sup>23</sup>

Pennsylvania Hospital is posited to have been the first hospital in the United States, dating back to 1750–51.<sup>24</sup> Dr. Thomas Bond and Benjamin Franklin were

16. Barbara Mann Wall, *History of Hospitals*, U. PENN. NURSING (1998), <http://www.nursing.upenn.edu/nhhc/Welcome%20Page%20Content/History%20of%20Hospitals.pdf> [<https://perma.cc/V9ND-KTT5>] (discussing that as society became more industrialized and “medical practices grew in their sophistication and complexity, the notion that responsible families and caring communities took care of their own became more difficult to apply”).

17. *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456, 465 (2015) (discussing the “early origins as charitable alms houses providing free basic medical treatment to the infirm poor”); George A. Nation, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep’s Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 155 (2010) (providing a historical overview of the provision of charity care in the United States).

18. Charles Hirschman & Elizabeth Mogford, *Immigration and the American Industrial Revolution from 1880 to 1920*, 38 SOC. SCI. RES. 897, 920 (2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760060/> [<https://perma.cc/6LNY-EHWW>].

19. Michele Goodwin & Naomi Duke, *Parent Civil Unions: Rethinking the Nature of Family*, 2013 U. ILL. L. REV. 1337, 1344 (2013) (citing JOHN E. B. MYERS, CHILD PROTECTION IN AMERICA: PAST, PRESENT, AND FUTURE 43 (2006); Cecelia Tichi, Chair of Modern Culture, John W. Kluge Ctr. at the Library of Cong., Speech: Justice, Not Pity: Julia Lathrop, First Chief of the U.S. Children’s Bureau (June 28, 2007)) (discussing impoverished children in the streets and the corresponding public health crisis in this country).

20. *Id.*

21. *History of Public Hospitals in the United States*, AMERICA’S ESSENTIAL HOSPS., <http://essentialhospitals.org/about-americas-essential-hospitals/history-of-public-hospitals-in-the-united-states/> [<https://perma.cc/6E53-N8XF>] (last visited June 2, 2019).

22. *Id.*

23. J.B. Cutter, *Early Hospital History in the United States*, 20 CAL. STATE J. MED. 272 (1922), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1517304/pdf/calstatejmed00022-0020.pdf> [<https://perma.cc/PZ5B-YUUM>].

24. *Id.*



instrumental in pushing for the creation of this modern hospital, “working up public sentiment, and pushing the matter before the Assembly.”<sup>25</sup> The next hospital to have been created was the Public Hospital of Baltimore in 1789, which “was established for low-income populations, people with mental or physical illness, and the seafaring of Maryland.”<sup>26</sup> These hospitals and others started out as places “where the sick poor went to die, not a place to receive treatment”<sup>27</sup> and primarily served to isolate the sick and dangerously ill from the rest of the population.<sup>28</sup> Over time, most cities created almshouses to care for the poor and “almost every city of any size in early America had a pest house to isolate patients during epidemics.”<sup>29</sup> These pest houses originated as places to isolate “sailors and other shipboard victims of contagious diseases” when they arrived at ports to protect cities’ populations from the spread of disease.<sup>30</sup> The original pest house facilities were not meant to house local residents and were typically located outside of city limits.<sup>31</sup>

Early hospitals were intended for the poor, and there is evidence that they prohibited charging patients fees for services rendered.<sup>32</sup> During this time, “hospital care was a last resort for many rather than the initial point of care, as there was a high risk of infection and death.”<sup>33</sup> These early hospitals were funded solely by private donors’ voluntary contributions, and after the Revenue Act of 1894, were treated as nonprofit entities.<sup>34</sup> In the late nineteenth and early twentieth centuries, as technology developed and anesthesia was discovered, the medical care being administered at hospitals advanced rapidly.<sup>35</sup> This caused a shift in the use of hospitals away from providing free care to the sick poor to providing care to the wealthy who paid for treatment.<sup>36</sup> This shift is evidenced by contemporaneous changes in hospital design away from large wards to private rooms.<sup>37</sup>

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25. *Id.*

26. SULTZ & YOUNG, HEALTH CARE USA 71 (7th ed. 2010), [http://www.jblearning.com/samples/0763749745/49745\\_Ch03.pdf](http://www.jblearning.com/samples/0763749745/49745_Ch03.pdf) [[http://web.archive.org/web/20160327211027/http://www.jblearning.com/samples/0763749745/49745\\_Ch03.pdf](http://web.archive.org/web/20160327211027/http://www.jblearning.com/samples/0763749745/49745_Ch03.pdf)] (from Chapter 3, Hospitals: Origin, Organization and Performance).

27. Nation, *supra* note 17, at 155.

28. SULTZ & YOUNG, *supra* note 26.

29. *Id.*

30. *Id.* at 70.

31. *Id.* at 71.

32. Nation, *supra* note 17, at 156 (citing PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 145, 149, 158 (1982)).

33. Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit*, 23 J. CONTEMP. HEALTH L. & POLY 302, 305 (2007), <http://scholarship.law.edu/cgi/viewcontent.cgi?article=11116&context=jchlp> [<https://perma.cc/6PC3-A49E>] (discussing the origins and history of support for charity care as directly tied to religious charities).

34. Utah Cty. v. Intermountain Health Care, Inc., 709 P.2d 265, 270 (Utah 1985) (providing overview of the history of nonprofit hospital tax-exemption); Corbett, *supra* note 2, at 111.

35. McGregor, *supra* note 33. (citing *Intermountain Health Care, Inc.*, 709 P.2d at 270).

36. *Id.* (citing ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 17–51 (1989)).

37. *Id.*

As cities continued to develop and large families lived in close quarters in urban environments, people “turned to hospitals for care that was not easily delivered at home.”<sup>38</sup> There was a significant increase in the number of hospitals during this time period (1872–1910), from 178 to over 4000 nationwide, with many of the emerging hospitals entering the market as for-profit entities.<sup>39</sup> By 1922, patient fees constituted sixty-five percent of hospital revenues.<sup>40</sup>

The next fifty years brought about “increased formalization, standardization, and institutionalization to American medicine.”<sup>41</sup> The significant advances in medical technology that were occurring were complex and incredibly expensive.<sup>42</sup> This led to a favoring of the nonprofit entity model, where physicians would maintain more control (by not being subject to corporate board priorities and extensive government regulation such as antitrust laws); and which was more financially stable with the tax benefits and support from religious affiliates.<sup>43</sup> Thus, the modern nonprofit hospital was born.

### B. Federal Standards for Nonprofit Taxation Status

Federal statutory law provides that certain hospitals can obtain tax-exempt status as a charitable nonprofit organization.<sup>44</sup> Section 501(c)(3) of the Internal Revenue Code exempts from income taxation “[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.”<sup>45</sup> Under section 501(c)(3), hospitals along with certain other “charitable” organizations can obtain an array of benefits including tax deductions for contributions and exemption from federal, state, and local taxes and several other regulatory schemes.<sup>46</sup> Congress has not defined the word “charitable,”<sup>47</sup> but

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38. JOHN C. BURNHAM, *HEALTH CARE IN AMERICA: A HISTORY* 157 (2015).

39. McGregor, *supra* note 33 (citing STEVENS, *supra* note 36).

40. *Intermountain Health Care, Inc.*, 709 P.2d at 270.

41. Theodore R. Marmor et al., *A New Look at Nonprofits: Health Care Policy in a Competitive Age*, 3 YALE J. ON REG. 313, 322 (1986).

42. *Id.*

43. *Id.*

44. 26 U.S.C. § 501(c)(3) (2014).

45. *Id.*

46. Theodore J. Patton, *The Calamity of Community Benefit: Redefining the Scope and Increasing the Accountability of Minnesota's Nonprofit Hospitals*, 37 HAMLINE L. REV. 1, 4 (2014) (citing JAMES J. FISHMAN & STEPHEN SCHWARZ, *NONPROFIT ORGANIZATIONS: CASES AND MATERIALS* 327 (3d ed. 2006); Sara Rosenbaum & Ross Margulies, *Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 283, 283 (2011)).

47. Corbett, *supra* note 2, at 112–13 (citing Steven T. Miller, Comm'r, Tax Exempt and Government Entities, Internal Revenue Service, U.S. Dep't Treasury, *Remarks Before the Office of the Attorney General of Texas* 2 (Jan. 12, 2009)).

there is consensus that “the promotion of health is considered to be a charitable purpose.”<sup>48</sup>

While there was never an official threshold amount of charity care required to maintain nonprofit status, auditors “den[ie]d or revoke[d] the nonprofit status of hospitals if charity care amounted to less than 5% of gross revenues.”<sup>49</sup> The creation of the Medicare and Medicaid programs in 1965 spurred nonprofit hospitals to push for reform of the charity care requirement that would allow them more flexibility in the face of what they argued would be a resulting decline in the need for charity care.<sup>50</sup> This led the IRS in 1969 to institute the “community benefit standard” that is used today.<sup>51</sup>

A 1969 Revenue Ruling “defined promoting the health of any broad class of persons as a community benefit, including, perhaps, such activities as charity care, health screening, community education about health risks, emergency room services, and basic research.”<sup>52</sup> The 1969 Ruling included a requirement for nonprofit hospitals to have “an emergency room open to all regardless of ability to pay,” but in 1983, Revenue Ruling 83-157 eliminated this requirement.<sup>53</sup> In 1986, “Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.”<sup>54</sup> EMTALA “imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual’s ability to pay.”<sup>55</sup>

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48. INTERNAL REVENUE SERVICE, REVENUE RULING 69-545, *available at* <https://www.irs.gov/pub/irs-tege/rr69-545.pdf> [<https://perma.cc/AXK5-N22B>] (last visited June 2, 2019) [hereinafter REVENUE RULING 69-545] (citing RESTATEMENT (SECOND) OF TRUSTS § 368, § 372; 4 AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, SCOTT ON TRUSTS § 368, § 372 (3d ed. 1967)).

49. *Benefiting from Charity Care: California Not-for-Profit Hospitals*, INST. HEALTH & SOCIO-ECONOMIC POL’Y 10 (Aug. 15, 2012), [http://nurses.3cdn.net/2c18b9633089481d2c\\_qrm6yn2ci.pdf](http://nurses.3cdn.net/2c18b9633089481d2c_qrm6yn2ci.pdf) [<https://perma.cc/E3AC-UNCB>] (citing John D. Colombo, *Federal and State Tax Exempt Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 433, 438 (2007); Bill Benson, Jr. California Board of Equalization Email Communication (May 14, 2012)).

50. *Id.*

51. REVENUE RULING 69-545, *supra* note 48; *see also* Corbett, *supra* note 2, at 113–14.

52. CONG. BUDGET OFF., NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 7 (Dec. 2006), <https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf> [<https://perma.cc/HZ9S-L4BC>] (citing INTERNAL REVENUE SERVICE, REVENUE RULING 83-157, 1983-2 C.B. 94, [www.irs.gov/pub/irs-tege/rr83-157.pdf](http://www.irs.gov/pub/irs-tege/rr83-157.pdf) [<https://perma.cc/QF79-F4Z5>]).

53. Corbett, *supra* note 2, at 113–14.

54. *Emergency Medical Treatment & Labor Act (EMTALA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/> [<https://perma.cc/3H9G-9SEL>] (last modified Mar. 26, 2012).

55. *Id.*

In 2010, the Affordable Care Act (ACA) was enacted.<sup>56</sup> Among other changes, the ACA amended some of the existing laws governing nonprofit hospital status.<sup>57</sup> First, it added a new section to Internal Revenue Code Section 501 that created new community benefit requirements for nonprofit hospitals, including the addition of community health needs assessments, financial assistance policies, limitations on charges, and billing and collections requirements.<sup>58</sup> The newly required community health needs assessments mandate that each nonprofit hospital conduct an assessment—at least once every three years—of the health needs of the communities it serves, which “takes into account input from persons who represent

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56. The ACA made great strides in improving access to care for all Americans, paying particular attention to women’s health care needs. These included the contraceptive coverage mandate, the prohibition on women getting denied coverage or charged more because of their gender or pre-existing conditions, and the Medicaid expansion which increased access to care for the nation’s poorest patients in states that opted for expansion. *ACOG Committee Opinion 552: Benefits to Women of Medicaid Expansion Through the Affordable Care Act*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (Jan. 2013), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Benefits-to-Women-of-Medicaid-Expansion-Affordable-Care-Act> [<https://perma.cc/STH3-28AF>]; *Affordable Care Act Improves Women’s Health*, OFF. ON WOMEN’S HEALTH, <https://www.womenshealth.gov/30-achievements/31> [<https://perma.cc/UJ42-E3QF>] (last updated Apr. 1, 2019). Before the ACA, one-third of women who tried to buy a health plan (outside of the employer group insurance context) were either denied coverage or charged higher premiums because of their gender or pre-existing conditions. Munira Z. Gunja et al., *How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care*, COMMONWEALTH FUND (Aug. 10, 2017), <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and> [<https://perma.cc/2ALJ-8B59>]. The recent barrage of attempts to rollback protections from the ACA put patients’ lives at risk and disproportionately harmed women, especially poor women of color from rural areas. See Usha Ranji et al., *Ten Ways That the House American Health Care Act Could Affect Women*, KAISER FAM. FOUND. (May 8, 2017), <https://www.kff.org/womens-health-policy/issue-brief/ten-ways-that-the-house-american-health-care-act-could-affect-women/> [<https://perma.cc/7WV5-VGAH>]; Kevin Quealy & Margot Sanger-Katz, *Obama’s Health Law: Who Was Helped Most*, N.Y. TIMES (Oct. 28, 2014), <https://www.nytimes.com/interactive/2014/10/29/upshot/obamacare-who-was-helped-most.html> [<https://perma.cc/L3BQ-48SQ>].

