

Journal of Law and Policy

Volume 29 | Issue 1

Article 5

12-1-2020

Community Health Benefits and For-Profit Hospitals: The Need for New Legislation

Sarah Colgan

Follow this and additional works at: <https://brooklynworks.brooklaw.edu/jlp>

Recommended Citation

Sarah Colgan, *Community Health Benefits and For-Profit Hospitals: The Need for New Legislation*, 29 J. L. & Pol'y 202 (2020).

Available at: <https://brooklynworks.brooklaw.edu/jlp/vol29/iss1/5>

This Note is brought to you for free and open access by the Law Journals at BrooklynWorks. It has been accepted for inclusion in Journal of Law and Policy by an authorized editor of BrooklynWorks.

COMMUNITY HEALTH BENEFITS AND FOR-PROFIT HOSPITALS: THE NEED FOR NEW LEGISLATION

*Sarah Colgan**

The price of liberty is eternal vigilance, and . . . the price of taking care of poor people is the same.

– Sean Hamill, *Pittsburgh Post-Gazette*¹

For-profit hospitals and non-profit hospitals fundamentally have two separate goals they wish to achieve. For-profits seek profit maximization, while non-profits, as a result of their federal tax-exempt status, are required to maintain missions dedicated to serving the public and subsequently, the indigent and uninsured. With the passage of the Patient Protection and Affordable Care Act, the goals of the Nation's health care system began to shift towards more cost effective and high-quality treatment that focuses on providing preventative health care access to all Americans to reach a more health equitable society. This Note offers a dual approach that will help to ensure that the central themes of the Patient Protection and Affordable Care Act are met by both for-profit and non-profit hospitals. Namely, this Note proposes incentivizing for-profits to participate in the health equity goals of the healthcare system by conditioning two important sources of state funding and

* J.D. Candidate, Brooklyn Law School, 2021; B.A., The Ohio State University, 2016. Thank you to my parents, Tom and Claudia, for their endless love, guidance and encouragement. Thank you to my brother and friends for their unwavering support. Lastly, thank you to the members of the Journal of Law and Policy for their invaluable feedback and edits.

¹ Sean D. Hamill, *For-Profit Hospitals Provide Less Charity Care*, PITTSBURGH POST-GAZETTE (Sept. 4, 2016, 1:03 AM), <https://www.post-gazette.com/news/health/2016/09/04/For-profit-hospitals-provide-less-charity-care-counting-charity-care-series/stories/201605050208>.

regulation, Medicaid and a Certificate of Need, respectively, on the completion of a Community Health Needs Assessment.

INTRODUCTION

In 2001, The Orphans Court of Chester County approved the sale of Brandywine Hospital to Community Health Systems of Nashville, the largest for-profit health care system in the United States.² At the time of the sale, Brandywine was only the second non-profit hospital in the State of Pennsylvania to be sold to a for-profit company.³ During the hearing that would decide the sale, Judge Woods asked Community Health Systems' Vice President a pointed question: "I'm particularly concerned, sir, you understand, or at least it's my understanding that your organization will be obliged to provide health care to all economic levels of the communities?"⁴ The Vice President answered affirmatively, confirming the pledge Community Health Systems made in its petition to the court to maintain the "historic levels of charity care⁵ and indigent care" provided by the former non-profit owners for "at least ten years' . . . after the purchase."⁶

Despite Community Health Systems' promises in court, in the first year after the purchase, charity care at Brandywine Hospital plummeted by half.⁷ Care levels fell from 1 million dollars per year, or 1% of net patient revenue, prior to purchase, to \$400,000, or 0.5% of net patient revenue, after purchase.⁸ By 2014, Brandywine's charity care fell to a low of \$20,000, which constituted just 0.02%

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Charity care is one type of uncompensated care that hospitals provide to patients. It is care in which hospitals provide services to patients but do not receive, or expect to receive, any type of payment from that patient because the hospital understands the patient cannot afford the care. *American Hospital Association Uncompensated Care Cost Fact Sheet*, AM. HOSP. ASS'N (Dec. 2010), <https://www.aha.org/system/files/content/00-10/10uncompensatedcare.pdf>.

⁶ Hamill, *supra* note 1.

⁷ *Id.*

⁸ *Id.*

of net patient revenue.⁹ This drastic drop in services for the indigent is not new for for-profit hospitals, who have generally provided significantly less charity care than their non-profit counterparts.¹⁰

Health care delivery in our country is a highly pluralistic system¹¹ that revolves around three different types of ownership: public, private non-profit, and private for-profit.¹² Historically, different types of ownership were often associated with different types of institutions,¹³ but as the health care market becomes increasingly more competitive, the clear line between ownership types, and their traditionally associated institutions, has blurred.¹⁴ Despite this, the labels and values of these ownership types have remained the same.¹⁵ For non-profit and for-profit organizations, specifically, the former is often associated with “voluntarism, charity [and] community” and the latter is deemed “efficient [and] innovative but self-interested.”¹⁶ Currently, there are 6,146 hospitals in the United States.¹⁷ Of those, 2,937 are non-governmental non-profit community hospitals and 1,296 are investor-owned for-profit

⁹ *Id.*

¹⁰ *Id.*

¹¹ INST. OF MED. COMM. ON IMPLICATIONS OF FOR-PROFIT ENTER. IN HEALTH CARE, FOR-PROFIT ENTER. IN HEALTH CARE 4 (Bradford H. Gray ed., 1986) [hereinafter INST. OF MED.].

¹² Cristian A. Herrera et al., *Does Ownership Matter? An Overview of Systematic Reviews of the Performance of Private For-Profit, Private Not-For-Profit and Public Health Care Providers*, PLOS ONE, 2 (Dec. 1, 2014), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0093456>.

¹³ Nursing homes have been “predominately . . . for-profit institutions. Acute care general hospitals are typically private, not-for-profit institutions.” Specialized institutions such as psychiatric and tuberculosis hospitals have historically been government-owned. INST. OF MED., *supra* note 11.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.* at 5.

¹⁷ The total number of hospitals in the U.S. include community hospitals, which are “nonfederal, short-term general, and other special hospitals”; federal government hospitals; nonfederal psychiatric hospitals; and “other” hospitals, which include “nonfederal long term care hospitals and hospital units within an institution” (i.e., prisons or schools). *Fast Facts on U.S. Hospitals, 2020*, AM. HOSP. ASS’N, <https://www.aha.org/statistics/fast-facts-us-hospitals> (last updated Mar. 2020).

community hospitals.¹⁸ The availability of these two delivery systems varies widely by state, but statistics show that the majority of for-profit hospitals reside in America's sunbelt while the majority of non-profit hospitals are located in the Northeast.¹⁹

There has been some debate in recent years as to whether non-profit hospitals are living up to their charitable status or are instead seeking profits like their for-profit counterparts.²⁰ But, without some profit-seeking, non-profit hospitals might not survive in the market-driven, capitalistic structure of today's healthcare system.²¹ Because money has become a driving factor in many of the choices hospitals make, concern has been sparked about the possible negative effects profit motivations will have in the healthcare field.²² Non-profit hospitals, while not free from this market-driven attitude, are constrained in how and to what extent they may turn a profit through their status as tax-exempt charitable organizations under Section 501 of the Internal Revenue Code ("IRC").²³ On the other hand, for-

¹⁸ *Id.*

¹⁹ See *Hospitals by Ownership Type (2017)*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/hospitals-by-ownership/> (last visited Sept. 29, 2020) (noting that the top five states with the most for-profits are Texas, Nevada, Florida, New Mexico and Arizona, while the top five states with the most non-profits are Vermont, Maryland, Connecticut, North Dakota and Maine).

²⁰ Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH L. REV. 103, 126–27 (2015).

²¹ INST. OF MED., *supra* note 11, at 3–6.

²² See *id.* (noting that profit motivation in the health care field may threaten the autonomy and values of physicians and may destroy the "implicit social arrangement" of providing medical care to individuals who cannot afford it).

²³ More specifically, for a charitable hospital to be considered tax exempt it must comply with two distinct IRC provisions. The general requirements for tax exemption are provided under IRC Section 501(c)(3) and Revenue Ruling 69-545. Four additional requirements for tax exemption were imposed by IRC Section 501(r)(1) after the enactment of the Patient Protection and Affordable Care Act. See *Charitable Hospitals—General Requirements for Tax-Exemption Under Section 501(c)(3)*, INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3> (last updated Sept. 19, 2020) [hereinafter *Charitable Hospitals*] (stating that a hospital must pass the community benefit standard to determine if it is organized and operated exclusively for a charitable purpose, which is a requirement to be recognized as a 501(c)(3) organization); see *Requirements for*

profit hospitals, as their namesake implies, are driven by profit and seek to treat people who can pay for their care.²⁴ This goal has caused some to believe that for-profit hospitals are mutually incompatible with the recognized goals of the healthcare system,²⁵ which state that medical care should be “affordable, high quality, and accessible.”²⁶

Part I of this Note examines the distinction between for-profit hospitals and non-profit hospitals. It identifies the legal differences between these two types of institutions and highlights the required care and services each type of hospital is mandated and encouraged to provide. Part II assesses the background of the Patient Protection and Affordable Care Act, more colloquially known as the Affordable Care Act (“ACA”),²⁷ and the historical effects of its implementation within the healthcare system. The ACA sparked national uproar after its passage, largely due to partisan politics, but also because of concerns regarding the individual mandate and the increasing involvement of the government in healthcare.²⁸ As such,

501(c)(3) Hospitals Under the Affordable Care Act—Section 501(r), INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r> (last updated Sept. 19, 2020) [hereinafter *Requirements for 501(c)(3) Hospitals*] (detailing the four additional requirements implemented after the ACA was enacted that hospitals must meet to be a 501(c)(3) organization, which include the completion of a Community Health Needs Assessment and a Financial Assistance Policy, as well as limitations on charges, billing and collections).