57. Pub. L. No. 111-148, 124 Stat. 119 (2010); see also Corbett, *supra* note 2, at 145–49 (citing Jackie Calmes, *After Health Care Passage, Obama Pushes to Get It Rolling*, N.Y. TIMES, Apr. 18, 2010, at A16 (quoting David Cutler, Harvard economist and President Obama’s chief campaign adviser of health policy); Gary S. Davis & Michael L. Silhol, *Healthcare Reform: The Law and Its Implications* 98, (AHLA Seminar Papers, Paper No. 20101206, 2010)); Sara Ferris, *New IRS Rules Crack Down on Nonprofit Hospitals*, HILL (Dec. 29, 2014), <http://thehill.com/policy/healthcare/228211-new-irs-rules-crack-down-on-nonprofit-hospitals> [<https://perma.cc/8U4K-U66G>] (discussing “[n]ewly finalized regulations from the Internal Revenue Service, announced Monday, will require nonprofit hospitals to ‘take an active role in improving the health of the communities’ by making payment methods more fair and making costs more transparent”). The provisions in the ACA putting additional requirements on nonprofit hospitals went into effect in March 2010. *Health Reform Implementation Timeline*, KAISER FAM. FOUND. (July 8, 2013), <http://kff.org/interactive/implementation-timeline/> [<https://perma.cc/K963-B9BC>].

58. 26 U.S.C. § 501(e) (2018); see also Erika K. Lunder & Edward C. Liu, *501(c)(3) Hospitals: Proposed IRS Rules Under § 9007 of the Affordable Care Act*, CONG. RES. SERV. (July 27, 2012), <http://www.naccho.org/uploads/downloadable-resources/501c3-Hospitals-Proposed-IRS-Rules-under-9007-of-the-Affordable-Care-Act-2.pdf> [<https://perma.cc/7U2N-RBVZ>]. See *infra* notes 127–33 for more discussion of the ACA. The relevant statutory language is included as Appendix 1. *Id.*

the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”<sup>59</sup> The hospital is required to make these assessments publicly available and adopt a strategy for responding to the identified community health needs.<sup>60</sup> There are no specific requirements for how the assessments must be conducted, what factors need to be taken into consideration, what corrective steps must be taken, or what results must be achieved in terms of implementation.<sup>61</sup> Moreover, there is no definition of or guidelines addressing how a hospital determines what or which community it serves, other than requiring the hospital to consider the “interests of the community served by the hospital facility.”<sup>62</sup>

The required written financial assistance policy must include “eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,” “the basis for calculating amounts charged to patients,” “the method for applying for financial assistance,” and in the absence of a separate collections and billing policy, the steps the hospital will take in collecting unpaid bills.<sup>63</sup> The financial assistance policy must be widely publicized within the communities served by the hospital.<sup>64</sup> However, there is no real “guidance for implementing these requirements.”<sup>65</sup> The nonprofit hospitals’ “limitations on charges” provision “limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance . . . to not more than the amounts generally billed to individuals who have insurance covering such care, and [] prohibits the use of gross charges.”<sup>66</sup> It also prohibits nonprofit hospitals from taking “extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance.”<sup>67</sup> This provision, like that above, fails to define key terms.<sup>68</sup>

Second, the ACA put into place new reporting requirements for nonprofit hospitals.<sup>69</sup> Specifically, when the provisions of section 501(r) apply, the hospital must provide to the IRS “a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed

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59. 26 U.S.C. § 501(r)(3).

60. *Id.*

61. *Id.*; see also Folkemer et al., *supra* note 1, at 5.

62. 26 U.S.C. § 501(r)(3).

63. *Id.*

64. *Id.*

65. Folkemer et al., *supra* note 1, at 5 (discussing example that no key terms from the statute are defined, including “‘community served by the hospital’ or ‘widely publicized’”).

66. 26 U.S.C. § 501(r)(3).

67. *Id.*

68. Folkemer et al., *supra* note 1, at 6.

69. *Id.*

together with the reasons why such needs are not being addressed,” and the organization’s audited financial statements.<sup>70</sup>

*C. The California Story (California Standards for Nonprofit Taxation Status)*

In California, hospitals that qualify for nonprofit status are exempt from paying state and local property taxes (Welfare Exemption),<sup>71</sup> as well as state income and franchise taxes.<sup>72</sup> To qualify as a nonprofit hospital under the state statutory scheme, a California hospital must be “determined to be exempt from taxation under the United States Internal Revenue Code”<sup>73</sup> and have a “mission statement that requires its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization.”<sup>74</sup> The purpose of these laws is that, in exchange for favorable taxation treatment, “nonprofit hospitals assume a social obligation to provide community benefits in the public interest.”<sup>75</sup> Current California laws on nonprofit hospital taxation were signed into law in 1994 with the passage of SB 697, a law that would later serve as a model for the new ACA standards governing nonprofit hospitals.<sup>76</sup>

Similar to the ACA requirements, California nonprofit hospitals must perform “a community needs assessment evaluating the health needs of the community serviced by the hospital.”<sup>77</sup> These hospitals must also adopt and maintain “a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational

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70. *Id.*; 26 U.S.C.A. § 6033.

71. CAL. REV. & TAX. CODE §§ 214–4214.9 (2019); *see also* CAL. REV. & TAX. CODE § 212 (1996).

72. CAL. REV. & TAX. CODE §§ 23701, 23736 (2018); *Nonprofit/ Exempt Organizations*, CAL. TAX SERV. CTR., <https://www.taxes.ca.gov/exemptbus.html> [<https://perma.cc/8TVW-WBG6>] (last visited June 2, 2019).

73. CAL. HEALTH & SAFETY CODE § 127345 (2017).

74. CAL. HEALTH & SAFETY CODE § 127350 (2019).

75. CAL. HEALTH & SAFETY CODE § 127340 (2019).

76. C. Duane Dauner, *Disclosure, Transparency for Not-for-Profit Hospitals*, CAPITOL WKLY. (Apr. 2, 2015), <http://capitolweekly.net/hospital-community-medi-cal-californians-transparency-disclosure/> [<https://perma.cc/MCJ4-JLSU>] (“SB 697 has been so successful that it became the model for the federal Affordable Care Act’s guidelines for nonprofit hospitals to assess community health needs.”).

77. CAL. HEALTH & SAFETY CODE § 127350 (requiring inclusion of “a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement”).

arrangements.”<sup>78</sup> This plan must be submitted annually to the Office of Statewide Health Planning and Development.<sup>79</sup> “Community benefits” is defined to include:

- (1) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs.
- (2) The unreimbursed cost of services included in subdivision (d) of Section 127340.
- (3) Financial or in-kind support of public health programs.
- (4) Donation of funds, property, or other resources that contribute to a community priority.
- (5) Health care cost containment.
- (6) Enhancement of access to health care or related services that contribute to a healthier community.
- (7) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services.
- (8) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person’s health.<sup>80</sup>

California law “requires that hospitals allow uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level to apply for participation under a hospital’s charity care or partial charity care policy.”<sup>81</sup> The California story can only be fully understood if we also take a close look at recent legislative efforts around nonprofit taxation status in California. These efforts reflect legislators’ understanding that there are systemic deficiencies

78. *Id.* A “community benefits plan” is defined as “the written document prepared for annual submission to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.” CAL. HEALTH & SAFETY CODE § 127345. The community benefits plan must include “(a) Mechanisms to evaluate the plan’s effectiveness including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan; (b) Measurable objectives to be achieved within specified timeframes; (c) Community benefits categorized into the following framework: (1) Medical care services; (2) Other benefits for vulnerable populations; (3) Other benefits for the broader community; (4) Health research, education, and training programs; and (5) Nonquantifiable benefits.” CAL. HEALTH & SAFETY CODE § 127355 (2019).

79. CAL. HEALTH & SAFETY CODE § 127350.

80. CAL. HEALTH & SAFETY CODE § 127345.

81. CAL. STATE AUDITOR, NONPROFIT HOSPITALS: STATUTE PREVENTS STATE AGENCIES FROM CONSIDERING COMMUNITY BENEFITS WHEN GRANTING TAX-EXEMPT STATUS, WHILE THE EFFECTS OF PURCHASES AND CONSOLIDATIONS ON PRICES OF CARE ARE UNCERTAIN 17 (Aug. 9, 2012), <http://www.bsa.ca.gov/pdfs/reports/2011-126.pdf> [<https://perma.cc/U36S-N736>].

in nonprofit status standards that need to be addressed. Though these recent attempts have not yet been able to resolve the current California problem.

*D. Recent Legislative History in California (The California Problem)*<sup>82</sup>

There have been seven attempts in the last five years by California legislators to amend the system for classifying hospitals as nonprofit, as it pertains to their charity care or community benefits requirements.<sup>83</sup> In February 2014, AB 1952 was introduced by Assembly Member Richard Pan, a Democrat from Sacramento, requiring a minimum of five percent of each nonprofit hospital's net patient revenue go towards charity care and instituting a mandatory reporting system whereby nonprofit hospitals would have to file a report with the State Department of Public Health every year "stating the amount of charity care provided by the hospital."<sup>84</sup> It would also have required "the State Public Health Officer to assess a penalty against noncomplying hospitals" and would have established "the Nonprofit Hospital Charity Care Penalty Fund," where the penalty revenues would be deposited and then used to support Medi-Cal.<sup>85</sup> Had this legislation been authorized, AB 1952 would have required the Office of Statewide Health Planning and Development (OSHPD) to "issue a report to the Legislature addressing the unique accounting difficulties in calculating charity care for integrated nonprofit health systems and issue recommendations for how to calculate the amount of

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82. There have also been significant pushes in recent years at the federal level to make substantive change to the standards required for nonprofit hospital status. *See* Folkemer et al., *supra* note 1, at 2 (describing Senate Finance Committee hearings and reports in 2004 and 2006–07 on this issue and a study conducted by the Government Accountability Office in 2009 on the variation in state interpretation and application of the community benefits standard, as well as subsequent reform of the IRS Form 990). These pushes for reform came from both the Democratic and Republican sides of the aisle, with Senator Charles E. Grassley, a Republican from Iowa, Senator Max Baucus (ret.), a Democrat from Iowa, and Assembly Member Bill Thomas, a Republican from California, leading the charge on these reforms at the federal level. Corbett, *supra* note 2, at 136–37. However, as discussed above, while these initial attempts to reform the standards for nonprofit hospitals at the federal level were unsuccessful, the ACA changed the standards to include many of the proposed changes from these legislative inquiries and proposals. *Id.*

83. It is worth noting that the frequency of these attempts seems to have diminished significantly in the latter two years of this five-year period. There were no bills in the 2017–2018 legislative session directly addressing nonprofit hospital status standards for charity care or community benefit. It is also worth noting that in May 2016 Assembly Concurrent Resolution Number 169 was passed, which designated May 2016 as Health Care District Month, drawing attention to health care districts serving rural populations, but without taking concrete action aimed at reducing medically underserved or underserved parts of these districts. Assemb. Con. Res. 169, Health Care District Month (Cal. 2016), [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160ACR169](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160ACR169) [<https://perma.cc/48VD-V4UJ>]. There was also an Assembly Concurrent Resolution in 2015 to designate May as Health Care District Month. Assemb. Con. Res. 69 (Cal. 2016), [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160ACR69](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160ACR69) [<https://perma.cc/48VD-V4UJ>].

84. Assemb. B. 1952 (Cal. 2014), [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201320140AB1952](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB1952) [<https://perma.cc/FZN8-XRHD>].

85. *Id.*



charity care required by these provisions.”<sup>86</sup> However, after being referred to the Assembly Health Committee and amended numerous times, the bill died in committee.<sup>87</sup>

AB 1952 was not the last attempt in California to address this problem. In February 2015, SB 346 was introduced by Senator Bob Wieckowski, a Democrat from Fremont, and co-sponsored by the Greenlining Institute and the California Rural Legal Assistance Foundation.<sup>88</sup> SB 346 was “designed to establish a more accountable system, which advocates say could ultimately go a long way in pressuring hospitals with typically weaker investments in low-income care to improve their practices.”<sup>89</sup> Recognizing “the necessity of establishing uniform standards for reporting the amount of charity care and community benefits a facility provides,” the bill would have required nonprofit hospitals and clinics “to provide community benefits to the public by allocating a specified percentage of the economic value of community benefits to charity health care, as defined, and community building activities, as specified.”<sup>90</sup>

SB 346 would also have required the hospitals, prior to completing the requisite community needs assessment, “to develop a community benefits statement and a description of the process for approval of the community benefits plan by the hospital’s or clinic’s governing board” and “would authorize the hospital or clinic to create a community benefits advisory committee for the purpose of soliciting community input.”<sup>91</sup> The community benefits plan required under this bill would have been submitted annually to OSHPD, including a summary of the needs assessment, statement discussing the community need the plan would address, and list of services “that the hospital or clinic intends to provide in the following year to address community health needs identified in the community health needs assessments.”<sup>92</sup> All this required information would need to be publicly posted on the hospital’s website and available free of charge to any person who requested it.<sup>93</sup> Finally, it would have required the OSHPD Director to adopt regulations with a “standardized format for community benefits plans” and allowed OSHPD to monetarily penalize hospitals that fail to meet any of these requirements.<sup>94</sup>

However, after being referred to the Senate Health Committee, SB 346 failed

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86. *Id.*

87. *Id.*

88. Sam Levin, *California Lawmaker Seeks Stricter Community Benefit Standards for Nonprofit Hospitals*, EAST BAY EXPRESS (Feb. 24, 2015), <http://www.eastbayexpress.com/SevenDays/archives/2015/02/24/california-lawmaker-seeks-stricter-community-benefit-standards-for-nonprofit-hospitals> [<https://perma.cc/5JVS-P4RK>].