²⁴ Herrera et al., *supra* note 12, at 1–3.

²⁵ INST. OF MED., *supra* note 11.

²⁶ *Strategic Goal 1: Reform, Strengthen, and Modernize the Nation’s Healthcare System*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., <https://www.hhs.gov/about/strategic-plan/strategic-goal-1/index.html> (last updated Apr. 2, 2020).

²⁷ The Patient Protection and Affordable Care Act was enacted on March 23, 2010 and amended seven days later, on March 30, 2010, by the Health Care and Education Reconciliation Act. This final, amended version of the law is what is commonly referred to as the “Affordable Care Act.” *Patient Protection and Affordable Care Act*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.healthcare.gov/glossary/patient-protection-and-affordable-care-act/> (last visited Nov. 16, 2020).

²⁸ Julie Rovner, *Why Do People Hate Obamacare, Anyway?*, KAISER HEALTH NEWS (Dec. 13, 2017), <https://khn.org/news/why-do-people-hate-obamacare-anyway/>.

this section also addresses significant cases and legislation following the ACA and their effect on its implementation. In particular, this Note will examine the Supreme Court's landmark decision in *National Federation of Independent Business v. Sebelius*,²⁹ the ACA's Medicaid expansion, and the "repeal" of the Act's individual mandate effected by the Tax Cuts and Jobs Act of 2017.³⁰ Part III addresses how hospitals are meant to confront community needs, examining how the Community Health Needs Assessment ("CHNA"), a requirement for all non-profit hospitals,³¹ as well as Certificates of Need, help tackle those obligations.

Finally, Part IV discusses a proposed solution to address those health care inequities resulting from the current regime. Through federal and state regulation, for-profits could begin to shoulder more of the burden the rest of healthcare system has been forced to carry in regard to health disparities and the achievement of health equity, and in the process shift their goals to align more with the aims of the ACA's sweeping healthcare reforms. While in general the profit maximization objectives of for-profit entities can often increase efficiency and results³² in the market, those objectives are not always consistent with the other goals inherent in the healthcare field, such as patient welfare, research, and teaching.³³ Under a profit-seeking model, treating and maintaining the health of indigent

²⁹ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

³⁰ *See* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11801, 131 Stat. 2054 (2017) (reducing the ACA's shared responsibility payment to \$0, starting in 2019).

³¹ *Community Health Needs Assessment for Charitable Hospital Organizations—Section 501(r)(3)*, INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3> (last updated Aug. 21, 2020).

³² The increase in market results refers to profits the for-profit entities generate. In general, any for-profit entity, not just for-profit hospitals, will see increased results and efficiency when "profit maximization is its overriding activity, there are no barriers to entry in the market, and there is an observable and measurable outcome." Herrera et al., *supra* note 12, at 2.

³³ *See id.* at 2, 6–7 (stating that an analysis of various systematic reviews revealed that U.S. for-profit hospitals, compared to non-profit hospitals, were associated with an increased risk of death and higher care payments, as well as less qualified staff and less equipment and technology investments due to the emphasis on returning the highest investment possible).

members of the surrounding community is not a requirement, nor a goal, for many for-profit organizations.³⁴ While for-profit organizations are bound by certain federal laws, like the Emergency Medical Treatment and Labor Act (“EMTALA”), to treat indigent patients in need of immediate care,³⁵ those legal safeguards alone cannot realize the health equity goals of our nation’s healthcare system.³⁶ In fact, for-profit hospitals in the United States have “provided charity care equal to 1.07 percent of net patient revenue, while non-profits provided 2.2 percent on average.”³⁷ Even though there are more non-profit hospitals than for-profit hospitals in the United States,³⁸ the presence of a for-profit still places a heavy burden on non-profit hospitals in the surrounding area.³⁹ When for-profit hospitals enter the market and refuse to provide charity care or otherwise contribute toward the community’s needs, they not only take space that could be occupied by a charitable hospital organization, but also inadvertently increase the charitable care that surrounding non-profit hospitals must provide.⁴⁰ More specifically, the patients that are refused treatment by for-profit hospitals based on an inability to pay will re-route to surrounding non-profit hospitals who are required by law to take in and care for those patients.⁴¹

³⁴ Hamill, *supra* note 1.

³⁵ See 42 U.S.C. § 1395dd; see Sara Rosenbaum, *The Enduring Role of the Emergency Medical Treatment and Active Labor Act*, 32 HEALTH AFFAIRS 2075, 2075–77 (2013) (explaining that EMTALA was enacted as a way to prevent “patient dumping,” or, the refusal of emergency departments to treat indigent patients and the “medically inappropriate transfer of unstable patients,” and that the statute established a legal duty for all “Medicare-participating hospitals with emergency departments,” requiring them to screen and stabilize any patient that presents to the hospital with a medical emergency).

³⁶ See U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 26.

³⁷ Hamill, *supra* note 1.

³⁸ AM. HOSP. ASS’N, *supra* note 17.

³⁹ Hamill, *supra* note 1.

⁴⁰ See *id.* (noting that for-profits rely on the fact that indigent patients can go to neighboring non-profits, while they admit wealthy patients and those with insurance).

⁴¹ See Hamill, *supra* note 1 (noting that in Pennsylvania, after a for-profit health system bought a former non-profit hospital, charity care fell from 2.81% to .59% within a year. That same year, the non-profit across town saw its charity

Further, while there are some for-profits that do provide uncompensated care, those institutions do not qualify such services as charity care. Instead, they assign debt to patients unable to pay, leaving the uninsured to be pursued by debt collectors, suffer bad credit, and unable to return for needed free care.⁴² This fact is significant given the increasing number of uninsured individuals in the United States since 2017.⁴³ Prior to the enactment of the ACA in 2014, 16.6% of Americans were uninsured, a number that declined to 10% in 2016.⁴⁴ However, in 2017, the Nation saw the first increase of uninsured nonelderly individuals since the ACA's implementation, with 700,000 more people being left without health coverage.⁴⁵ Low-income families and adults are disproportionately affected by this lack of health coverage, largely due to the prohibitive cost of health care and the inability to gain coverage in states that have either chosen not to expand Medicaid or have not yet implemented the expansion,⁴⁶ which include five of the ten states with the highest percentage of for-profit hospitals.⁴⁷

While non-profit hospitals are often community orientated and provide care to indigent patients in order to maintain their tax-exempt status,⁴⁸ they cannot bear that burden alone. This is

care spending rise 6%, which its chief financial officer noted nothing could be done about since the reason for the increase was the decrease in charity care provided by the for-profit across town).

⁴² *Id.*

⁴³ Katie Keith, *Uninsured Rate Rose in 2018, Says Census Bureau Report*, HEALTH AFFAIRS (Sept. 11, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190911.805983/full/>.

⁴⁴ *Why Do We Need the Affordable Care Act?*, AM. PUB. HEALTH ASS'N (2017), https://www.apha.org/~media/files/pdf/topics/aca/why_need_aca_2017.ashx.

⁴⁵ Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 13, 2019), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

⁴⁶ *Id.*

⁴⁷ *Hospitals by Ownership Type, supra* note 19; *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Nov. 2, 2020), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

⁴⁸ Elizabeth King, *Tax Reform, Mixed-Entity Markets, and Hospitals: How the 2017 Tax Cuts and Jobs Act Favors the For-Profit Hospital Model*, 37 YALE

especially true given the shift in health care to quality, accessible and cost-effective treatment that emphasizes preventative care⁴⁹ and the improvement of health outcomes, disparities and inequity.⁵⁰ As it stands, for-profit hospitals have not been required by law to provide charity care or uncompensated care beyond emergency room obligations, or address the needs of their community.⁵¹ Regardless, they should be held to a standard that makes them

L. & POL'Y REV. 527, 547 (2019) (noting that in exchange for their tax-exempt status, non-profits must "provide community benefits including uncompensated care").

⁴⁹ Chronic conditions, which are the most expensive and most preventable health issues, account for 86% of the nation's health care costs, yet only 3% of health care spending is focused on preventative health. *See* AM. PUB. HEALTH ASS'N, *supra* note 44 (explaining that a main goal of the ACA is to support "public health prevention efforts," which the Act has pursued through the creation of the Prevention and Public Health Fund, coverage of essential health benefits, and grant programs).

⁵⁰ The idea of improving health outcomes, health disparities and health inequity can be seen as a general aim of improving population health. This is a "concept of health" that is defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." David Kindig and Greg Stoddart, *What Is Population Health?*, 93 AM. J. PUB. HEALTH 380, 380 (2003).

⁵¹ This is not to say that for-profit hospitals never provide charity care or that non-profit hospitals always meet the level of charity care believed to be sufficient to be considered a charitable organization. There have been attempts by a number of states to heighten the charity care standard that non-profits must meet in order to receive state property tax exemption, as well as state laws allowing the state's attorney general to set charity care quotas when there are non-profit hospital sales. John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U.L.J. 433, 448 (2007); *see* Pauline Bartolone, *Hospitals Want to Cut Back on Free Care. Critics Say No Way*, CAL. HEALTHLINE (Feb. 15, 2018), <https://californiahealthline.org/news/hospitals-want-to-cut-back-on-free-care-critics-say-no-way/> (detailing the implications of a petition by four California non-profit hospitals asking the attorney general to reduce state-based charity care obligations); *see* Pauline Bartolone, *California Hospitals Must Cough Up Millions to Meet Charity Care Rules*, CAL. HEALTHLINE (Apr. 18, 2018), <https://californiahealthline.org/news/california-hospitals-must-cough-up-millions-to-meet-charity-care-rules/> (explaining the 2018 decision of the California Attorney General ordering three hospitals to pay out millions of dollars to other local non-profits under a California law allowing the attorney general to establish specific charity care requirements when non-profit hospital ownership changes).

productive members in meeting America's goals of providing quality, affordable, and accessible health care.

The ACA requires non-profit hospitals to report on their charity care and community benefit investments through a CHNA.⁵² This mandated reporting gives a community the ability to hold their healthcare institutions accountable when they are not doing their part, and leverage “their health care systems in ways that benefit the most vulnerable residents.”⁵³ Communities need a way to hold their for-profit healthcare institutions to the same standards. By implementing legislation that predicates Medicaid participation or facility expansion on the completion of a CHNA, for-profits can retain a profit-driven business model while addressing key community health needs and disparities.⁵⁴ On the federal level, the government could require for-profit hospitals serving Medicaid patients to complete a CHNA and implement a plan to address identified needs.⁵⁵ For their part, state governments could require a CHNA and implementation plan for any entity, whether non-profit or for-profit, requesting a Certificate of Need to either build a new hospital or expand on an already existing one.⁵⁶ This solution ensures that any hospital participating in the Federal Medicaid

⁵² See Karen Kahn, *How Do Nonprofit and For-Profit Hospitals Differ? It's Complicated*, NONPROFIT Q. (Sept. 10, 2019), <https://nonprofitquarterly.org/how-do-nonprofit-and-for-profit-hospitals-differ-its-complicated/> (noting that a major difference between for-profit and non-profit hospitals is that non-profit hospitals are required under the ACA to publicly report on charity care and community programs, making them answerable to their communities when they fail to live up to community standards).

⁵³ *Id.*

⁵⁴ See *Community Health Needs Assessment: A Brief Background*, ALTARUM HEALTHCARE VALUE HUB (Apr. 2016), <https://www.healthcarevaluehub.org/advocate-resources/publications/community-health-needs-assessment-brief-background> (noting that the CHNA was implemented after the ACA as a way to broaden the way in which a hospital can provide “impactful community benefits” outside of providing charity care to indigent patients).

⁵⁵ INTERNAL REVENUE SERV., *supra* note 31.

⁵⁶ See *CON—Certificate of Need State Laws*, NAT'L CONF. OF STATE LEG. (Dec. 1, 2019), <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> (explaining that a Certificate of Need is a “state regulatory mechanism[]” that requires a health care facility to obtain the approval of the state health planning agency who decides whether the facility can create a new location or expand on an existing one based on “a set of criteria and community need”).

Program or receiving a state endorsement through a Certificate of Need will be active in the health equity and access-to-care goals of their community.

I. LEGAL DIFFERENCES BETWEEN FOR-PROFIT AND NON-PROFIT HOSPITALS

Research has shown that hospitals provide certain services based on “their overall goals and objectives.”⁵⁷ Put simply, the services that a hospital provides and the patients the hospital treats depend on what that hospital hopes to achieve.⁵⁸ For-profit hospitals are profit-maximizers, which makes them more “likely to respond to economic incentives, avoid unprofitable patients, and up-code⁵⁹ . . . to generate higher reimbursements.”⁶⁰ Oppositely, non-profits often prioritize goals aimed at the public interest, “devoting more resources to serving the needy, or . . . maximiz[ing] the quality and quantity of medical services at the expense of profits.”⁶¹ For example, for-profit hospitals are more likely to provide consistently profitable services like open heart surgery, while their non-profit counterparts are more likely to provide consistently unprofitable services such as psychiatric emergency care.⁶² For-profit and non-

⁵⁷ Bobby A. Courtney, Note, *Hospital Tax-Exemption and the Community Benefit Standard: Considerations for Future Policymaking*, 8 IND. HEALTH L. REV. 365, 378 (2011).

⁵⁸ Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. ON REG. 139, 157 (2007).

⁵⁹ Upcoding is a fraudulent medical billing practice wherein providers or hospitals submit to insurance companies a billing code that provides a higher payment rate than the billing code that actually correlates to the services provided to the patient. See 2 AM. HEALTH LAWS. ASS’N, HEALTH LAW PRACTICE GUIDE § 30:15 (2020).

⁶⁰ Horwitz, *supra* note 58, at 157.

⁶¹ *Id.*

⁶² Courtney, *supra* note 57. Psychiatric emergency care and other similar treatment is often considered unprofitable because emergent care in general attracts patients whose care is expensive, making emergency rooms an unprofitable setting; psychiatric care reimbursement through Medicare and Medicaid is often low and uncertain; and mental health services often “attract a poor, poorly insured, sick and difficult to manage population.” See Horwitz, *supra* note 58, at 166.

profit hospitals do, however, have some things in common.⁶³ They both “operate under the same substantive health care regulations, employ professionals trained in the same manner, and are governed by the same professional and ethical obligations to supply appropriate health care.”⁶⁴ Further, both hospital ownership types are required to abide by EMTALA if they care for Medicaid patients.⁶⁵

Over the years, the systematic differences (or lack thereof) between non-profit and for-profit hospitals, and the care they provide, have been hotly debated.⁶⁶ Some studies have found that differences in hospital ownership are generally non-existent, while others have found conflicting results.⁶⁷ Regardless of these findings, non-profit hospitals still disproportionately feel the financial burden and resource strain when it comes to providing services that work to achieve the system’s fundamental health care goals, such as uncompensated care⁶⁸ or preventative care.⁶⁹

⁶³ See Horwitz, *supra* note 58, at 141.

⁶⁴ *Id.*

⁶⁵ EMTALA is a federal law that requires anyone who enters an emergency department be treated, regardless of ability to pay. *EMTALA Fact Sheet*, AM. COLL. OF EMERGENCY PHYSICIANS, <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/> (last visited Nov. 17, 2020).

⁶⁶ Corbett, *supra* note 20, at 127.

⁶⁷ The conflicting results found in certain studies may indicate that the inconsistencies found have something to do with the way the study was framed and the analysis methods employed. *Id.* at 126–27.

⁶⁸ See AM. HOSP. ASS’N, *supra* note 5 (noting that uncompensated care is a measure of care that a hospital provides for which no payment was received, including the sum of its bad debt and charity care, but excluding any underpayment from Medicaid and Medicare); see also Alanna Moriarty, *Balancing Uncompensated Care and Hospital Bad Debt*, DEFINITIVE HEALTHCARE, <https://blog.definitivehc.com/balancing-uncompensated-care-and-hospital-bad-debt> (last updated Jan. 2020) (noting uncompensated care is provided to patients who are “uninsured, impoverished, or who otherwise cannot pay for their medical care”).

⁶⁹ Corbett, *supra* note 20, at 126–27.

A. Non-Profit Hospitals

Non-profit hospitals are extremely difficult to characterize and are often described as intermediate associations, sitting somewhere between for-profit and governmental organizations.⁷⁰ Their roles and boundaries comprise a complex mix of characteristics.⁷¹ For example, although non-profit hospitals are non-governmental organizations, they are still required, like government-owned hospitals, to “use their assets to further a public purpose.”⁷² Additionally, almost all non-profit hospitals are considered charitable organizations that qualify for federal tax-exemptions, as well as other state and local property, income, and sales tax exemptions.⁷³ These organizations are not per se tax exempt.⁷⁴ Rather, non-profit hospitals must meet the requirements of tax exemption set forth in IRC Section 501(c)(3), which defines a tax exempt organization as one that proves that it is operating exclusively for a charitable purpose and does not operate for the benefit of any “private shareholder or individual.”⁷⁵ Thus, unlike their for-profit counterparts, non-profit organizations are bound by a non-distribution constraint, which ensures tax-exempt organizations are not distributing profits to any individuals exercising control over the hospital.⁷⁶ Instead, the hospital’s net earnings and profits must be reinvested back into the hospital and its patients.⁷⁷ In addition, non-profit organizations must meet the requirements of Revenue Ruling 69-545—an IRS interpretative rule describing, for the purposes of tax-exemption under 501(c)(3),

⁷⁰ Horwitz, *supra* note 58, at 140.

⁷¹ *Id.*

⁷² *Id.*

⁷³ Kim Simmons, *Nonprofit Hospitals’ Community Benefits Should Actually Benefit the Community: How IRS Reforms can Improve the Provision of Community Benefits*, 22 RICH. PUB. INT. L. REV. 465, 468 (2019).

⁷⁴ Courtney, *supra* note 57, at 368.

⁷⁵ 26 U.S.C.A. § 501(c)(3).

⁷⁶ James J. Fishman, Professor of Law Emeritus, Elisabeth Haub School of Law at Pace University, What Do We Mean By “Nonprofit”?, Presentation at Bridge-the-Gap: Corporate & Litigation New York City Bar Center for CLE (Feb. 3, 2017), in 2017 WL 772088 (Westlaw 2017).

⁷⁷ *Id.*

whether a given non-profit hospital's activities constitute serving a public or a private interest.⁷⁸ Finally, with the passage of the ACA, non-profit hospitals are also required to adhere to the four requirements imposed under IRC Section 501(r)(1).⁷⁹ These requirements include (1) the triennial completion of a CHNA and the adoption of an implementation strategy;⁸⁰ (2) the establishment of a written Financial Assistance Policy ("FAP") and medical care policy;⁸¹ (3) limiting the amount charged to FAP-eligible patients for emergency or medically necessary care;⁸² and (4) making a reasonable effort to determine a patient's FAP-eligibility before undertaking extraordinary collection actions against the patient.⁸³

To operate as a 501(c)(3) organization, non-profit hospitals must pass both an operational test and an organizational test.⁸⁴ To meet these tests' requirements, hospitals must generally show that they are organized and operated exclusively for a charitable purpose, and that they will not distribute net earnings to any private shareholder or individual.⁸⁵ They must also adhere to statutory limitations related to legislative and political lobbying and campaigning.⁸⁶ Since the term "charitable" was never expressly defined by

⁷⁸ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁷⁹ *Requirements for 501(c)(3) Hospitals*, *supra* note 23.