89. *Id.*

90. S.B. 346 (Cal. 2015), [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201520160SB346](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB346) [<https://perma.cc/L4AZ-VA35>].

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

to pass in committee and was returned to the Secretary of the Senate pursuant to Rule 56.<sup>95</sup> The bill failed because one of the Senators with whom the Greenlining Institute had worked to make “significant concessions” to the bill “flipped his vote at the last second.”<sup>96</sup> It was described as “a difficult, purely political situation to witness, and it exemplified the strength of the hospital lobby in the state legislature.”<sup>97</sup>

In the two years prior to the introduction of SB 346, Senator Wieckowski and Senator Rob Bonta, a Democrat from Oakland, introduced two similar bills, AB 975 and AB 503, both of which failed to pass due to “strong opposition from the California Hospital Association.”<sup>98</sup> Critics of these bills argued that “nonprofits already provide extensive community benefits and that efforts to establish new regulations would create an unnecessary layer of bureaucracy that would do more harm than good” and “a more uniform reporting system could limit an organization’s ability to tailor its specific community benefit program to the needs of its population—and could pose a challenge for hospitals that are located in more affluent areas and thus treat relatively lower rates of poor and uninsured patients.”<sup>99</sup>

Senator Wieckowski’s argument in support of the bills was that “[w]e give these hospitals favorable tax treatment, so it makes sense that we come together to establish an appropriate and transparent way to calculate the amount of community benefits we are getting in return” and that “[t]his bill makes no changes to how many community benefits a hospital must provide, but it will increase accountability and provide a clearer picture of the level of community benefits invested back into our local communities.”<sup>100</sup> Specifically,

The intent of SB 346 and prior attempts on this issue was to make a standard in the delivery of charity care and update the community benefits requirements for nonprofit hospitals and multispecialty clinics. By requiring California nonprofit hospitals to meet public accountability standards and boost intensive community involvement through these methods, [it] would have created transparency. This would have measured

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95. “Bills introduced in the first year of the regular session and passed by the house of origin on or before the January 31st constitutional deadline are ‘carryover bills.’ Immediately after January 31, bills introduced in the first year of the regular session that do not become ‘carryover bills’ shall be returned to the Chief Clerk of the Assembly or Secretary of the Senate, respectively. Notwithstanding Rule 4, as used in this rule ‘bills’ does not include constitutional amendments.” Cal. S. Con. Res. 37, at 184 (Cal. 2015), [http://www.leginfo.ca.gov/rules/joint\\_rules.pdf](http://www.leginfo.ca.gov/rules/joint_rules.pdf) [<https://perma.cc/M5XG-BWZC>].

96. E-mail from Anthony Galace, Bridges to Health Dir., The Greenlining Inst., to author (Mar. 1, 2016, 5:51 PST) (on file with author).

97. *Id.*

98. Levin, *supra* note 88; Assemb. B. 975 (Cal. 2013), [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201320140AB975](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB975) [<https://perma.cc/W2R8-QGG9>]; Assemb. B. 503 (Cal. 2013), [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201320140AB503](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140AB503) [<https://perma.cc/9VDW-ETFA>].

99. *Id.*

100. *Id.*

how much charity care and community benefit spending should be allocated to underserved and vulnerable communities.<sup>101</sup>

Anthony Galace, the Bridges to Health Director at the Greenlining Institute, in supporting SB 346 as well as earlier community benefit legislation (AB 975 in 2013 and AB 503 in 2014), said his organization “firmly believe[s] that community benefits represents an important opportunity for hospitals to invest in the social determinants of health - social and environmental factors that influence health more directly than medical care.”<sup>102</sup> When asked about why they have worked to support such bills, Mr. Galace said, “The lack of data and information about hospital investments towards community health improvement, coupled with the dubiously low investment portfolio, made us question whether not-for-profit hospitals were truly committed to the overall and holistic health of their patients.”<sup>103</sup>

In February 2015,<sup>104</sup> AB 1046 was introduced by Assembly Member Dababneh, a Democrat from Encino, which would have revised the current provisions of the Health and Safety Code to replace the requisite community benefit plan with a community health needs assessment (CHNA) report.<sup>105</sup> Despite its past opposition to legislation aimed at reforming the standards for nonprofit hospital status in California, the California Hospital Association (CHA) co-sponsored this bill.<sup>106</sup> California Healthline, describing comments from CHA spokesperson Jan Emerson-Shea, said, “[T]he bill will aim to align community benefits provisions under the Affordable Care Act and California law so that ‘there’s not one set for the feds and another for the state,’ which would ‘help hospitals operate more efficiently.’”<sup>107</sup>

AB 1046 was “aimed at providing even greater disclosure and transparency on how California’s not-for-profit hospitals report community benefits by aligning federal and state community benefit laws.”<sup>108</sup> It was intended to build on the current California standards “by streamlining the reporting process and conforming state

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101. E-mail from Catalina Sanchez, Legislative Assistant, Office of Senator Bob Wieckowski, to author (Mar. 11, 2016, 3:06 PST) (on file with author).

102. E-mail from Anthony Galace, *supra* note 96.

103. *Id.*

104. In February 2015, Assembly Member Thurmond, a Democrat from Richmond, also introduced a bill, AB-1460, which addressed community benefits standards for nonprofit hospitals but would only have made non-substantive technical changes to existing law. Assemb. B. 1460 (Cal. 2015), [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160AB1460](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1460) [<https://perma.cc/85PQ-34L7>]. However, the bill did not make it through the legislative process.

105. Assemb. B. 1046 (Cal. 2015), [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160AB1046](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1046) [<https://perma.cc/ZZJ2-PPBG>].

106. *Calif. Bills Aim to Set Standard Charity Care Requirements*, CAL. HEALTHLINE (Mar. 3, 2015), <http://californiahealthline.org/morning-breakout/calif-bills-aim-to-set-standard-charity-care-requirements/> [<https://perma.cc/5FSS-WX7Q>] (quoting CHA spokesperson Jan Emerson-Shea).

107. *Id.*

108. Dauner, *supra* note 76.

and federal laws.”<sup>109</sup> The bill provided a comprehensive list of steps that hospitals must take in making CHNA reports:

- (1) A hospital facility shall complete all of the following steps:
  - (A) Define the community it serves.
  - (B) Assess the health needs of that community.
  - (C) In assessing the health needs of the community, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
  - (D) Document the CHNA in a written report that is adopted for the hospital facility by an authorized body of the hospital facility.
  - (E) Make the CHNA report widely available to the public.<sup>110</sup>

The hospital would also be required to “identify significant health needs of the community, prioritize those health needs, and identify resources potentially available to address those health needs, such as organizations, facilities, and programs in the community, including those of the hospital facility.”<sup>111</sup> The bill added a list of parties whose input must be sought and considered in evaluating community health needs<sup>112</sup> and required hospitals to report which parties’ input they considered along with descriptions of the processes and methods used to determine community health needs, a description of how and why they prioritized certain health needs over others, and an evaluation of the effectiveness of their community benefit actions from the prior year.<sup>113</sup> AB 1046 also required the

109. *Id.*

110. *Id.*

111. *Id.*

112. (5) A hospital facility shall solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

(A) At least one state, local, tribal, or regional governmental public health department or equivalent department or agency, or a State Office of Rural Health described in Section 338] of the Public Health Service Act (42 U.S.C. Sec. 254r), with knowledge, information, or expertise relevant to the health needs of that community.

(B) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of those populations. For purposes of this paragraph, medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care, as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

(C) Written comments received on the hospital facility’s most recently conducted CHNA and most recently adopted implementation strategy.

(6) A hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives. *Id.*

113. *Id.*

hospital's implementation strategy to either "[d]escribe how the hospital facility plans to address the health need by describing the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions; identifying the resources the hospital facility plans to commit to address the health need" or "[i]dentify the health need as one the hospital facility does not intend to address, and explain why the hospital facility does not intend to address the health need."<sup>114</sup>

The CHNA report would have to be submitted every three years, but the hospital would also have to submit annual updates of its community benefits activities.<sup>115</sup> The bill would have eliminated the current provision that exempts small and rural hospitals and clinics from these requirements.<sup>116</sup> The bill contained an entirely new definitions section with detailed explanations for what is meant by "charity care,"<sup>117</sup>

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114. *Id.*

115. *Id.*

116. *Id.*

117. "Charity care" means free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Charity care shall be recorded at cost. Charity care does not include bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay." *Id.*

“community benefits,”<sup>118</sup> and “community building activities”<sup>119</sup> as well as a number of other terms not defined or included in the original statutes.<sup>120</sup>

The bill had explicit provisions stating that a hospital may not define its community “to exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital facility draws its patients, unless those populations are not part of the hospital facility’s target

118. (d) “Community benefits” includes, but is not limited to, any of the following:

- (1) The unpaid cost of charity care and other financial assistance.
- (2) The unpaid cost of government-sponsored health care programs, including, but not limited to all of the following:
  - (A) Medicare.
  - (B) Medicaid, including the Medi-Cal program.
  - (C) State Children’s Insurance Program.
  - (D) State or local medically indigent programs.
  - (E) Other means-tested government programs.
- (3) The cost of community benefit programs and activities, including, but not limited to, the following:
  - (A) Community health improvement services.
  - (B) Health professions education.
  - (C) Subsidized health services.
  - (D) Research.
  - (E) Cash and in-kind contributions.
  - (F) Community building activities.
  - (G) Community benefit operations.

*Id.*

119. (f) “Community building activities” includes, but is not limited to, all of the following:

- (1) Physical improvements and housing, which may include the provision or rehabilitation of housing for vulnerable populations.
- (2) Economic development, which may include assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.
- (3) Community support, which may include child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities.
- (4) Environmental improvements, which may include activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.
- (5) Leadership development and training for community members, which may include training in conflict resolution, civic, cultural, or language skills, and medical interpreter skills for community residents.
- (6) Coalition building, which may include participation in community coalitions and other collaborative efforts with the community to address health and safety issues.
- (7) Community health improvement advocacy, which may include efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation.
- (8) Workforce development, which may include recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, and collaboration with educational institutions to train and recruit health professionals needed in the community.
- (9) Other community building activities that protect or improve the community’s health or safety that are not described in the categories listed in paragraphs (1) to (8), inclusive.*Id.*

120. *Id.*

patient population or affected by its principal functions . . . .”<sup>121</sup> Finally, it changed the list of community benefits to include (but not be limited to) programs or activities that:

- (1) Are available broadly to the public and serve low-income consumers.
- (2) Reduce geographic, financial, or cultural barriers to accessing health services, which, if they ceased, would result in access problems, including, but not limited to, longer wait times or increased travel distances.
- (3) Address federal, state, or local public health priorities, such as eliminating disparities in access to health care services or disparities in health status among different populations.
- (4) Leverage or enhance public health department activities, such as childhood immunization efforts.
- (5) Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- (6) Otherwise would become the responsibility of the government or another tax-exempt organization.
- (7) Advance increased general knowledge through education or research that benefits the public.<sup>122</sup>

However, after being referred to the Assembly Health Committee and having two set hearings cancelled at the author’s request, AB 1046 died in committee pursuant to Article IV, Section 10(c)<sup>123</sup> of the California Constitution.<sup>124</sup>

In February 2016, Assembly Member Gomez, a Democrat from Los Angeles, introduced AB 2849, which would have made technical, non-substantive changes to the reporting requirements for community benefits.<sup>125</sup> The bill did not make it through the legislative process

### III. WHAT DOES A NONPROFIT HOSPITAL REALLY LOOK LIKE?

Does it make sense in modern times to grant hospitals nonprofit status? This is a question that lawmakers, pundits, and scholars have debated over the last few decades with no real consensus or resolution.<sup>126</sup> Part of the explanation for the

121. *Id.*

122. *Id.*

123. Any bill introduced during the first year of the biennium of the legislative session that has not been passed by the house of origin by January 31 of the second calendar year of the biennium may no longer be acted on by the house. No bill may be passed by either house on or after September 1 of an even-numbered year except statutes calling elections, statutes providing for tax levies or appropriations for the usual current expenses of the State, and urgency statutes, and bills passed after being vetoed by the Governor. CAL. CONST. art. IV, § 10(c).

124. *Id.*

125. AB-2849 (Feb. 19, 2016), [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201520160AB2849](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2849) [<https://perma.cc/3VJX-HRLZ>].

126. Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980) (examining the basis for nonprofit status for hospitals and analyzing

persistence of this debate is the ongoing difficulty of empirically evaluating whether the charity care and community benefits contributions of nonprofit hospitals are equal to the cost to society in granting these institutions tax exemptions.<sup>127</sup> Substantial evidence shows something is wrong with the current system.<sup>128</sup> There is also evidence that eliminating the tax exemption for nonprofit hospitals could have a devastating effect on access to health care for the remainder of Americans who still lack insurance under the current system.<sup>129</sup> In evaluating how to resolve these tensions in California, it is important to look at the system holistically. The following

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whether this makes sense in a modern world); *see, e.g.*, Corbett, *supra* note 2 (arguing a new business entity form “that can reconcile promotion of the public good with limited profit-seeking - accomplished through a legally-enforceable organizational form that acknowledges the legitimate interests of multiple stakeholders while mandating both mission primacy and fiduciary obligation - may well be better-suited to the modern environment and new imperatives of the ACA”); Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 URB. LAW. 143 (1994) (proposing to “eliminat[e] the tax-exempt status of most nongovernmental nonprofit hospitals”); A. Kay B. Roska, *Nonprofit Hospitals: The Relationship Between Charitable Tax Exemptions and Medical Care for Indigents*, 43 SW. L.J. 759, 761 (1989) (questioning “whether private nonprofit hospitals that have abandoned their historic mission to serve the sick poor should continue to qualify for tax exemption”); Jeremy J. Schirra, *A Veil of Tax Exemption?: A Proposal for the Continuation of Federal Tax-Exempt Status for “Nonprofit” Hospitals*, 21 HEALTH MATRIX 231 (2011) (arguing in “support a continuation of the tax exemption for nonprofit hospitals through a proposed new method to qualify for tax exemption”); James E. Tyrrell, III, *Non-Profits Under Fire: The Effects of Minimal Charity Care Requirements Legislation on Not-for-Profit Hospitals*, 26 J. CONTEMP. HEALTH L. & POL’Y 373 (2010) (arguing that federal and state legislation attempting to reform the standard for nonprofit hospital status “pose a nation-wide threat to the financial stability of these essential institutions”).

127. AHS Hosp. Corp. v. Town of Morristown, 28 N.J. Tax 456, 464–65 (2015) (quoting David Brunori, *It’s Time to End Property Tax Exemptions - - For Everyone*, FORBES, (Feb. 14, 2015, 8:35am), <http://www.forbes.com/sites/taxanalysts/2015/02/14/its-time-to-end-property-tax-exemptions-for-everyone/> [<https://perma.cc/L9GA-8DVN>] (“[I]f you narrow the tax base by exempting some property, everyone else pays more . . . . The effects of the exemption are exacerbated by the fact that nonprofits use local government services.”); *see* Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139, 142 (2007) (“Given the similar missions of most hospitals, determining whether and how nonprofits differ from their counterparts, particularly for-profit hospitals, has presented a persistent puzzle.”); Corbett, *supra* note 2, at 130–31 (quoting Fred Joseph Hellinger, *Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements*, 34 J. HEALTH POL., POL’Y & L. 37, 38 (2009) (citing *The Tax-Exempt Hospital Sector: Hearing Before the Comm. on Ways & Means U.S. H.R.*, 109th Cong., Serial No. 109-17 (May 26, 2005) (statement of Mark Everson, Comm’r of the Internal Revenue Serv.)) (“What we have seen since 1969 has been a convergence of practices between the for-profit and nonprofit hospital sectors, rendering it increasingly difficult to differentiate for-profit from not-for-profit health care providers. In our review of tax-exempt hospitals, some of the issues we are finding include complex joint ventures with profit-making companies, excessive executive compensation, operating for the benefit of private interest rather than the public good, unrelated business income and employment taxes.”).

128. *Benefiting from Charity Care: California Not-for-Profit Hospitals*, INST. FOR HEALTH & SOCIO-ECON. POL’Y 10 (Aug. 15, 2012), [http://nurses.3cdn.net/2c18b9633089481d2c\\_qrm6yn2ci.pdf](http://nurses.3cdn.net/2c18b9633089481d2c_qrm6yn2ci.pdf) [<https://perma.cc/8D66-Q8TS>]; *see* Justin Rausa, Sydney Fang & Carla Saporta, *Not-for-Profit Hospitals and Community Benefit: What We Don’t Know Can Hurt Us*, GREENLINING INST. 13 (Nov. 2013), <http://greenlining.org/wp-content/uploads/2013/11/GLI-Community-Benefits-2013.pdf> [<https://perma.cc/7RLN-GBEK>].

129. Horwitz, *supra* note 127, at 143.



sections briefly touch on a number of factors that must be considered to get a complete picture of the current status of California's nonprofit hospitals.

*A. Emergency Medical Treatment and Labor Act (EMTALA)*

The interplay of the Emergency Medical Treatment and Labor Act (EMTALA)<sup>130</sup> requirements and nonprofit hospitals' provision of charity care is worth noting. EMTALA was enacted in 1986 in response to the problem of "patient dumping," where hospitals would "deny[] people emergency medical screening and stabilization services by either 'dumping' emergency room patients or transferring them to other hospitals once it is discovered that the patients are uninsured or have no way to pay for their treatment."<sup>131</sup>

EMTALA provides that:

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.<sup>132</sup>

EMTALA defines an emergency medical condition as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions—

- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.<sup>133</sup>

If any individual (regardless of eligibility for benefits or insurance status)

130. 42 U.S.C. § 1395dd(a) (2011).

131. Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 590 (2003); see also Alexa E. Welzien, *Balancing EMTALA's Duty to Stabilize Hospital Inpatients and CMS's Regulations in the Midst of a Struggling Hospital Industry*, 23 HEALTH LAW. 21, 21 (2011).

132. 42 U.S.C. § 1395dd(a).

133. 42 U.S.C. § 1395dd(e)(1).

shows up at a hospital presenting with an emergency medical condition, the hospital is required to provide either: “(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.”<sup>134</sup> While EMTALA requires the provision of emergency medical care, it does not prevent hospitals from billing patients for the services rendered and it does not require medical care be provided in non-emergency situations. Thus, a substantial portion of the services provided by nonprofit hospitals that are considered charity care would be provided regardless of nonprofit taxation status.

*B. The Affordable Care Act (ACA)*<sup>135</sup>

In 2010, when the ACA was signed into law, it extended insurance coverage to a significant percentage of Americans who were previously dependent on charity care.<sup>136</sup> In theory, this may “free up hospitals’ community benefit dollars for more upstream spending going forward, as more of California’s uninsured and underinsured population receives coverage through Covered California and the Medi-Cal expansion.”<sup>137</sup> The ACA prohibits nonprofit hospitals from including bad debt and Medicare shortfalls<sup>138</sup> as community benefits in their community benefit plans.<sup>139</sup> California law has no such provision, continuing to allow bad debt and Medicare shortfalls to count as community benefits for California’s state tax exemptions.<sup>140</sup> There are significant gaps in the ACA requirements in terms of

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134. 42 U.S.C. § 1395dd(b).

135. While the health care system seems to be going in the direction of more coverage, and discussions about the possibility of universal health care are becoming more frequent, any coverage progress will not alleviate the problem of health care access in underserved locations. See, e.g., Ezra Klein, *Two Charts That Should Be in Every Health-Care Discussion*, WASH. POST (Jan. 25, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/01/25/the-charts-that-should-dominate-the-health-care-discussion/> [<https://perma.cc/9886-QHX7>] (discussing that “Obamacare will mostly fix the universal coverage problem, but it won’t fix the cost problem”); *500+ Organizations Launch Global Coalition to Accelerate Access to Universal Health Coverage*, GLOBAL HEALTH WORKFORCE ALLIANCE (Dec. 12, 2014), [https://www.who.int/workforcealliance/media/news/2014/500\\_Orgs/en/](https://www.who.int/workforcealliance/media/news/2014/500_Orgs/en/) [<https://perma.cc/Z9HK-VGDX>] (discussing that a “new global coalition of more than 500 leading health and development organizations worldwide is urging governments to accelerate reforms that ensure everyone, everywhere, can access quality health services without being forced into poverty”).

136. Folkemer et al., *supra* note 1, at 4.

137. Rausa, Fang & Saporta, *supra* note 128, at 28.

138. Medicare shortfalls is referring to the amount of money hospitals lose because of government underpayments from Medicare and Medicaid. See *American Hospital Association Underpayment by Medicare and Medicaid Fact Sheet*, AM. HOSP. ASS’N 1 (Nov. 2008), <http://www.aha.org/content/00-10/08-medicare-shortfall.pdf> [<https://perma.cc/A8GE-MLX7>]. Specifically, often those on Medicare or Medicaid receive treatment that costs more to the hospital than the government will reimburse under Medicare or Medicaid. *Id.*

139. Rausa, Fang & Saporta, *supra* note 128, at 10, 28.

140. *Id.* at 28.

uniformity of charity care and community benefit standards. Specifically, “the ACA lacks guidelines for providing charity care, and federal law sets no minimum requirements for community benefit activities.”<sup>141</sup> The ACA reforms do not adequately fix the uniformity problem or force hospitals to define the communities they serve in a way that is targeted at helping those in greatest need or most beneficial to society. Thus, the reporting and other requirements are insufficient to fix the nonprofit status problem in this country.

*C. Cost vs. Benefit Analysis of Nonprofit Status*

Assuming that the benefits of allowing nonprofit hospitals to remain tax-exempt outweigh the costs, there is still a uniformity problem that existing standards fail to address. This problem is one of fairness and whether current requirements maximize the societal benefit that nonprofit hospitals should provide. Even in a state like California that adds its own charity care policies and reporting requirements to those imposed by the federal government, it is incredibly difficult to determine whether nonprofit hospitals are providing much more charity care and community benefits than their for-profit counterparts. It is, however, abundantly clear that California nonprofit hospitals benefit from their nonprofit status—with combined financial benefits of more than \$24 billion each year.<sup>142</sup>

In a recent study, University of California San Francisco researchers determined that in California, on average, charity care constituted 1.9% of nonprofit hospitals’ operating expenses, and 1.4% of for-profit hospitals’ operating expenses.<sup>143</sup> While the researchers concluded this difference was “significant,” when asked about this conclusion, Dr. Erica Valdovinos said

[O]ur characterization of the difference between spending on charity care at not for profit and for profit hospitals as ‘significant’ was in the statistical sense of the word. That is, our finding that there was a difference in spending is unlikely to have occurred by chance, and it is very likely that a true difference exists between levels of spending at the two types of hospitals.<sup>144</sup>

Dr. Valdovinos further clarified that, in terms of whether the 0.5% difference is meaningful in a practical sense, “[a]s researchers, we can share our findings and help add some context and data to the conversation, but ultimately it is up to policymakers and the public to determine what is expected of not for profit hospitals in exchange for their not for profit status.”<sup>145</sup> To go about determining whether this difference should be considered meaningful in a policy sense and if

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141. Valdovinos et al., *supra* note 14, at 1296.

142. *Id.*

143. *Id.* at 1299.

144. Email from Erica Valdovinos, Emergency Med. Resident, Alameda Cty. Med. Ctr., to author (Feb. 24, 2016, 8:37 PST) (on file with author).

145. *Id.*

not, what standards would work best for nonprofit hospitals to ensure a meaningful difference between nonprofit and for-profit hospitals' charity care and community benefits, we need to take a closer look at what nonprofits really look like in operation.

### 1. *Lack of Uniformity in Nonprofit Hospitals*

The results of the UCSF study “suggest that there is a lot of variability in charity care delivery and . . . a need for more accountability in the system. If we are granting these tax exemptions in the interest of the public, then it is in the public's best interest for policymakers to introduce policies that increase accountability.”<sup>146</sup> First, “because individual hospitals set their own charity care policies, a patient who qualifies for charity care at one hospital might have his or her charges counted as bad debt at another hospital.”<sup>147</sup>

Second, while the “study did not include Medicaid shortfalls which have been shown to account for a sizable proportion of not-for-profit hospitals' community benefit activities,” there was “no significant difference between not-for-profit and for-profit hospitals in the percentages of Medicaid patients served,” and the study found that “hospitals that cared for more Medicaid patients also spent more on charity care.”<sup>148</sup> Third, the study found “substantial variation in charity care spending at not-for-profit hospitals and identified factors other than not-for-profit status that affected this spending.”<sup>149</sup> Ultimately,

[b]ecause there aren't uniform standards—even in terms of how hospitals calculate their charity care spending—the community benefit investments can vary widely across different nonprofits and there is an overall lack of transparency, advocates have argued. As a result, it can be difficult to assess whether these nonprofit corporations—some which report huge profits each year—are doing enough to earn their large tax breaks.<sup>150</sup>

A new study in Health Affairs found that “[s]even of the 10 hospitals in the U.S. with the biggest surpluses from patient care services in 2013 were not-for-profits.”<sup>151</sup> A number of factors influenced which hospitals had such surpluses, including “a hospital's market power, whether the hospital's market has a dominant insurer, retail price markup, prestige, teaching status, the mix of uninsured and Medicare patients, and for-profit or not-for profit ownership.”<sup>152</sup> At the same time,

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146. *Id.*

147. Valdovinos et al., *supra* note 14, at 1298.

148. *Id.* at 1301.

149. *Id.* at 1302.

150. Levin, *supra* note 88.

151. Harris Meyer, *Not-for-Profits Dominate Top-10 List of Hospitals with Biggest Surpluses*, MOD. HEALTHCARE (May 2, 2016, 1:00 AM), <https://www.modernhealthcare.com/article/20160502/NEWS/160509991/not-for-profits-dominate-top-10-list-of-hospitals-with-biggest-surpluses> [<https://perma.cc/85LS-AUB6>].

152. *Id.*

the “median not-for-profit and the median public hospital lost money, while the median for-profit hospital made money.”<sup>153</sup>

At the other extreme, “[r]ural hospitals, hospitals with less than 50 beds and major teaching hospitals had larger losses than urban hospitals, larger hospitals, and those with no teaching or minor teaching status.”<sup>154</sup> The study seems to draw the inference that a hospital’s market share in the relevant market plays a significant role in determining whether the hospital will have a surplus.<sup>155</sup> This is because hospitals with dominant market shares are acting like monopolists and charging higher prices for patient services than their counterparts in more competitive markets.<sup>156</sup> Ultimately, these studies demonstrate that the hospital market is incredibly complex and that the locations of hospitals play a critical role in how hospitals interact with consumers, what consumers they serve, and overarching institutional operations.

## 2. *Nonprofit Hospitals with For-profit Tendencies*

The UCSF study “found that hospitals dedicate a minority of their budgets to providing charity care, which suggests that even not-for-profit hospitals sometimes behave more like economic entities such as businesses instead of charity operations.”<sup>157</sup> A New Jersey court described that “[l]ike their new for-profit competitors, today’s non-profit hospitals have evolved into labyrinthine corporate structures, intertwined with both non-profit and for-profit subsidiaries and unaffiliated corporate entities.”<sup>158</sup> There has also been an increase in recent years of private sector involvement in nonprofit hospitals’ operations.<sup>159</sup> This is cause for concern because it tends to make nonprofit hospitals look and feel a lot more like their for-profit counterparts.

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153. *Id.*

154. *Id.*

155. *Id.*

156. Alex Kacik, *Dominant Hospitals Dictate Price and Contract Terms*, MOD. HEALTHCARE (May 9, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180509/NEWS/180509912> [<https://perma.cc/A8PE-SZ8A>].

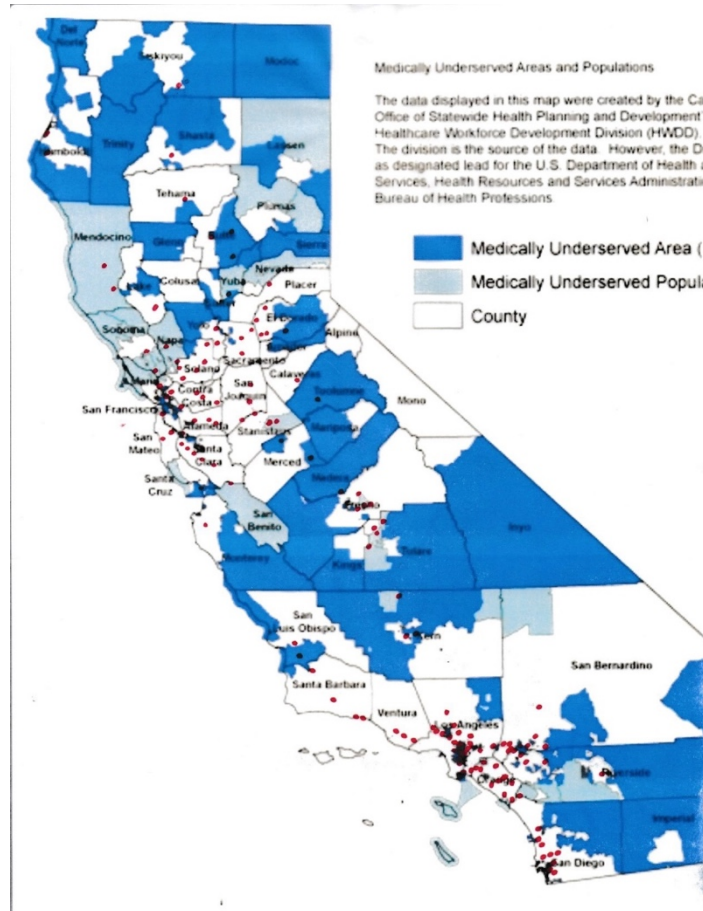
157. Valdovinos et al., *supra* note 14, at 1302.

158. *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456, 465 (2015).

159. Sam Catherman, *Is California Trying to Kill the Non-profit Hospital?*, BUILDING BETTER WORLD NEWS (Dec. 5, 2015), <http://www.babwnews.com/2015/12/is-california-trying-to-kill-the-non-profit-hospital/> [<https://perma.cc/J536-527W>].

### 3. Locations of Nonprofit Hospitals

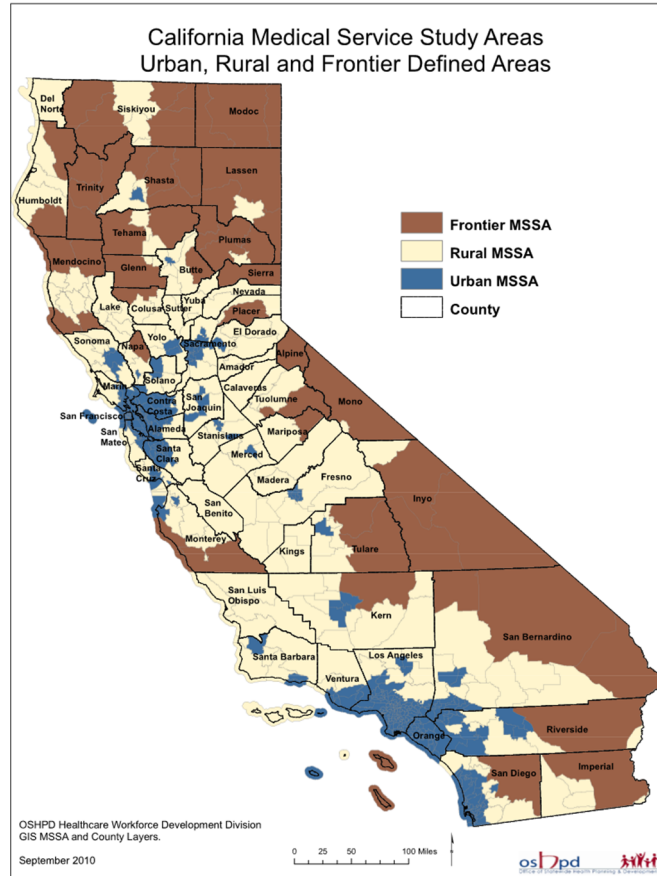
Below is a mapping of the locations of nonprofit hospitals throughout California, with the red dots indicating their approximate locations. The dark blue sections of the image indicate medically underserved areas and the light blue sections of the map image indicate medically underserved populations.



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160. This map has been altered from its original design, but it is based on a map provided by OSHPD. See *Medically Underserved Areas and Populations Map*, Posting to *California's Healthcare Workforce: Meeting our Healthcare Needs*, OSHPD (Oct. 19, 2010), [http://www.oshpd.ca.gov/hwdd/pdfs/Shortage/20101027\\_MUAP\\_v10.pdf](http://www.oshpd.ca.gov/hwdd/pdfs/Shortage/20101027_MUAP_v10.pdf) [<https://perma.cc/D8MM-LZ22>]. The nonprofit hospitals plotted on this map are an underestimate of the location disparity.

The majority of California nonprofit hospitals are located in regions of the state that are neither medically underserved nor have medically underserved populations. This further calls into question whether the goals of tax exemption are actually being served by the nonprofit hospital system. Huge swaths of the state, largely rural and frontier areas, have unserved and underserved communities that are too far away from any nonprofit hospital to benefit from the charity care or community benefits provided. The chart below identifies the rural, urban, and frontier parts of the state by county.



161. *California Medical Service Study Areas Urban, Rural and Frontier Defined Areas*, OSHPD (Sept. 2010), [http://www.oshpd.ca.gov/HWDD/pdfs/GIS/20100921\\_RuralMSSA.pdf](http://www.oshpd.ca.gov/HWDD/pdfs/GIS/20100921_RuralMSSA.pdf) [<https://perma.cc/XLJ3-XD9N>].

California has 344 hospitals and 7063 licensed health care facilities in the state.<sup>162</sup> Only sixty-two are located in rural areas, with only thirty-four being critical access hospitals.<sup>163</sup> The areas of the state with the highest concentrations of nonprofit hospitals are urban, often in the highest rent districts.<sup>164</sup> This indicates that under the current system, it may not have much overall impact on the larger disparity problem if the state were to increase the percentage of charity care required or change the reporting requirements for charity care and community benefits. Such changes would not force nonprofit hospitals to serve the most needy communities or reach outside of the communities that happen to surround the hospitals' locations.

There is an argument that locating the vast majority of nonprofit hospitals in the most densely populated areas is logical based on population density. However, this argument obscures the fact that there are low-income people living in all areas of the state. The percentage of individuals living below the poverty line is modestly higher in the state's medically underserved rural and frontier areas than in the state's more densely populated regions, a relevant factor in the context of the concentration of nonprofits in urban areas. Specifically, 16.4% of California's rural populations live below the poverty line and 13.2% of its urban populations live below the poverty line.<sup>165</sup> The average per capita income is also lower in rural areas, with an average income of \$156,374 overall in the state and \$44,673 for rural residents.<sup>166</sup> The unemployment rate in rural areas in California is 5.5% while the unemployment rate in urban areas is 4.7%.<sup>167</sup>

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162. *Hospital Statistics by State*, AM. HOSP. DIRECTORY, [https://www.ahd.com/state\\_statistics.html](https://www.ahd.com/state_statistics.html) [<https://perma.cc/49W2-DRLZ>] (last visited June 2, 2019); *Licensed Healthcare Facility Listing*, OSHPD, <https://data.chhs.ca.gov/dataset/licensed-healthcare-facility-listing> [<https://perma.cc/PKY6-2R9N>] (last visited June 2, 2019).

163. *California Rural Healthcare Facilities*, *supra* note 9; *Medicare Rural Hospital Flexibility Program: Critical Access Hospital Designation*, CAL. DEP'T HEALTH CARE SERVS., [https://www.dhcs.ca.gov/services/rural/Documents/CAHResourceGuide\\_6\\_2014.pdf](https://www.dhcs.ca.gov/services/rural/Documents/CAHResourceGuide_6_2014.pdf) [<https://perma.cc/SR9V-GMM8>] (last modified June 2014) (Critical Access Hospitals are "rural community hospital[s]" that are "certified to receive cost-based reimbursement from the Medicare Program" and have "no more than 25 inpatient beds" and must be located in a rural area and 1) over 35 miles from another hospital, or 2) 15 miles from another hospital in mountainous terrain (or area with only secondary roads.); *Rural Hospitals*, OSHPD (Jan. 1, 2015), [http://gis.oshpd.ca.gov/atlas/topics/rh\\_dashboard](http://gis.oshpd.ca.gov/atlas/topics/rh_dashboard) [<https://perma.cc/2GCK-WF72>]; *see also* [http://www.oshpd.ca.gov/HWDD/pdfs/GIS/20100921\\_RuralMSSA.pdf](http://www.oshpd.ca.gov/HWDD/pdfs/GIS/20100921_RuralMSSA.pdf) [<https://perma.cc/642A-LYNV>].

164. Sara Kimberlin, *Rents and Home Prices Are High in Many Parts of California*, CAL. BUDGET & POL'Y CTR. (Sep. 2017), <https://calbudgetcenter.org/resources/rents-home-prices-high-many-parts-california/> [<https://perma.cc/7E7Y-39M7>].

165. *California Rural Healthcare Facilities*, *supra* note 9.

166. *Id.*

167. *Id.*



Nationally, the average age of the population tends to increase as you move from more urban to more rural areas.<sup>168</sup> Rural areas have a higher percentage of individuals who smoke cigarettes at 13.8% versus 10% in suburban areas.<sup>169</sup> Rural residents in the western parts of the country report higher alcohol consumption levels than those living in more urban areas.<sup>170</sup> There are significantly higher morbidity and mortality rates in rural areas, including higher death rates for rural youth than urban youth and higher death rates for rural working age adults than those in non-rural areas.<sup>171</sup>

Rural women experience higher rates than their urban counterparts of self-reported poor or fair health, unintentional injury and motor vehicle-related deaths, cerebrovascular disease deaths, ischemic heart disease deaths, suicide, cigarette smoking, difficulty with basic actions or limitations of complex activities, and incidence of cervical cancer.<sup>172</sup> Rural areas have higher incidences of obesity with 47.2% of rural women as obese compared to 38.1% of women in metropolitan areas.<sup>173</sup> Women die from pregnancy-related complications in rural areas at a 64% higher rate than women in large cities.<sup>174</sup> Rural areas also have higher infant mortality rates.<sup>175</sup>

Additionally, more rural residents report their overall health as poor, (4.51% as compared to 3.64% of urban residents) and rural populations are “more likely to have chronic or life-threatening diseases and to face significant mental health issues

168. MICHAEL MEIT ET AL., RURAL HEALTH REFORM POLICY RESEARCH CTR., THE 2014 UPDATE OF THE RURAL-URBAN CHARTBOOK (Oct. 2014), <https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf> [<https://perma.cc/47LY-474H>].

169. CAL. DEP'T PUB. HEALTH, CALIFORNIA TOBACCO FACTS AND FIGURES 2016, at 16 (2016), <http://tobaccofreeca.com/wp-content/uploads/2016/10/2016-California-Tobacco-Facts-Figures.pdf> [<https://perma.cc/V9ZM-LFBJ>].

170. MEIT ET AL., *supra* note 169, at 22.

171. *Id.* at 2.

172. AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, ACOG COMMITTEE OPINION 586: HEALTH DISPARITIES IN RURAL WOMEN (2014), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women> [<https://perma.cc/33EL-Y4NF>].