⁸⁰ INTERNAL REVENUE SERV., *supra* note 31.

⁸¹ *Financial Assistance Policy and Emergency Medical Care Policy—Section 501(r)(4)*, INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4> (last updated Aug. 21, 2020).

⁸² The amount charged should not be more than "the amount generally billed to individuals who have insurance covering such care." *Limitations on Charges—Section 501(r)(5)*, INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/limitation-on-charges-section-501r5> (last updated Aug. 21, 2020).

⁸³ *Billings and Collections—Section 501(r)(6)*, INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6> (last updated Aug. 21, 2020).

⁸⁴ *Charitable Hospitals*, *supra* note 23.

⁸⁵ See 26 C.F.R. § 1.501(a)-1(c) (defining a private shareholder or individual as a person or persons "having a personal and private interest in the activities of the organization").

⁸⁶ Courtney, *supra* note 57, at 369; *see also Charitable Hospitals*, *supra* note 23 (explaining that tax-exempt hospitals cannot "attempt to influence legislation" or participate in any sort of political campaign for public office).

Congress, the IRS first relied on a finding that a hospital was “engaged in relief of the poor or distressed” to determine its tax exempt status.⁸⁷ This changed in 1956 when the IRS issued Revenue Ruling 56-185 announcing “a substantive rule of charitable purpose.”⁸⁸ Under this Ruling, to be considered “charitable,” a hospital may not operate exclusively for paying patients, and, instead, must operate for those who cannot pay for the services rendered.⁸⁹

Thirteen years later, the IRS again revisited the term “charitable” with Revenue Ruling 69-545.⁹⁰ Modifying Revenue Ruling 56-185, the IRS removed the requirement that an exempt hospital provide charity care and uncompensated care; instead finding that the general “promotion of health”⁹¹ is a sufficient charitable purpose.⁹² Subsequently, the IRS established the “community benefit standard,” under which a hospital must demonstrate that it promotes “the health of a class of persons that is broad enough to benefit the community,” in order to receive exemption.⁹³ Rather than creating a defined list of requirements, the IRS used case illustrations to help non-profits understand what the community benefit standard, and

⁸⁷ Courtney, *supra* note 57, at 368.

⁸⁸ *Id.*

⁸⁹ While the ruling states a non-profit must operate for those who cannot afford care “to the extent of its financial ability,” it also states that a “hospital must . . . not refuse to accept patients in need of hospital care who cannot pay for such services.” Rev. Rul. 56-185, 1956-1 C.B. 202; *see* Courtney, *supra* note 57, at 368 (noting that revocation is almost always recommended when a hospital lacks a “substantial charity care program,” and that charity care is not met “simply because the hospital expects, but does not receive, full payment for services”).

⁹⁰ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁹¹ *See id.* (highlighting the fact that “the promotion of health is considered to be a “charitable purpose” under “the general law of charity”).

⁹² *Id.* Importantly, the shift towards a broader “promotion of health” standard came at a time when Congress was considering Medicaid and Medicare legislation. The IRS issued Revenue Ruling 69-545 in direct response to hospital complaints that this new public insurance program (in combination with already available private insurance) would decrease the need for charity care and make it hard for hospitals to meet Revenue Ruling 56-185’s stringent “charitable” requirement for exemption. Courtney, *supra* note 57, at 369.

⁹³ *Charitable Hospitals, supra* note 23.

thus the promotion of health, requires.⁹⁴ For example, it found that a 250-bed community hospital that was run by a Board of Trustees made up of members of the community was entitled to exemption,⁹⁵ so long as the hospital ran a full-time emergency room that did not deny care, and dedicated its annual excess funds to improving patient care, advancing medical training and research, and expanding and replacing equipment and facilities.⁹⁶ In general, the Ruling established a number of factors that the IRS will consider when determining that a community benefit has been established: (1) the operation of an emergency room open to all, regardless of ability to pay; (2) the establishment of a board of directors filled by community members and an open medical staff policy; (3) the provision of hospital care for all patients able to pay, including those who pay through public programs like Medicare and Medicaid; and (4) the use of surplus funds to improve facilities and patient care, and to advance training, education and research.⁹⁷

Although the community benefit standard is still controlling, both courts and the IRS have shown concern that, in application, it does not do enough to promote charitable, rather than commercial, purposes.⁹⁸ Subsequently, the IRS has made clear that the much more restrictive exemption requirements set forth by Revenue Ruling 56-185⁹⁹ continue to be a significant factor in assessing exemption, as courts and the IRS often look to “the provision of free or subsidized care to the indigent” to decide whether “a hospital promotes health for the benefit of the community.”¹⁰⁰

⁹⁴ Rev. Rul. 69-545, 1969-2 C.B. 117.

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ The presence or absence of any one particular factor is not dispositive. The IRS will weigh all the relevant factors before making a decision. *Id.*; see also *Charitable Hospitals*, *supra* note 23 (detailing the factors provided by Revenue Ruling 69-545 that demonstrate a community benefit).

⁹⁸ Challenges to exemption by the IRS and decision by the Tax Court and Circuit Courts illustrate that a “substantial charity care program” is needed to qualify for exemption. Courtney, *supra* note 57, at 369-71; see also *IHC Health Plans, Inc. v. C.I.R.*, 325 F.3d 1188, 1200 (10th Cir. 2003).

⁹⁹ Revenue Ruling 56-185 required that non-profit tax-exempt hospitals provide patient care without charge or at rates below cost. See Rev. Rul. 56-185, 1956-1 C.B. 202.

¹⁰⁰ *Charitable Hospitals*, *supra* note 23.

After the passage of the ACA in 2010, hospital organizations¹⁰¹ were assigned new requirements in order to be considered for exemption.¹⁰² The failure to meet any of these requirements by one or more hospital facility within the organization could result in the revocation of the organization's tax-exempt status.¹⁰³ The new requirements were codified by the IRS in IRC Section 501(r)(3)-(6), and are applied on a facility-by-facility basis.¹⁰⁴ The first requirement, and the most important to the solution advanced in this Note, is the rule that requires hospitals to complete a CHNA.¹⁰⁵ The CHNA, discussed in more detail below, requires hospitals to define and assess the needs of the community it serves every three years.¹⁰⁶ Then, through an implementation strategy, the hospital must detail how it will address the "significant health need[s]" that the CHNA identifies.¹⁰⁷ As an accountability mechanism, the IRS requires an exempt hospital to describe how it actually addresses the health needs identified in its last CHNA every year on its Form 990.¹⁰⁸

The new stipulations also include mandatory requirements related to financial assistance and emergency medical care, billing and collections, and charge limitations.¹⁰⁹ Non-profit hospitals are now required to create a written FAP and "medical care policy" that specifies the eligibility criteria that must be satisfied to receive either discounted or free care.¹¹⁰ The FAP must apply to all care given at the hospital, and must list all "nonemployee third-party providers" who provide emergency or medically necessary care, and indicate if

¹⁰¹ A hospital organization under Section 501(r) includes "any Section 501(c)(3) organization that operates one or more 'hospital facilities.'" *Protecting Your Hospital's Tax-Exempt Status: Compliance with the Affordable Care Act and Final IRS Section 501(r) Regulations*, JONES DAY (Mar. 2015), <https://www.aha.org/system/files/2018-05/150317-aha-commentary.pdf>.

¹⁰² *Requirements for 501(c)(3) Hospitals*, *supra* note 23.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ INTERNAL REVENUE SERV., *supra* note 31.

¹⁰⁷ JONES DAY, *supra* note 101.

¹⁰⁸ *Id.*

¹⁰⁹ *Requirements for 501(c)(3) Hospitals*, *supra* note 23.

¹¹⁰ INTERNAL REVENUE SERV., *supra* note 81.

those third-party providers are covered by the hospital's FAP.¹¹¹ Further, the hospital must adopt its own emergency medical care policy stating that emergency care will be provided without discriminating and regardless of ability to pay.¹¹² Additionally, a non-profit hospital must limit the amount it charges for emergencies, and other medically necessary care provided to an individual who qualifies for financial assistance, to no more than the same amount it charges those with insurance.¹¹³ Finally, non-profit hospitals are required to make "reasonable efforts" to determine whether a patient is eligible for the institution's financial assistance before seeking to collect from that individual.¹¹⁴

None of these financial measures, especially those enacted after the ACA's passage, affect for-profit hospitals; they are limited to only those hospitals seeking tax exemption. Because current laws do not require for-profits to consider the financial and health needs of the uninsured and underinsured, it follows that the tax-exempt, charitable role that non-profits play in our society is particularly important. This is especially true given that more than 50 million people in the United States live without health insurance.¹¹⁵ Although only making up roughly 13% of all charitable organizations under the IRS, non-profit health care organizations account for 41.6% of total public charity revenues and 28.5% of total public charity assets.¹¹⁶ They are a critical source of charity and uncompensated care which the uninsured have historically relied on to receive the treatment they need.¹¹⁷

B. For-Profit Hospitals

Perhaps the biggest difference between for-profit hospitals and non-profit hospitals is that for-profits, as their namesake implies, are

¹¹¹ JONES DAY, *supra* note 101, at 4.

¹¹² This is already required by the Emergency Medical Treatment & Labor Act (EMTALA), so it is satisfactory for a hospital to create a policy that "requires operation consistent with the requirements of [EMTALA]." *Id.* at 5.

¹¹³ INTERNAL REVENUE SERV., *supra* note 82.

¹¹⁴ INTERNAL REVENUE SERV., *supra* note 83.

¹¹⁵ Courtney, *supra* note 57, at 366.

¹¹⁶ Horwitz, *supra* note 58, at 145–46.

¹¹⁷ Courtney, *supra* note 57, at 368.

always seeking to maximize profits.¹¹⁸ They are most often organized as corporations governed by shareholders and, as such, operate their businesses in ways that will produce profits for those shareholders.¹¹⁹ The shareholders, in turn, typically elect a board of directors who control how the hospital is run and how to allocate the hospital's funds.¹²⁰ All for-profit corporations, even those established as hospitals, are subject to the business corporation laws of the state in which they are incorporated,¹²¹ unlike their non-profit counterparts which are subject to a number of federal and state laws regarding incorporation. The purpose of these business laws is "to protect the rights of the shareholders in relation to the corporation's board or management."¹²² Unlike non-profit hospitals, for-profit hospitals are generally free to engage in any business that lawfully promotes their goals, which often allows these hospital entities to pursue activities that may not involve the general duties traditionally associated with providing health care.¹²³ Rather, for-profit hospitals may seek out patients and treatments that will generate a profit that can be returned to the shareholders.¹²⁴

Although for-profits are not required to follow the strict federal and state regulatory requirements imposed upon their non-profit counterparts, they are subject to certain regulatory and accreditation requirements that must be met in order to remain licensed.¹²⁵ Like non-profit hospitals, almost all for-profit hospitals depend on payments through subsidized programs like Medicare and Medicaid,

¹¹⁸ King, *supra* note 48, at 533.

¹¹⁹ *Id.* at 548–49.

¹²⁰ John F. Harty & Daniel M. Mulholland III, *Legal Differences Between Investor-Owned and Nonprofit Health Care Institutions*, in *THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 17–19 (Bradford H. Gray ed., 1983).

¹²¹ *Id.* at 18.

¹²² *Id.* at 19.

¹²³ *See id.* (stating that investor-owned companies, including hospitals, have limited restrictions on the kind of business they can conduct).

¹²⁴ *See id.* (stating that the general goal of corporate law is to protect the rights of shareholders and that the purpose of investor-owned companies is to promote that goal).

¹²⁵ *See id.* (stating that hospitals, whether for-profit or non-profit, "are not as free to fashion some portion of their bylaws as other corporations may be" because of additional "regulatory and accreditation requirements").

which requires them to comply with a number of federal regulations, including EMTALA.¹²⁶ In addition, they are also subject to various state and local laws that impose varying degrees of regulation, affecting a noticeable impact on the proportion of for-profit hospitals in a given state.¹²⁷ For example, 52.3% of hospitals in Nevada are for-profit, while Connecticut, Hawaii, New York and Vermont do not have any for-profit hospitals.¹²⁸

II. THE AFFORDABLE CARE ACT AND RELATED SUBSEQUENT LEGISLATION

A. Background

The Affordable Care Act was considered “the biggest transformation of government since World War II.”¹²⁹ Since its inception, the ACA was meant to be a “wide-sweeping health care reform plan” with a goal to “provid[e] quality, affordable health care to all Americans and improv[e] the quality and efficiency of health care.”¹³⁰ Indeed, the ACA substantially changed the quality of services that health care organizations provided and the access to care individuals received.¹³¹ In general, the Act signifies the health care system’s adoption of the principle that everyone needs access to some form of basic medical care in order to maintain a healthy and thriving society.¹³² More specifically, the Act’s central themes

¹²⁶ King, *supra* note 48, at 547–48.

¹²⁷ Horty & Mulholland III, *supra* note 120, at 19–20.

¹²⁸ *Hospitals by Ownership Type*, *supra* note 19.

¹²⁹ Jackie Calmes, *After Health Care Passage, Obama Pushes to Get It Rolling*, N.Y. TIMES (Apr. 17, 2010), <https://www.nytimes.com/2010/04/18/health/policy/18cost.html>.

¹³⁰ ROBERT JOHN KANE & LAWRENCE E. SINGER, THE LAW OF MEDICAL PRACTICE IN ILLINOIS § 40:24 (3d ed. 2020).

¹³¹ See *A Guide to the Supreme Court’s Affordable Care Act Decision*, KAISER FAM. FOUND. (July 2012), <https://www.kff.org/wp-content/uploads/2013/01/8332.pdf> (noting that through the ACA’s individual mandate and Medicaid expansion, people were required to maintain, and were given increased access to, affordable health insurance either through their employer, federal or state exchanges, Medicare, or through the expanded eligibility Medicaid benefits).

¹³² BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 5 (8th ed. 2018).

(cost, quality, and access) highlight the reality that “health is a fundamental human right.”¹³³

B. Medicaid Expansion

The Affordable Care Act had a particularly significant impact on the United States’ Medicaid program by expanding eligibility for Medicaid services throughout the healthcare sector,¹³⁴ covering an estimated 17 million uninsured, low-income Americans.¹³⁵ Since its inception, Medicaid has been a voluntary option for states.¹³⁶ If states choose to participate, which all states currently do, they are subjected to a certain set of “federal core requirements”¹³⁷ that must be followed to receive congressional Medicaid funding.¹³⁸ One such requirement details the core groups of people that must be covered by the state’s Medicaid program, which include: (1) pregnant women and children under the age of six with family incomes at or below 133% of the federal poverty level (“FPL”); (2) children between the ages of six and eighteen with family incomes at or below 100% FPL; (3) parents and relatives of caretakers who had previously met financial eligibility requirements for cash assistance; and (4) elderly and disabled individuals who qualify for supplemental security income benefits based on low income.¹³⁹

Importantly, the federal Medicaid law prior to the ACA did not include coverage for “non-disabled, non-pregnant adults without

¹³³ *Id.*

¹³⁴ See Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1584 (2011).

¹³⁵ KAISER FAM. FOUND., *supra* note 131.

¹³⁶ *Id.*

¹³⁷ These core requirements are the federal government’s attempt to ensure that states are supporting Medicaid’s “statutory purpose of providing health services to certain low-income individuals.” See *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues*, KAISER FAM. FOUND. (Apr. 2011), <https://www.kff.org/wp-content/uploads/2013/01/8174.pdf> (explaining that the federal core requirements include provisions related to eligibility, benefits and cost-sharing, care delivery and provider payments, long-term services and support, and care of dual eligibles).

¹³⁸ KAISER FAM. FOUND., *supra* note 131.

¹³⁹ *Id.*; see also KAISER FAM. FOUND., *supra* note 137.

dependent children.”¹⁴⁰ Congress, in passing the ACA’s Medicaid provision, attempted to expand this coverage so that it was near universal for low-income citizens.¹⁴¹ Specifically, the Act changed Medicaid to apply to “all lawful residents with family incomes of less than 133% of the federal poverty level.”¹⁴² This move by Congress was the first time that the United States had “explicitly recognize[d] a national entitlement to health care for all of the poor”¹⁴³ To facilitate the expansion, the federal government agreed to cover 100% of the funding for states to extend their coverage from 2014 to 2016, before gradually decreasing its contribution over the ensuing years.¹⁴⁴

On the day the ACA was signed into law, the State of Florida filed a lawsuit challenging the constitutionality of the entire Act.¹⁴⁵ Soon after, twenty-five other states and several other individual plaintiffs joined the challenge.¹⁴⁶ The Supreme Court granted certiorari, issuing an opinion on the last day of its 2011–2012 term in *National Federation of Independent Business v. Sebelius*.¹⁴⁷ In it,

¹⁴⁰ Although states were allowed to obtain waivers to include coverage for these individuals. KAISER FAM. FOUND., *supra* note 131; *see also* KAISER FAM. FOUND., *supra* note 137 (noting that prior to the ACA the core group of covered individuals included “pregnant women, children, parents, elderly individuals, and individuals with disabilities up to specified minimum income levels”).

¹⁴¹ *See* FURROW ET AL., *supra* note 132, at 689 (explaining that this expansion was significant because it provided coverage to a number of individuals who did not fit within any of the original eligibility categories but who were in jobs that did not provide insurance and were not able to afford private insurance); *see also* KAISER FAM. FOUND., *supra* note 131.

¹⁴² Baker, *supra* note 134, at 1584.

¹⁴³ *Id.*

¹⁴⁴ KAISER FAM. FOUND., *supra* note 131.

¹⁴⁵ *See* Florida ex rel. Bondi v. U.S. Dep’t of Health and Hum. Servs., 780 F.Supp.2d 1256 (N.D.Fl. 2011).

¹⁴⁶ *See* Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519, 540 (2012) (stating that on the day the ACA was signed into law, thirteen states, including Florida, filed a complaint in the Federal District Court for the Northern District of Florida alleging that the Acts individual mandate exceeded Congress’s Article I powers).