173. Craig Hales et al., *Differences in Obesity Prevalence by Demographic Characteristics and Urbanization Level Among Adults in the United States, 2013-2016*, JAMA (June 19, 2018), <https://jamanetwork.com/journals/jama/fullarticle/2685156> [<https://perma.cc/4VEU-VUJY>].

174. Betsy McKay & Paul Overberg, *Rural America's Childbirth Crisis: The Fight to Save Whitney Brown*, WALL ST. J. (Aug. 11, 2017, 10:42 AM), <https://www.wsj.com/articles/rural-americas-childbirth-crisis-the-fight-to-save-whitney-brown-1502462523> [<https://perma.cc/QF7R-X4J5>]. It is also worth noting that from 2004 to 2014, the number of rural hospitals even offering labor and delivery services dropped by 15% (compared to a 5% drop seen by hospitals in urban areas). *Id.*

175. Danielle Ely et al., *Infant Mortality Rates in Rural and Urban Areas in the United States, 2014*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 2017), <https://www.cdc.gov/nchs/products/databriefs/db285.htm> [<https://perma.cc/RK2T-YZVB>].

including substance abuse and seasonal affective disorder.”<sup>176</sup> There is evidence that rural populations suffer increased detrimental effects from pollution and other environmental factors than their urban and suburban counterparts. As Professor Kirk Smith from the University of California Center for Occupational and Environmental Health described, “[R]ural areas are subject to local sources of pollution as well as secondary effects from urban areas—which means the total global health burden from air pollution falls largely on rural populations.”<sup>177</sup>

In addition to increased poverty and overall poorer health status, rural populations too frequently experience significant barriers to accessing health care services, including a lack of medical professionals, geographic barriers, higher incidences of motor vehicle accidents, and less access to health benefits through government programs and employers.<sup>178</sup> Only 10% of physicians practice in rural areas in the United States.<sup>179</sup> This impacts the distances individuals in rural areas must travel to access health services, which, compounded with “extreme weather conditions, environmental and climatic barriers, lack of public transportation, and challenging roads,” make it extraordinarily difficult for rural populations to access medical care.<sup>180</sup>

There is evidence that the difficulties these geographic barriers impose on individuals seeking medical care can have a negative impact on their health outcomes “by increasing patients’ physical and emotional stress, reducing the likelihood of seeking follow-up care, and limiting proximate family support.”<sup>181</sup> Geographic barriers are also particularly problematic when it comes to emergency situations, where timely access is critical and “[r]esponse times by emergency medical personnel and transport times via ambulance to the hospital are notably greater than in urban areas.”<sup>182</sup> Further, the majority of emergency medical services personnel in rural areas are volunteers.<sup>183</sup> One-third of all the motor vehicle accidents in the United States occur in rural areas, with two-thirds of all motor vehicle-related deaths occurring in rural areas.<sup>184</sup> Finally, rural populations are less

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176. *Health Status and Health Behaviors*, STAN. MED.: ECAMPUS RURAL HEALTH, <http://med.stanford.edu/ruralhealth/health-pros/factsheets/health-status-behaviors.html> [https://perma.cc/UP8N-5PPZ].

177. BERKELEY ENVTL. HEALTH SCI. SCH. PUB. HEALTH, RURAL AIR POLLUTION OFTEN OVERLOOKED (2007), <http://ehs.sph.berkeley.edu/newsbefore2014/2015/1/26/rural-air-pollution-often-overlooked> [https://perma.cc/PR58-NZYS] (quoting Kirk Smith, Professor of Environmental Health Sciences at UC Berkeley’s School of Public Health).

178. STANFORD MED., HEALTHCARE DISPARITIES & BARRIERS TO HEALTHCARE, <http://med.stanford.edu/ruralhealth/health-pros/factsheets/disparities-barriers.html> [https://perma.cc/AX2Z-T4D9] (last visited June 2, 2019).

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

likely to have employer-provided health insurance and are less likely to be covered by Medicaid benefits.<sup>185</sup>

#### 4. Loopholes

Nonprofit hospitals are theoretically given tax breaks in order to offset the government's burden in caring for uninsured individuals.<sup>186</sup> However, there is a significant gap between the amount of the tax benefits nonprofit hospitals receive and the amount of charity care they provide. According to the California Nurses Association's research branch, the Institute for Health and Socio-Economic Policy, California nonprofit hospitals "received \$3.27 billion in total government subsidies and benefits in 2010, while only providing \$1.43 billion in charity care (meaning free or discounted health services to low-income patients)."<sup>187</sup>

Nonprofit hospitals are also able to use loopholes to claim higher amounts contributed towards the community. Since 2009, the IRS has allowed "hospitals to claim external grants as their own community benefit dollars, which allows hospitals with large research facilities to claim tens of millions of dollars in grants received from the National Institutes of Health as their own community benefit spending."<sup>188</sup> This affects the community benefit totals for both federal and state tax-exemptions.<sup>189</sup>

There is also evidence that California public hospitals<sup>190</sup> are bearing the burden of caring for indigent patients and nonprofits are not sufficiently serving their share of these underserved communities. *The East Bay Express* describes that in Alameda and Contra Costa Counties, "public hospitals, like DMC [(Doctors Medical Center)], shoulder the burden of caring for the poorest and sickest patients while private, nonprofit hospitals fail to contribute their fair share of treatment of patients who can't afford to pay their medical bills."<sup>191</sup> Further,

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185. *Id.*

186. Chuck Grassley, *Some Tax-Exempt Hospitals Are Lax at Providing Charity Care and Accountability*, STATNEWS (Sept. 18, 2017), <https://www.statnews.com/2017/09/18/hospitals-tax-exempt-accountability/> [<https://perma.cc/QUQ7-FVV4>]; Bradley Herring et al., *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, 55 INQUIRY 1 (Feb. 13, 2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5813653/> [<https://perma.cc/L5JH-Z6PB>].

187. Sam Levin, *Fatal System Error*, EAST BAY EXPRESS (Jan. 7, 2015), <http://www.eastbayexpress.com/oakland/fatal-system-error/Content?oid=4162218> [<https://perma.cc/8PVS-4ALZ>].

188. Rausa, Fang & Saporta, *supra* note 128, at 13.

189. *Id.*

190. Public hospitals are government owned and funded hospitals, which are distinct from private nonprofit and for-profit hospitals. Six percent of hospitals in California account for public hospitals. CAL. ASS'N PUB. HOSP. & HEALTH SYS., FAST FACTS, <https://caph.org/memberdirectory/facts/> [<https://perma.cc/3VNG-5S9U>] (last visited June 2, 2019).

191. Levin, *supra* note 187.

[P]rivate nonprofit hospitals don't just reap financial benefits derived from serving most of the region's privately insured patients. They also profit from massive tax breaks they receive each year because of their status as tax-exempt organizations. As a result, advocates say the nonprofits are failing to meet their ethical obligation to provide both care for the poor and uninsured and meaningful benefits to the community in exchange for the tax breaks they reap. An *Express* analysis of hospital data in Alameda County and Contra Costa County—an examination of where low-income patients receive care and how different hospitals devote resources to low-income patients—backs up the arguments made by healthcare advocates: Tax-exempt nonprofit hospitals serve comparatively low numbers of uninsured patients and low-income residents covered by government programs like Medi-Cal and Medicare.<sup>192</sup>

*The East Bay Express* highlights that part of the problem is how private nonprofit hospitals “promote community benefit programs that actually do little to help vulnerable populations.”<sup>193</sup> This is problematic when looking at nonprofit hospital status because, although these hospitals are technically complying with the law by creating and promoting community benefit programs, their programs do not actually serve needy communities to justify the lofty tax benefits received.

#### 5. How Do Nonprofit Hospitals View Themselves?

When California nonprofit hospital executives were asked about what community benefits (both monetary and those not so easily quantifiable) they provide to their communities, I received exactly the kinds of responses you would expect. Chris Van Gorder, President and CEO of Scripps Health, said, “We are proud of the significant charity care we deliver and other community benefit programs. Our two Scripps Mercy Hospital campuses are both safety net or Disproportionate Share Hospital (DSH)<sup>194</sup> sites and that is roughly 50% of our system.”<sup>195</sup>

Robert Braithwaite, President and CEO of Hoag Hospital, said, “We spend a considerable amount of time and resources not only complying with the letter of the law associated with those requirements, but the spirit of the law as well. We do many things that are not specific requirements, but are consistent with the theme of the delivery of non-profit healthcare. While some of those are management

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192. *Id.*

193. *Id.*

194. Disproportionate Share Hospitals (DSH) sites are hospitals that “serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.” HEALTH RESOURCES & SERVS. ADMIN., U.S. DEP’T HEALTH & HUM. SERVS., DISPROPORTIONATE SHARE HOSPITALS, <http://www.hrsa.gov/opa/eligibilityandregistration/hospitals/disproportionate-sharehospitals/> [https://perma.cc/9LLJ-ZW6T] (last visited June 2, 2019).

195. E-mail from Chris Van Gorder, President/CEO, Scripps Health, to author (Feb 17, 2016, 6:24 PM PST) (on file with author).

decisions, many of them reflect priorities that the Board of Directors establish.”<sup>196</sup> He further described Hoag’s charity care policy as “based on a sliding scale that uses the Federal Poverty Guidelines. It is reviewed about every two years by both our Finance group as well as a committee of our Board that oversees many of our charity and community benefit activities.”<sup>197</sup> When asked about whether there was a less easily quantifiable way that Hoag’s nonprofit status benefits the community, Braithwaite said:

We have a multi-million dollar community benefit program which we established about 20 years ago. The idea stemmed from seeing great needs in the community that were associated with health and healthcare, but were not issues that we were seeing in the hospital. Nevertheless, they were associated with “health”. We also realized that to address the issues, it would not be wise for us to try and become the expert in all of these areas, especially when there are experts in the community, usually associated with another non-profit that has built up some expertise. So, our solution was to partner with the expert non-profit and help them expand and grow to meet the needs of those with the identified health conditions. You can see some examples of how we partner if you google “Heart of Hoag”. We publish a document every 6 months to help educate the community on worthy endeavors that are going on in the community that are “health related”. This document has stimulated some significant donations to some of those non-profits as they read the stories and become interested in joining the cause.<sup>198</sup>

Cottage Health also responded to my inquiry.<sup>199</sup> A Cottage Health representative said, “First and foremost, as a nonprofit organization in the community, it is our job to be stewards of the community’s resources. Everything we do is looked at from the lens of what is best for the patients and the employees, who are the members of the community that we serve most directly.”<sup>200</sup> In discussing their reinvestment of funds into the community, Cottage Health provided:

Another big way in which our nonprofit status affects us is the fact that all of our revenues must be reinvested into the organization. This means that, instead of giving money to shareholders, we spend additional funds on expanding the clinical services that we provide to the community. One example of this is the pediatric services that we provide through Cottage Children’s Medical Center (CCMC). It is often challenging to generate revenue on pediatric services, but we can use revenues generated from

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196. E-mail from Robert Braithwaite, President/CEO, Hoag Hosp., to author (Feb. 13, 2016, 8:33 AM PST) (on file with author).

197. *Id.*

198. *Id.*

199. E-mail from Taryn O’Connell, Admin. Fellow, Cottage Health, to author (Feb. 24, 2016, 9:43 AM PST) (on file with author).

200. *Id.*

more profitable service lines to subsidize any pediatric services that operate at a loss. This allows the children of our community to receive valuable healthcare services close to home.<sup>201</sup>

Cottage Health's responses seemed to indicate Cottage Health believes there is a quantifiable charity care requirement, stating, "Cottage Health typically provides charity care well beyond the required amount."<sup>202</sup> The representative provided a graph indicating the dollar amount of charity care provided over the last twelve years, which shows a drop from \$17,000,000 in 2012 to \$8,000,000 in 2014.<sup>203</sup> They explained this drop by stating, "The organization did not change practice in terms of when to provide charity care, but a decrease in overall charity care has occurred due to Medi-Cal expansion, as part of the ACA."<sup>204</sup> In describing the less quantifiable ways Cottage Health benefits the community, they stated, "We are committed to moving outside of the four walls of the hospital to provide services to the community that will help improve their overall health, even though this is out of alignment with the way in which healthcare organizations are currently reimbursed for services."<sup>205</sup>

#### IV. OTHER STATE SYSTEMS

Other states use a variety of different systems to determine which hospitals get nonprofit taxation status within their borders. In looking forward to how California and the nation can best reduce current health disparities, it is important to consider what other state programs look like and whether they have been successful in their implementation. Below, I have included a sampling of different state approaches to determining which hospitals receive the benefit of state tax exemption.