¹⁴⁷ Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

the Court addressed whether the Medicaid expansion was a “constitutional exercise of Congress’ Spending Clause power.”¹⁴⁸

As to the constitutionality of the Medicaid expansion, the Court split 7-2, with Chief Justice Roberts, along with Justices Scalia, Kennedy, Thomas, Breyer, Alito, and Kagan, concluding that the threat to withdraw all Medicaid funding was unconstitutionally coercive.¹⁴⁹ The Court recognized the power of the federal government to use federal funds to incentivize states to implement certain policies, but found that the Medicaid expansion “crossed the line distinguishing encouragement from coercion.”¹⁵⁰ The Court explained that states “did not have adequate notice to voluntarily consent and the Secretary could potentially withhold all of a state’s existing federal Medicaid funds for non-compliance.”¹⁵¹ Chief Justice Roberts, along with Justices Ginsburg, Breyer, Sotomayor and Kagan concluded that the constitutional violation could be remedied, holding that Congress was still able to offer conditional federal funds to states that were willing to expand Medicaid, but that Congress was not allowed to make every state’s “existing Medicaid funds contingent upon the state’s compliance with the ACA Medicaid expansion.”¹⁵² Thus, the Court’s decision effectively made the Medicaid expansion optional for states because the only funds the Secretary could withhold were those designated for the expansion, not the funds the states were already receiving prior to the enactment of the ACA.¹⁵³

C. The “Repeal” of the Individual Mandate

Despite finding the Medicaid expansion unconstitutional, the *Sebelius* Court did affirm the constitutionality of the minimum essential coverage provision of the Affordable Care Act.¹⁵⁴ The provision, also known as the individual mandate, required

¹⁴⁸ KAISER FAM. FOUND., *supra* note 131; *Sebelius*, 567 U.S. at 575.

¹⁴⁹ *Sebelius*, 567 U.S. at 588.

¹⁵⁰ *Id.* at 579.

¹⁵¹ KAISER FAM. FOUND., *supra* note 131.

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

individuals to maintain a minimum level of health insurance coverage. This minimum coverage could be obtained from their employer, a government-subsidized program like Medicare or Medicaid, or from newly implemented health insurance exchanges, which offered premium tax credits towards health insurance to those who fell within a certain limit of the federal poverty level.¹⁵⁵ If an individual did not receive health coverage from one of these sources, and thus did not comply with the mandate, they would be sanctioned with a financial penalty known as a shared responsibility payment.¹⁵⁶ The payment would be reported on the individual's federal income tax return as a percentage of their household income to be collected by the IRS.¹⁵⁷

After the individual mandate was challenged in court, the majority in the *Sebelius* decision came to the surprising conclusion that the mandate was a constitutional exercise of Congress' power to tax.¹⁵⁸ The Court reasoned that even though the mandate was not necessarily labeled as a tax, it functioned like a tax¹⁵⁹ and had the "essential feature of any tax."¹⁶⁰ Thus, having confirmed the constitutionality of the individual mandate provision, the Court never had to address whether it was severable from the rest of the

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 574 (2012). The conclusion that the mandate fell under Congress' taxing power was an unexpected determination since none of the lower federal courts had even considered the constitutionality of the mandate under Congress' taxing power. *See generally* Florida v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011); Florida v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011).

¹⁵⁹ According to Chief Justice Roberts, it functioned like a tax because it was collected by the IRS, was reported and paid through the filing of federal tax returns, was not applicable to those who were not required to file federal taxes, and took into consideration tax related factors like taxable income and dependents. *Sebelius*, 576 U.S. at 566.

¹⁶⁰ The payment would create revenue for the government, which the Congressional Budget Office believed could be close to \$4 billion dollars a year by 2017. *Id.* at 564.

Affordable Care Act.¹⁶¹ The dissent, however, comprised of Justices Scalia, Kennedy, Thomas and Alito, did not believe the mandate was a valid exercise of Congress' taxing power and would have held the mandate non-severable, invalidating the entire Affordable Care Act.¹⁶² The dissenters' line of reasoning and belief that the ACA was constitutionally invalid would become an issue central to the state of the American healthcare system almost a decade later.

In December of 2017, five years after the Supreme Court found the individual mandate constitutional, the Tax Cuts and Jobs Act of 2017 ("TCJA") was signed into law.¹⁶³ The TCJA made a number of changes to individual and corporate tax laws.¹⁶⁴ However, the most striking change was the provision repealing the individual mandate penalty, which was added to the TCJA by the Senate only a month before the law was passed.¹⁶⁵

The reduction of the shared responsibility payment to zero, which went into effect on January 1, 2019,¹⁶⁶ will likely have a significant impact on public health.¹⁶⁷ Indeed, the number of uninsured individuals has increased in the past two years for the first time since the passage of the ACA,¹⁶⁸ while the Congressional Budget Office predicts the "repeal of the penalties will increase the

¹⁶¹ If the Court did have to answer that question and found the individual mandate was not severable, the question would be whether all or part of the ACA must be invalidated along with the individual mandate. KAISER FAM. FOUND., *supra* note 131, at 5.

¹⁶² *Id.*; *Sebelius*, 567 U.S. at 646–708 (Scalia, J., Kennedy, J., Thomas, J., Alito, J., dissenting).

¹⁶³ The TCJA was signed into law on December 22, 2017 and was "the most sweeping tax legislation since the Tax Reform Act of 1986. . . ." *2018 Tax Cuts & Jobs Act Overview*, SMITH & HOWARD: CERTIFIED PUB. ACCTS. AND ADVISERS (Mar. 2018), <https://www.smith-howard.com/2018-tax-cuts-jobs-act-overview/>.

¹⁶⁴ Sherry Glied, *Implications of the 2017 Tax Cuts and Jobs Act for Public Health*, 108 (No. 6) AM J. PUB. HEALTH 734, 734 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5944881/pdf/AJPH.2018.304388.pdf>.

¹⁶⁵ King, *supra* note 48, at 563.

¹⁶⁶ MaryBeth Musumeci, *Explaining Texas v. U.S.: A Guide to the 5th Circuit Appeal in the Case Challenging the ACA*, KAISER FAM. FOUND. 1 (July 2019), <http://files.kff.org/attachment/Issue-Brief-Explaining-Texas-v-US-A-Guide-to-the-5th-Circuit-Appeal-in-the-Case-Challenging-the-ACA>.

¹⁶⁷ Glied, *supra* note 164, at 734.

¹⁶⁸ Keith, *supra* note 43.

number of Americans without insurance by four million in 2019 and by 13 million in 2027.”¹⁶⁹ Without the financial incentive to gain health coverage, lower-income, and even middle-income individuals, will fail to gain coverage through either Medicaid, their employers, or marketplace coverage because they are not immediately in need of health care, thus prioritizing their money elsewhere.¹⁷⁰ In fact, the Congressional Budget Office projects, because of the removal of the penalty, that there will be five million fewer people enrolled in Medicaid by 2025 because the “immediately tangible consequences” for failing to enroll no longer exist. Accordingly, enrollment loses some of its relevancy.¹⁷¹

With this increase of uninsured individuals will come an increased need for uncompensated care.¹⁷² This need will force mostly non-profit hospitals to shift finances and resources to cover uncompensated care, diverting those funds from “invest[ment] in public health, social determinants, and prevention,” which constituted a major effort by hospitals as a result of the significant increases in health insurance coverage brought on by the ACA.¹⁷³ When it enacted the TCJA and repealed the individual mandate, Congress failed to acknowledge that in exchange for the containment of health insurance costs and the reduction of uninsured patients created by the individual mandate, the ACA required disproportionate-share hospital (“DSH”) funds¹⁷⁴ “be cut by \$43 billion between fiscal year 2018 and 2025.”¹⁷⁵ Generally, the

¹⁶⁹ Glied, *supra* note 164, at 735.

¹⁷⁰ “Eliminating [the individual mandate] is likely to reduce coverage among people for whom obtaining insurance was less immediately relevant. These are likely to be people who do not have current illnesses requiring treatment, who are busy, or who face other spending decision and time pressures.” *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ “Medicaid [DSH] payments are statutorily required payments intended to offset hospitals’ uncompensated care costs to improve access for Medicaid and uninsured patients.” *Disproportionate Share Hospital Payments, MEDICAID AND CHIP PAYMENT AND ACCESS COMM’N*, <https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/> (last visited Oct. 1, 2020).

¹⁷⁵ Michael Brady & Jessica Kim Cohen, *DSH Fund Cuts Face Difficult Fight from Hospital*, MODERN HEALTHCARE (Sept. 24, 2019, 4:42 PM),

government disperses money from DSH funds to hospitals “that serve a disproportionate number of Medicaid and uninsured patients.”¹⁷⁶ These payments are critical since the hospitals that receive DSH funds are usually not able to “fully cross-subsidize” the care for Medicaid and uninsured patients with the profits made from privately paying patients.¹⁷⁷ Thus, the ACA’s cut of DSH funds is a blow to the country’s “health care infrastructure,” since a significant number of the nation’s hospitals rely on DSH payments to remain financially viable.¹⁷⁸

While the ACA’s DSH cuts reduced funding for hospitals who treated Medicaid and uninsured patients, its impact, though important, was not catastrophic, since the Act’s individual mandate significantly reduced the number of uninsured patients that hospitals needed to care for.¹⁷⁹ Importantly, when Congress repealed the individual mandate penalty in the TCJA, it failed to acknowledge, and in fact ignored, the original ACA DSH cuts and mandatory insurance tradeoff.¹⁸⁰ Now, not only will hospitals have the burden of ensuring that the uninsured receive the uncompensated care they need, they must also provide that care “while simultaneously retaining major cuts to uncompensated care payments.”¹⁸¹ The brunt of this repeal will hit non-profits the hardest, since they are required to care for any person who needs medical assistance regardless of whether or not that person is insured.¹⁸² For-profit hospitals, though they may choose to care for the uninsured if they wish, are not mandated by any law to provide care to an individual without insurance, and given their profit maximization mantra, it may not

<https://www.modernhealthcare.com/politics-policy/dsh-fund-cuts-face-difficult-fight-hospitals>; King, *supra* note 48, at 563.

¹⁷⁶ FURROW ET AL., *supra* note 132, at 703.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ King, *supra* note 48, at 564.