##### *A. New Jersey*

New Jersey uses the "profit test" for determining whether to grant or maintain hospitals' nonprofit status.<sup>206</sup> The test for exemption under title 54, section 54:4-43.6 of the New Jersey Statutes is as follows:

To secure an exemption for its real property, a corporation must meet the following three criteria: (1) it must be organized exclusively for the moral and mental improvement of men, women and children; (2) its property must be actually and exclusively used for the tax-exempt purpose; and (3)

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201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456, 465 (N.J. Tax Ct. 2015); *see also Paper Mill Playhouse v. Millburn Twp.*, 95 N.J. 503, 518 (1984).

its operation and use of its property must not be conducted for profit.<sup>207</sup>

The burden is on the hospital seeking exemption to prove it satisfies the elements of this test.<sup>208</sup> New Jersey courts have established that “[t]he test for whether property is used for profit is a ‘pragmatic inquiry into profitability. . . . [A] realistic common sense analysis of the actual operation of the taxpayer; mechanical centering on income and expense figures is to be avoided.’”<sup>209</sup> Courts have further provided that “[a]n organization claiming exemption is permitted to have both exempt and non-exempt uses occurring on its property ‘so long as the two purposes can be separately stated and accounted for and so long as the non-exempt use is never subject to the property tax exemption.’”<sup>210</sup> With regard to for-profit activities conducted on nonprofit property, New Jersey requires such activities to be “conducted so as to be evident, readily ascertainable, and separately accountable for taxing purposes.”<sup>211</sup> Courts will deny nonprofit exemption “where there is significant and substantial ‘comingling of effort and entanglement of activities and operations’ on the property.”<sup>212</sup>

It is proper to deny nonprofit exemptions if “the court is unable to discern between nonprofit activity and ‘activities in the same location that [are] in furtherance of the interests of various for-profit entities.’”<sup>213</sup> The hospital claiming nonprofit status has the burden of proving it satisfies the exemption criteria, and “the New Jersey Supreme Court has held that ‘the claimant has the corollary duty to conduct its affairs in such a fashion as to allow local taxing authorities to readily determine its eligibility for exemption.’”<sup>214</sup> In its evaluation of whether property owned by a nonprofit is actually used for nonprofit purposes, the court “evaluates whether the property is ‘reasonably necessary’ for such tax-exempt purposes.”<sup>215</sup>

In June 2015, the New Jersey Tax Court decided a case of first impression, *AHS Hospital Corp. v. Town of Morristown*, where the court considered the “non-profit hospital’s entire property tax exemption.”<sup>216</sup> The court examined the entity’s structure and operations and denied the hospital’s exemption because it entangled its nonprofit activities and operations with a number of for-profit activities and operations, including renting out space to private physicians throughout the hospital; providing subsidies to various for-profit entities “in the form of working

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207. *Paper Mill Playhouse*, 95 N.J. at 518; N.J. STAT. ANN. § 54:4–43.6.

208. N.J. STAT. ANN. § 54:4–43.6(citing *Int’l Schs. Servs., Inc. v. West Windsor Twp.*, 207 N.J. 3, 24 (N.J. 2011)).

209. 28 N.J. Tax at 496 (quoting *Paper Mill Playhouse*, 95 N.J. at 521).

210. *Id.* at 500 (quoting *Int’l Schs. Servs., Inc.*, 207 N.J. at 23).

211. *Id.* (quoting *Int’l Schs. Servs., Inc.*, 207 N.J. at 23).

212. *Id.* (quoting *Int’l Schs. Servs., Inc.*, 207 N.J. at 25).

213. *Id.* (quoting *Int’l Schs. Servs., Inc.*, 207 N.J. at 24).

214. *Id.* (quoting *Int’l Schs. Servs., Inc.*, 207 N.J. at 24).

215. *Id.* (citing *Roman Catholic Archdiocese of Newark v. East Orange City*, 18 N.J. Tax 649 (App. Div. 2000)).

216. *AHS Hosp. Corp.*, 28 N.J. Tax at 456, 464.

capital loans, capital loans, and recruitment loans”; and “entangl[ing] its activities and commingl[ing] its efforts” with its insurance subsidiary.<sup>217</sup> The court also examined executive salaries, employed physician contracts, third-party agreements, and operation of the on-site gift shop in making its determination.<sup>218</sup> In its conclusion, the court stated, “If it is true that *all* non-profit hospitals operate like the Hospital in this case, as was the testimony here, then for purposes of the property tax exemption, modern non-profit hospitals are essentially *legal fictions* . . . .”<sup>219</sup>

### B. Illinois

Under Illinois law, “community benefit is not the test”; rather “the issue is whether the property at issue is used exclusively for a charitable purpose.”<sup>220</sup> In *Provena Covenant Medical Center v. Department of Revenue*, the Illinois Supreme Court identified the “distinctive characteristics of a charitable institution” as follows:

- (1) it has no capital, capital stock, or shareholders; (2) it earns no profits or dividends but rather derives its funds mainly from private and public charity and holds them in trust for the purposes expressed in the charter; (3) it dispenses charity to all who need it and apply for it; (4) it does not provide gain or profit in a private sense to any person connected with it; and (5) it does not appear to place any obstacles in the way of those who need and would avail themselves of the charitable benefits it dispenses.<sup>221</sup>

In applying these requirements, Illinois courts view charity as a gift used “for the benefit of an indefinite number of persons, persuading them to an educational or religious conviction, for their general welfare-or in some way reducing the burdens of government.”<sup>222</sup> Nonprofit hospitals “must establish that the subject property is ‘actually and exclusively used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit.’”<sup>223</sup>

Contracting with a for-profit, third-party provider “for ancillary services does not, in itself, preclude the organization from being characterized as an institution of charity within the meaning of [the statute]. . . . The real concern is whether any portion of the money received by the organization is permitted to inure to the benefit of any private individual engaged in *managing* the organization.”<sup>224</sup>

The Illinois Supreme Court found that the hospital at issue was not entitled to tax exemption because “its funds [were] not derived mainly from private and public

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217. *Id.* at 513–14.

218. *Id.* at 515–31.

219. *Id.* at 536.

220. *Provena Covenant Med. Ctr. v. Dep’t of Revenue*, 236 Ill. 2d 368, 403 (2010).

221. *Provena Covenant Med. Ctr.*, 236 Ill. 2d at 390 (citing *Methodist Old Peoples Home*, 39 Ill. 2d at 157).

222. *Id.* at 390–91 (citing *Methodist Old Peoples Home*, 39 Ill. 2d at 156–57).

223. *Id.* at 394 (quoting 35 ILL. COMP. STAT. ANN. 200 / 15—65 (West 2002)).

224. *Id.* at 392.



charity and held in trust for the purposes expressed in the charter. They [were] generated, overwhelmingly, by providing medical services for a fee.”<sup>225</sup> The court also found that the hospital failed to show that “it dispensed charity to all who needed it and applied for it and did not appear to place any obstacles in the way of those who needed and would have availed themselves of the charitable benefits it dispenses.”<sup>226</sup> Similarly, the hospital failed to show charitable use.<sup>227</sup> The court discussed that the hospital did not advertise its charity care program and only provided charity care to those who applied. Everyone else was billed, and the hospital sent unpaid bills to collection agencies.<sup>228</sup> The court discussed that the hospital’s practices looked like how a for-profit hospital would have handled bad debt and found that this system did not look like charity care, especially considering the minimal amount of charity care the hospital provided.<sup>229</sup>

Illinois law has a somewhat broad definition for “charity,” under which charity “is not confined to the relief of poverty or distress or to mere almsgiving’ but may also include gifts to the general public use from which the rich as well as the poor may benefit.”<sup>230</sup> Courts have found it appropriate to “[c]ondition[] charitable status on whether an activity helps relieve the burdens on government.”<sup>231</sup> The hospital argued that its provision of services to Medicare and Medicaid patients at a loss should be considered part of its total charity care.<sup>232</sup> The court found this unconvincing, stating that even though this concept is consistent with a charity mission, it is not considered charity care for state tax purposes because it is optional. The court supported this conclusion by pointing out that the hospital benefits from its “reliable stream of revenue and [] ab[ility] to generate income from hospital resources that might otherwise be underutilized” and its ability to qualify for federal tax breaks.<sup>233</sup> Throughout the court’s analysis, it focused on whether the services provided by the hospital were those that the state government’s taxing bodies would have otherwise had to bear.<sup>234</sup>

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225. *Id.* at 392–93.

226. *Id.* at 393.

227. *Id.* at 394.

228. *Id.* at 398.

229. *Id.* at 381, 398–99. In 2002, only 0.723% of total revenues were spent on charity care and only 302 patients were served. This is weighed against the context that the surrounding community has 25,000 people below the poverty level and 20,000 uninsured with no evidence of unusually low rates of illness or disease. *Id.*

230. *Id.* at 400–01 (citing *Quad Cities Open, Inc. v. City of Silvis*, 208 Ill. 2d 498, 510–011 (2004)).

231. *Id.* at 395.

232. *Id.* at 401.

233. *Id.*

234. *See, e.g., id.* at 405–06.

*C. Maryland*

Maryland requires all nonprofit hospitals to annually report to a state agency their community benefit expenditures.<sup>235</sup> Hospitals are also required to make this information public.<sup>236</sup> The categories of activities considered to be community benefit activities include “community health services, health professional education, mission-driven health services, research, financial contributions made by the hospital, community-building activities, and charity care.”<sup>237</sup> The activities that count as community benefit activities must not be activities that are “aimed at increasing market share or that are part of the cost of doing business . . . even if they could be fit into one of these categories.”<sup>238</sup> The required reports must also include each community benefit program’s operating costs, as well as community benefit activities (not reported elsewhere) funded by hospitals’ foundations.<sup>239</sup>

Maryland operates within a rate-setting system, where a state agency “sets rates for all payers, including Medicaid and Medicare, and uncompensated care expenses (charity and bad debt) are factored into each hospital’s rates.”<sup>240</sup> It is argued that this system eliminated disincentives to provide charity care because these hospitals do not have to “subsidize such care from charges to insured patients.”<sup>241</sup>

*D. Texas*

Nonprofit hospitals in Texas are required (with some specified exceptions) to put at least four percent of their total expenses toward providing charity care, which is defined broadly, and at least five percent of their overall expenses toward “charitable activities.”<sup>242</sup> While Texas’s original law did not allow for bad debt to be included in the total, the Texas Legislature passed an amendment in 1995 to allow bad debt to be considered.<sup>243</sup>

A study of the impact of this law showed that the charity care percentage requirements caused hospitals that were providing less than the required percentage to increase their charity care spending to comply with the statutory requirements.<sup>244</sup> On the other hand, the nonprofit hospitals that were providing higher percentages of charity care before the charity care percentage requirement was instituted

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235. Bradford H. Gray & Mark Schlesinger, *Charitable Expectations of Nonprofit Hospitals: Lessons from Maryland*, 28 HEALTH AFF. 809, 810 (2009).

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.* at 811.

240. *Id.*

241. *Id.*

242. *Id.* at 810.

243. Frances A. Kennedy et al., *Do Non-profit Hospitals Provide More Charity Care When Faced with a Mandatory Minimum Standard? Evidence from Texas*, 29 J. ACCT. PUB. POL’Y 242, 243 (2010).

244. *Id.*

decreased their percentage of charity care closer to the statutory minimum.<sup>245</sup> The study ultimately concluded that the law had little impact on increasing the provision of charity care by nonprofit hospitals and that the overall percentage of charity care by nonprofit hospitals actually decreased with the imposition of the charity care percentage requirement.<sup>246</sup>

#### V. PROPOSALS FOR CHANGE

There is clearly a problem with the operation of the current system for nonprofit taxation status in California. Despite the massive number of nonprofit hospitals throughout California, “low-income communities and people of color consistently show disproportionately poor health outcomes.”<sup>247</sup> These disparities are heightened for poor women of color, who suffer greatest without consistent access to health care services that meet their health needs.<sup>248</sup>

Recent attempts by California legislators to change nonprofit status standards present two primary options to address the current problems with the nonprofit taxation system in California.<sup>249</sup> The first option is increasing and strengthening the reporting requirements by nonprofit hospitals for charity care and community benefits.<sup>250</sup> The second option is adding a percentage requirement for charity care.<sup>251</sup> However, because these proposals have been unable to be passed into law and they present limitations that would not fully solve the existing systemic problems, I also present a number of possibilities under the umbrella of a third option: uprooting the current system and creating a new system by reallocating the lost tax revenue from nonprofit tax benefits to forms of charity care and community benefit more directly targeted to those in greatest need.

##### *A. Increased Transparency Measures*

As discussed above, California Legislators have attempted to implement increased transparency measures to no avail. However, based on the California Hospital Association’s supportive response to Assembly Bill 1046, it seems that it may be possible to increase nonprofit reporting requirements if community organizations continue to press for change and force legislators to make it a priority.<sup>252</sup>

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245. *Id.*

246. *Id.* at 243, 256.

247. Rausa, Fang & Saporta, *supra* note 128, at 13.

248. ELAINE ZAHND & ROBERTA WYN, PUB. HEALTH INST., RACIAL/ETHNIC HEALTH DISPARITIES AMONG WOMEN IN CALIFORNIA, (2014), <http://www.phi.org/uploads/application/files/hpx9cwokk00v7mh7wasu1nwbx00mhhb96fcsfwusbcut2ydclu.pdf> [<https://perma.cc/859T-YB9V>].

249. *See infra* notes 82–125.

250. *Id.*

251. *Id.*

252. Assemb. B. 1046, 2015–2016 Leg., Reg. Sess. (Cal. 2015).

However, it is important to consider whether this is a proposal worth rallying behind. Anthony Galace from the Greenlining Institute proposed that there are several changes needed in California:

First, hospitals must make a more concerted effort to engage underserved communities during their triennial community health needs assessments . . . . This will allow hospitals to better understand the root causes of health barriers in the community. Second, hospitals must disclose more concretely their community benefit investments in the local community. Currently, hospitals vary tremendously in their reporting of community benefit, with some not even disaggregating between the broader community (all community members) and vulnerable populations. This is a clear issue that prevents communities from understanding how hospitals are addressing health barriers and inequities. Finally, hospitals must invest more of their community benefit funds into upstream, preventive health resources in order to bridge health disparities, which disproportionately affect communities of color.<sup>253</sup>

These are all critical steps to establishing uniformity and ensuring that the charity care and community benefits from nonprofit hospitals provide a societal benefit equal to the tax benefit the hospitals receive. But transparency measures alone will not be enough.