¹⁸⁰ *Id.* at 536–64.

¹⁸¹ *Id.* at 564.; Brady & Cohen, *supra* note 175.

¹⁸² See discussion *supra* Part I.A; see also King, *supra* note 48, at 563 (stating that the TCJA will benefit “profitable corporations,” but will disadvantage entities like non-profits).

align with their goals to accept this new onslaught of uninsured patients.¹⁸³

Clearly, though promoted and passed as a tax law, the TCJA and its effects have created serious consequences for hospitals throughout our nation.¹⁸⁴ Initially, it seemed as though these consequences could be counteracted by the other provisions of the ACA, such as the Medicaid expansion and marketplace subsidies, which remain intact after the TCJA's repeal of the individual mandate.¹⁸⁵ However, Congress' decision to set the shared responsibility payment to zero under the TCJA has now prompted litigation challenging the Act's constitutionality, which has made its way to the United States Supreme Court. In July 2019, the Court of Appeals for the Fifth Circuit heard oral arguments in *Texas v. United States*, where it reviewed the District Court of Texas' holding that the individual mandate was unconstitutional and non-severable from the rest of the ACA.¹⁸⁶ The Fifth Circuit agreed that the individual mandate was unconstitutional, noting that with the financial penalty set at zero, the provision does not have the "essential feature of any tax" since it no longer produces "at least some revenue for the government," meaning that the mandate is no longer a valid part of Congress' taxing power.¹⁸⁷ However, the court found that the determination of inseverability was insufficient because the labeling of the individual mandate as "essential" to the Act's goal was not enough, on its own, to determine that the entire ACA was inseverable from the individual mandate.¹⁸⁸ It found that the District Court did not address the inseverability issue with enough specificity and remanded for further analysis;¹⁸⁹ however, the Supreme Court has now granted certiorari and will consider the Act's constitutionality in *California v. Texas* on November 10,

¹⁸³ See discussion *supra* Part I.B; see also King, *supra* note 48, at 533, 563 (explaining that not all hospitals "bear the burden of charity care equally," because for-profit hospitals are only subject to ethical requirements to treat the uninsured).

¹⁸⁴ King, *supra* note 48, at 565–66.

¹⁸⁵ Glied, *supra* note 164, at 735.

¹⁸⁶ Musumeci, *supra* note 166.

¹⁸⁷ *Texas v. U.S.*, 945 F.3d 355, 390 (5th Cir. 2019).

¹⁸⁸ *Id.* at 397–99.

¹⁸⁹ *Id.* at 402.

2020.¹⁹⁰ Should the Supreme Court reverse and invalidate the entire Affordable Care Act, there could be profound consequences¹⁹¹ for the health care system, and hospitals, specifically.

III. ADDRESSING COMMUNITY NEED: COMMUNITY HEALTH NEEDS ASSESSMENTS AND CERTIFICATES OF NEED

A. *The Community Health Needs Assessment*

The CHNA¹⁹² was a new requirement imposed upon non-profit, tax-exempt health care organizations after the enactment of the ACA in 2010.¹⁹³ Promulgated through IRC Section 501(r)(3), hospital organizations are required to “provide proof of community engagement”¹⁹⁴ by conducting a two-step CHNA consisting of “a health needs assessment and an implementation strategy.” The results of each CHNA are to be made into an official report filed with the IRS and made available to the public at large.¹⁹⁵ Every three

¹⁹⁰ Marybeth Musumeci, *Explaining California v. Texas: A Guide to the Case Challenging the ACA*, KAISER FAM. FOUND. 1 (Sept. 1, 2020), <https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/>.

¹⁹¹ Along with an increase in uninsured individuals, the Medicaid expansion, the expansion of coverage for preventive services, the establishment of public health initiatives, and improvement of quality of care and delivery system, could all be overturned, to name a few. Musumeci, *supra* note 166.

¹⁹² The CDC broadly defines a Community Health Needs Assessment as a “process of community engagement; collection, analysis, and interpretation of data on health outcomes and health correlates/determinants; identification of health disparities; and identification of resources that can be used to address priority needs.” *Community-Based Health Needs Assessment Activities: Opportunities for Collaboration Between Public Health Departments and Rural Hospitals (2017)*, ASS’N OF STATE AND TERRITORIAL HEALTH OFFS., https://www.astho.org/uploadedFiles/Programs/Access/Primary_Care/Scan%20of%20Community-Based%20Health%20Needs%20Assessment%20Activities.pdf.

¹⁹³ *Requirements for 501(c)(3) Hospitals*, *supra* note 23.

¹⁹⁴ ASS’N OF STATE AND TERRITORIAL HEALTH OFFS., *supra* note 192, at 2–3.

¹⁹⁵ ASS’N OF STATE AND TERRITORIAL HEALTH OFFS., THE INTERNAL REVENUE SERV. FINAL RULE: CHARITABLE HOSPITALS & COMMUNITY HEALTH NEEDS ASSESSMENTS, <https://www.astho.org/Public-Policy/Public-Health-Law/Resources/IRS-CHNA-Final-Rules-Issue-Brief/> (last updated Mar. 2, 2015).

years, a hospital must “define the community it serves,” and “assess [that] community’s health needs,” by taking into consideration input from individuals who “represent the broad interests of the community served by [that] hospital facility.”¹⁹⁶ To fully capture the broad interests of the community, a hospital must seek information from three different sources: (1) a “governmental public health department” that is familiar with the defined community needs; (2) the “underserved, low-income and minority populations” of the community; and (3) any comments the hospital receives in regard to the most recent CHNA conducted.¹⁹⁷

From the input received, a hospital must then look to pinpoint the community it serves, which cannot be defined “in a way that excludes medically underserved,¹⁹⁸ low-income, or minority populations” within the surrounding area.¹⁹⁹ Instead, a hospital must look at the geographic area in which it is located and its target population, such as women, children or the elderly.²⁰⁰ Once a hospital understands who it is serving, it then identifies the significant health needs of that community, prioritizes those needs, and identifies resources available to address them.²⁰¹ The final rule for the ACA’s CHNA requirement²⁰² expanded on the earlier proposed health needs requirement,²⁰³ which stated that in addition to improving access to care, health needs could also be discrete objectives such as “prevent[ing] illness, [ensuring] adequate

¹⁹⁶ INTERNAL REVENUE SERV., *supra* note 31.

¹⁹⁷ ASS’N OF STATE AND TERRITORIAL HEALTH OFFS., *supra* note 195, at 2.

¹⁹⁸ The IRS defines medically underserved populations as those “experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured, or due to geographic, language, financial or other barriers,” which can include “cost, transportation difficulties, [and stigma].” INTERNAL REVENUE SERV., *supra* note 31.

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² The IRS published the final rule for the ACA’s CHNA requirements on December 31, 2014. ASS’N OF STATE AND TERRITORIAL HEALTH OFFS., *supra* note 195.

²⁰³ The 2013 proposed rule required that a hospital “improv[e] access to care by removing financial and other barriers” in order to improve the health status of the community. *Id.* at 3.

nutrition, or [addressing] social, behavioral, and environmental factors that influence health in the community.”²⁰⁴

Once the community and its needs are defined, the hospital is required to document their findings in a report and provide a written implementation plan.²⁰⁵ The report must include, among other things: a definition of the community served and how that community was determined, a “prioritized description” of the health needs of the community, a description of the resources available to address those needs, and the impact of actions taken to address them.²⁰⁶ The implementation plan must also separately identify each significant health need and describe how the hospital plans to address it, by (1) relaying the specific actions it plans to take, (2) stating the likely impact its actions will have, and (3) identifying the resources the hospital will commit to its goal.²⁰⁷ Sufficient reasons to deny addressing an apparent need include resource constraints, a lack of knowledge or expertise to effectively address the issue, or a lack of identifiable effective implementation strategies.²⁰⁸

Though critics state the CHNA is ineffective, the assessment and the required implementation plan have proven to address the needs of the underserved and have aided in achieving more health-equitable communities. For example, Medstar, a non-profit health system in Maryland, conducted a systemwide CHNA and, as a result, implemented a three-year plan to incrementally address identified needs.²⁰⁹ A “community based advisory task force” led the assessment process at each hospital in the MedStar system, creating a hospital-specific “community benefit service area” which identified “a discrete geography with a high volume of preventable illness, premature mortality, poverty, unemployment, low literacy,

²⁰⁴ *Id.*

²⁰⁵ INTERNAL REVENUE SERV., *supra* note 31.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ The plan was meant to be a guide for how the hospital’s “community benefit resources will be allocated, deployed, and evaluated.” *Successes and Challenges in Community Health Improvement: Stories from Early Collaborations*, ASS’N OF STATE AND TERRITORIAL HEALTH OFFS. 8–9 (2014), <https://www.astho.org/Successes-and-Challenges-in-Community-Health-Improvement-Issue-Brief/>.

and other social conditions linked to poor health.”²¹⁰ In its response plan, the hospital started by looking at health outcomes of individuals participating in evidence-based programs and determining what health problems should become a priority.²¹¹ Next, it took a broad look at factors akin to the social determinants of health²¹² in order to address what was actually causing vulnerable populations to have poor health. The hospital’s ultimate goal was to create partnerships in the community that would help to provide populations with “wraparound services.”²¹³

B. *The Certificate of Need*

While the CHNA is a federally mandated requirement for non-profit hospital organizations, a Certificate of Need (“CON”) is a regulatory mechanism imposed by the state on any hospital system, regardless of ownership type.²¹⁴ The purpose of these regulations is to prevent hospitals from expanding their facilities, or otherwise buying new buildings and equipment, without first getting permission from the state government.²¹⁵ In states with a CON

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *Id.* The social determinants of health “are the conditions in which people are born, grow, live, work and age,” and “include factors like socioeconomic status, education, neighborhood and physical environment . . . as well as access to health care.” Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. (May 10, 2018), <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>.