While increasing reporting requirements is definitely a step in the right direction, increasing transparency alone will not fix the health disparity problem. The communities served by nonprofit hospitals will still be limited by their proximity to the hospital, and California's underserved areas and populations will continue to be underserved throughout the state.

Without some kind of requirement forcing hospitals to reach out beyond the communities closest to their locations, there will continue to be a gap in access to medical care.

#### *B. Percentage Charity Care Requirement*

The second option contemplated by the California Legislature (and implemented in at least one other state, Texas) is to create a minimum percentage requirement for charity care and community benefit expenditures.<sup>254</sup> However, creating a minimum charity care requirement is somewhat risky. While it would solve the uniformity problem, it is unclear whether it would increase the charity care and community benefit provided overall. Based on the study in Texas, it seems that any manageable charity care percentage requirement brings with it the risk of causing hospitals that exceed the baseline requirement to decrease the percentage of charity care they provide while forcing those who are not currently meeting the

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253. Email from Anthony Galace, *supra* note 96.

254. TEX. HEALTH & SAFETY CODE ANN. § 311.045 (West 2015); Assemb. B. 1952, 2013–2014 Leg., Reg. Sess. (Cal. 2014).

standard to increase just enough to comply with the law.<sup>255</sup> It has also been suggested that a kind of “pay-for-performance” strategy would be more effective than the current tax exemption system.<sup>256</sup> A pay-for-performance strategy would “[c]ondition[] a hospital’s exemption on provision of free care of equivalent value” to the tax benefit received.<sup>257</sup>

However, when EMTALA requirements are combined with the steadily increasing access to health insurance through the ACA and Covered California, it may be more important to have increased numbers of clinics in locations and communities with barriers to accessing care rather than encouraging nonprofit hospitals to provide more charity care in the locations and communities that they already serve. There is a version of the “pay-for-performance” idea that could be more effective, but much harder to legislate and implement. California could condition receipt of the California tax exemption on the creation or maintenance of community benefit programs that provide for underserved areas and populations and allocate varying percentages of tax exemptions based on the percentage of hospital funding that is being used to serve these underserved populations and areas.

### *C. Something Entirely Different*

The third option is to eliminate the nonprofit hospital tax exemption altogether or create a new system for the ways in which charity care and community benefits funds are used. California could use the \$24,000,000,000 in tax exemptions that nonprofit hospitals receive from federal, state, and local governments each year and invest it into preventative health care services for low-income communities, underserved communities of color, and medically unserved areas around the state. While in some respects this approach is appealing, it is less practical to start over and create a new health care system than to find ways to increase the efficiency of the existing system. It makes more sense to find the best strategies to improve the present system using other incentives or regulation to direct nonprofit tax incentives to better reach and help people in the communities that need health services the most.

### *D. Proposed Solutions*

Even with the implementation of the ACA and Covered California, there remain a significant number of Californians without health insurance.<sup>258</sup> In 2015,

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255. Kennedy et al., *supra* note 243.

256. M. Gregg Bloche, *Tax Preferences for Nonprofits: From Per Se Exemption to Pay-for-Performance*, 25 HEALTH AFF. W304 (2006).

257. *Id.* at W305.

258. PAUL FRONSTIN, CAL. HEALTH CARE FOUND., CALIFORNIA’S UNINSURED: COVERAGE EXPANDS, BUT MILLIONS LEFT BEHIND (2016), <http://www.chcf.org/publications/2016/03/californias-uninsured> [<https://perma.cc/TN9F-7JPQ>].

9% of California's population—about 2.9 million people—were still uninsured.<sup>259</sup> This is particularly troubling when one looks at the breakdown of those who are uninsured, of which 55% are Latino, and approximately 33% come from families making less than \$25,000 a year.<sup>260</sup>

Ultimately, none of these postured solutions alone are sufficient to remedy the problem with the possible exception of starting from scratch with the nonprofit hospital standards, which likely would be too disruptive to be effective within any reasonable time frame. Further, with the California Hospital Association's incredibly robust lobbying presence and involvement in related legislation, it is nearly impossible to get sufficient support from legislators to enact laws that would uproot or disrupt the current tax-exemption system. There is definitely a need for increased reporting requirements, and the more recent related legislative proposals have come closest to being implemented. Requiring nonprofit hospitals to more concretely and publicly demonstrate how the programs they offer are benefitting the community is a needed step in the right direction, but attempts to date in California have been unsuccessful. Most importantly, there needs to be a shift in how nonprofit hospitals view which communities they are obligated to serve. The current system encourages hospitals to default benefits to the communities in closest proximity to their locations, which does not serve the overall public interest.

To help alleviate the health and health care access gaps that currently exist, the current standards should be shifted so that the community benefit standard is one that requires providing a community benefit to underserved areas and underserved populations, as well as those individuals with incomes below the poverty line and without health insurance that live in proximity to the hospital's location. It is incredibly important that any new policy requires nonprofit hospitals to consider the perspectives and voices of people from medically underserved areas and populations, so that any new programs will address the concerns that these communities feel are the most pressing and are implemented in ways that allow underserved Californians to make reasonable decisions about where and how they access health services.

#### *E. Implementation—Accessing Unserved and Underserved Communities*

There are a number of ways that this solution could be implemented. First, the legislature could amend the nonprofit requirements to mandate that some percentage of the tax benefits received by nonprofits be used to establish satellite locations in underserved areas. No doubt this approach would be met with significant opposition from the California Hospital Association and nonprofit

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259. CAL. HEALTH CARE FOUNDATION, CALIFORNIA HEALTH CARE ALMANAC: CALIFORNIA'S UNINSURED: COVERAGE EXPANDS, BUT MILLIONS LEFT BEHIND (2016), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaUninsuredDec2016.pdf> [<https://perma.cc/DJP6-8595>].

260. *Id.* at 9, 14.

hospitals. A less drastic alternative would be for the legislature to amend state law to require that at least some percentage of each nonprofit hospital's charity care or community benefit expenditures be used in underserved areas or for underserved communities. The hospitals that are considered to be already serving underserved communities would not be required to behave any differently. Those that are not already serving the most needy populations in the state would have to shift some resources to the nearest deficient locations or communities.

Second, the government could collaborate with nonprofit hospitals to set up satellite locations in underserved areas, with any nonprofit hospital contributions considered part of the hospitals' charity care or community benefit. The state could expedite the process of facility approval and construction by enacting specific laws and/or regulations. By setting up the development infrastructure, it would be easier and perhaps less expensive for nonprofit hospitals to get involved with serving these underserved areas and populations. However, it is unclear whether this would be met with substantial opposition in the state legislature.

Third, the government could work with nonprofit hospitals to set up a fund for educational loan repayment or income supplement for physicians who commit to serving in rural or otherwise underserved communities.<sup>261</sup> This system would enable nonprofit hospitals that contribute funds to the loan repayment and income supplement programs to count the contributed funds as part of the hospitals' charity care contributions.

Finally, the government could work with nonprofit hospitals to set up a transportation and telehealth program in which both nonprofits and the state contribute funds toward transporting people in unserved or underserved communities from their community to a nonprofit hospital, giving these underserved individuals access to a range of health services and the specialists they need, potentially as charity care recipients. However, because of the sometimes-significant distances involved, this could be difficult to implement and of limited benefit in time-sensitive situations. It would likely require that certain dates be set up for people in underserved communities to be transported to nonprofit hospitals. This last approach is less than ideal, as it would impose a significant burden on the communities that have higher percentages of unemployment and poverty. This creates additional complications for those individuals, as they would likely need to take a whole day to access medical care services. These individuals would be treated

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261. Another option is to use some portion of the funds to add more rural training tracks to residency programs. Twenty-four family medicine programs across the country have set-up these programs thus far and have found that graduates who complete these programs are two to three times more likely to practice in rural areas than other family medicine residency graduates. AM. C. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 172. However, the majority of these rural health track graduates only remained practicing in rural locations for two years, thus significantly limiting the overall effectiveness of these types of programs.

and potentially hospitalized far away from their support networks and from any physicians they are currently seeing within their communities.

However, this solution could also incorporate contributing funds toward developing a telehealth program that would increase access to certain kinds of health services without the need for patients to travel to hospital locations. Telemedicine can be used for a wide range of issues, including mental health care, remote patient monitoring for high risk conditions, and specialist consultation—to name a few.<sup>262</sup> There have already been some great successes in using telehealth to treat rural patients. For example, the National TeleNursing Center (NTC) in Massachusetts has been using telehealth to connect Sexual Assault Nurse Examiners to clinicians in remote areas to help guide rural providers through examinations of sexual assault victims.<sup>263</sup> Additionally, using telehealth to increase access to medication abortion for rural patients has also proved to be a safe and cost-effective solution.<sup>264</sup> Investing funds in developing a telehealth program that could reduce the need for patients to physically go to hospital locations, paired with providing transportation when it is important for patients to be seen in person, could greatly increase access for unserved and underserved communities.

## VI. CONCLUSION

The ACA's increased reporting mandates and the requirement of community health needs assessments to gain information about the health needs of the communities served by each hospital are steps in the right direction, but they will not by themselves alleviate the significant health care services disparities in California or elsewhere in the country. Even with the new ACA requirements, there are still uniformity problems. Without any specific parameters for how the assessments are conducted, what is taken into consideration, what steps must be taken, or what results are achieved, there will always be some nonprofit hospitals fulfilling their obligation while others are not.

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262. *New Study Shows Medication Abortion Via Telemedicine Is As Safe As In-Person Provision*, IBIS REPROD. HEALTH (Sept. 2017), <https://ibisreproductivehealth.org/news/new-study-shows-medication-abortion-telemedicine-safe-person-provision>.

263. *Sexual Assault Nurse Exams Through the National TeleNursing Center*, RURAL HEALTH INFO. HUB (Feb. 8, 2016), <https://www.ruralhealthinfo.org/project-examples/889> [<https://perma.cc/YYJ8-SVJY>]. NTC nurses are currently licensed in California. *Id.*

264. *Medication Abortion*, KAISER FAM. FOUND. (June 1, 2018), <https://www.kff.org/womens-health-policy/fact-sheet/medication-abortion/> [<https://perma.cc/HVA2-UDYE>]. A handful of states have instituted programs to reduce the need for patients to go in to clinic offices, with a pilot program in four states even using telehealth to eliminate the requirement that patients go in to clinics at all. The pilot in Washington, Oregon, Hawaii, and New York allows patients to use their computer or smart phone to video chat with a provider, and then the pill is mailed directly to their home. Studies of telemedicine programs have found no difference in the safety or efficacy of using telemedicine as compared to in-office visits for medication abortion, and in fact, studies have shown that using telemedicine enabled rural patients to get a wanted abortion earlier in their pregnancy, which is safer and more cost efficient.



Most importantly, the current system does not require the communities served by nonprofits to be those that are in the greatest need of charity care or community benefit activities, and the current system does not require nonprofit hospitals to consider this at all. This often leaves the populations greatest in need of care, who will suffer the most without access to needed health care services, without access to life-saving medical treatment.

Letting hospitals determine which communities they serve has resulted in nonprofit hospitals primarily serving the communities in closest proximity to their locations. It also may be encouraging nonprofits to serve the communities with the highest reimbursement for services rendered. And, in some ways, this approach makes sense. It is easier and more efficient to serve the communities closest to your location than to try to serve those far away. However, because the vast majority of nonprofit hospitals are concentrated in urban centers, the nonprofit hospital system is failing those communities that are furthest away—especially in rural areas—which are experiencing significant community-level health disparities. If taxpayers are to see a full realization of the public benefit from nonprofit taxation status, changes must be made in the system to help address these gaps. The best plan for addressing these gaps is to amend the law so that nonprofit hospitals are required to serve the communities most in need of health services and consider the needs of underserved and unserved communities first and foremost.

California has shown itself to be a thought leader in protecting the rights of its citizens. If California is unable to find a way to use its nonprofit hospital standards to improve access to care for the most vulnerable, what hope can there be for those who live in Texas or Mississippi or other places around the country with less funds and even greater access to care issues and health disparities? Though this article has dived into the case study of California, it demonstrates that it is critical that we think about new and creative strategies to most effectively use limited state and federal resources to increase access to care and save lives, both in California and around the country.

## APPENDIX 1

(r) Additional requirements for certain hospitals.—

(1) In general.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

(A) meets the community health needs assessment requirements described in paragraph (3),

(B) meets the financial assistance policy requirements described in paragraph (4),

(C) meets the requirements on charges described in paragraph (5), and

(D) meets the billing and collection requirement described in paragraph (6).

(2) Hospital organizations to which subsection applies.—

(A) In general.—This subsection shall apply to—

(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

(B) Organizations with more than 1 hospital facility.—If a hospital organization operates more than 1 hospital facility—

(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

(3) Community health needs assessments.—

(A) In general.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

(B) Community health needs assessment.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

(ii) is made widely available to the public.

(4) Financial assistance policy.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

(A) Financial assistance policy.—A written financial assistance policy which includes—

(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

(ii) the basis for calculating amounts charged to patients,

(iii) the method for applying for financial assistance,

(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

(v) measures to widely publicize the policy within the community to be served by the organization.

(B) Policy relating to emergency medical care.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

(5) Limitation on charges.—An organization meets the requirements of this paragraph if the organization—

(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the amounts generally billed to individuals who have insurance covering such care, and

(B) prohibits the use of gross charges.

(6) Billing and collection requirements.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

(7) Regulatory authority.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).