²¹³ A wraparound service is a nonmedical service that is provided in conjunction with hospital care. Studies have shown that providing this type of service results in reduced hospitalizations and emergency room visits. Allen Cone, *Study: Wraparound Services Reduce Health Costs, Hospital Needs*, UNITED PRESS INT’L (Oct. 3, 2018, 1:30 PM), https://www.upi.com/Health_News/2018/10/03/Study-Wraparound-services-reduce-health-costs-hospital-needs/5211538580893/; ASS’N OF STATE AND TERRITORIAL HEALTH OFFS., *supra* note 209, at 8–9.

²¹⁴ NAT’L CONF. OF STATE LEG., *supra* note 56.

²¹⁵ Mercatus Ctr., *How State Certificate-of-Need (CON) Laws Affect Access to Health Care*, MEDIUM (May 12, 2015), <https://medium.com/concentrated->

program, hospitals are forbidden from beginning a project until they receive approval from a planning agency, which reviews the hospital's proposal "against a set of planning criteria and a finding of community need."²¹⁶ The state's goal is to reduce health care costs and ensure that its low-income population has access to the health care services it needs.²¹⁷

In 1964, New York became the first state to enact a CON law, and within the next decade, twenty-six more states followed.²¹⁸ In early years, the CON laws regulated costs spent on land, buildings, or equipment in excess of \$100,000.²¹⁹ They also controlled the addition of hospital beds and the expansion of any health care services.²²⁰ Congress then passed the National Health Planning and Resource Development Act ("NHPRD") of 1974, which afforded federal funds for state CON programs, but required the states to restructure their laws so that they complied with the new federal standards.²²¹ After the Act was passed, almost every state had some form of CON program that hospitals were required to comply with if they wanted to undertake a new project.²²² Then, after thirteen years in effect, the federal government repealed the NHPRD, in 1987, taking its funding with it.²²³ The repeal of the Act prompted a number of states to either remove or modify their CON laws.²²⁴ Although the amount of states with active CON programs has

benefits/how-state-certificate-of-need-con-laws-impact-access-to-health-care-b8d3ec84242f.

²¹⁶ James B. Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH 1225, 1225 (1985), <https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.75.10.1225>.

²¹⁷ See Mercatus Ctr., *supra* note 215 (noting that states would be able to lower costs and increase the availability of services to the poor by regulating market competition through a CON).

²¹⁸ NAT'L CONF. OF STATE LEG., *supra* note 56.

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ Simpson, *supra* note 216, at 1225.

²²² Louisiana was the only state that did not implement a CON program after the federal law was passed. NAT'L CONF. OF STATE LEG., *supra* note 56.

²²³ Mercatus Ctr., *supra* note 215.

²²⁴ NAT'L CONF. OF STATE LEG., *supra* note 56.

fluctuated since 1987,²²⁵ there are currently 35 that have enacted, and enforce, such laws.²²⁶

In many cases, CON laws were enacted as a way to regulate health care spending and ensure that health care was being distributed evenly across all geographic areas of the United States.²²⁷ Without such laws, there is a risk that hospital expansion and health technology development will be guided by “consumer demand” rather than an actual need for care, leading to an imbalance in systems between areas that need more hospitals and those that do not.²²⁸ Though not implemented with the current healthcare goals of quality, access, and affordability in mind, CON laws help to ensure that all members of our society, from those that can afford care to those that cannot, have access to adequate hospital care.²²⁹

IV. A PROPOSED APPROACH TO INCENTIVIZE FOR-PROFITS TO ACTIVELY AND EFFECTIVELY PARTICIPATE IN THE NATION’S HEALTH EQUITY GOALS

In 2018, the United States Department of Health and Human Services (“HHS”) released its Health and Human Services Strategic Plan for the fiscal years 2018–2022.²³⁰ Updated every four years, the strategic plan lays out the mission and goals HHS will work towards to address the current health problems facing our nation.²³¹ The strategic plan that is currently underway emphasizes the same

²²⁵ Between 1987 and 1990, twelve states removed their CON laws, leaving thirty-eight states with CON programs. That number rose to thirty-nine in 1993 when Wisconsin reinstated their program but fell again in 2000 when three more states repealed their programs. Since 2000, Wisconsin has removed their reinstated CON laws. Mercatus Ctr., *supra* note 215.

²²⁶ NAT’L CONF. OF STATE LEG., *supra* note 56.

²²⁷ *Id.*

²²⁸ Simpson, *supra* note 216, at 1225.

²²⁹ See NAT’L CONF. OF STATE LEG., *supra* note 56 (noting that the purpose of a state CON program is to “help distribute care to disadvantaged populations or geographic areas that new and existing medical centers may not serve”).

²³⁰ Assistant Secretary for Planning and Evaluation, *Overview: HHS Strategic Plan, FY 2018-2022*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., <https://www.hhs.gov/about/strategic-plan/overview/index.html> (last updated Feb. 28, 2018).

²³¹ *Id.*

goals that were set forth when the ACA was implemented—ensuring that our population remains healthy by providing health care that is affordable, accessible, and of high quality.²³² These goals were met largely through the efforts of hospitals and insurance companies to provide more coverage to a larger portion of our population, as well as provide care and services tailored to alleviate some of the health inequities facing our nation. While the availability of acute care²³³ will always be of concern for a hospital, especially a non-profit hospital, the real shift seen in the ACA, and the more recent HHS healthcare reform, is the spotlight on early intervention and preventive care,²³⁴ as well as the need for equitable population health.²³⁵

Prior to the TCJA, the increase in insured individuals caused by the ACA gave hospitals enough freedom to divest some of their funds away from covering uncompensated care and allowed them to instead invest their resources in the public health and preventive care.²³⁶ These efforts were stunted by the repeal of the individual mandate, and to some extent the *Sebelius* Court’s decision to make the Medicaid expansion optional, because without these incentives to participate in health insurance, hundreds of thousands of Americans have become uninsured and millions more will follow.²³⁷

²³² *Id.*

²³³ Acute care refers to care that is time sensitive, such as urgent care, emergency care, trauma care and critical care. Jon Mark Hirshon et al., *Health Systems and Services: The Role of Acute Care*, WORLD HEALTH ORG. (2013), <https://www.who.int/bulletin/volumes/91/5/12-112664/en/>.

²³⁴ The ACA required insurers to cover ten “essential health benefits,” one of which included preventive services such as chronic disease management, wellness exams, and mammograms. Deborah J. Cornwall, *ACA Purpose and Protections*, HUFFINGTON POST (May 2, 2017), https://www.huffpost.com/entry/aca-purpose-and-protections-part-two-of-a-four-part_b_59011258e4b00acb75f18465.

²³⁵ U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 230.

²³⁶ See Glied, *supra* note 164, at 735 (noting that the increase of insured individuals resulting from the ACA led to a growing effort by the healthcare community to “invest in public health, social determinants, and prevention”).

²³⁷ See Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, COMMONWEALTH FUND (July 11, 2018), <https://commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty->

The loss of healthy individuals in the insurance market, something the individual mandate was meant to address, will increase premiums for health insurance. Accordingly, the accessibility of insurance to all individuals, but especially those who desperately need it, will decline.²³⁸ The rate of uninsured persons may increase even more in those states that did not choose to expand their Medicaid program after *Sebelius*, because there is less coverage available for low-income residents who cannot afford the high premiums the repeal of the individual mandate spurred.²³⁹

Obviously, just because these individuals are uninsured does not mean they will not eventually need care. As Justice Ginsberg noted in her concurrence in *Sebelius*, “[v]irtually everyone . . . consumes health care at some point in his or her life,”²⁴⁰ and when the time comes for that care to be provided, federal and state law require physicians to treat those patients regardless of their ability to pay.²⁴¹ When the uninsured population increases, it is always non-profit hospitals that are affected with a significant increase in costs, as opposed to for-profit hospitals which see no change in their costs.²⁴² This is because the delivery of uncompensated care largely falls on the shoulders of non-profit hospitals which, because of their tax-exempt status, are required to provide care to all patients regardless of their ability to pay.²⁴³ Unless uncompensated care is rendered for a medical emergency that falls under the statutory requirements of EMTALA, for-profit hospitals are not required to treat patients who cannot pay for their care, simply because doing so may not align with their profit maximization goals.²⁴⁴

Since the ACA has not fully been repealed, pending the Fifth Circuit’s decision in *Texas v. United States*, non-profit organizations

behavioral-factors (noting that the Congressional Budget Office estimated that the repeal of the individual mandate would “reduce health insurance enrollment by 3 million to 6 million between 2019 and 2021”).

²³⁸ King, *supra* note 48, at 581.

²³⁹ *Id.* at 580.

²⁴⁰ Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519, 608 (2012). (Ginsberg, J., concurring).

²⁴¹ *Id.* at 593.

²⁴² King, *supra* note 48, at 581.

²⁴³ See *supra* Part I.A.

²⁴⁴ See *supra* Part I.B.

are still required to complete a CHNA every three years.²⁴⁵ However, the repercussion of the TCJA may force “non-profit hospitals to forgo preventive community health engagement and outreach.”²⁴⁶ Since the legal battle over the ACA began and the changes to its provisions started to take shape, for-profit hospitals have been largely unaffected by the repercussions as compared to non-profit hospitals. In fact, the actual tax reforms of the TCJA provided for-profit corporations with higher tax breaks than their non-profit counterparts.²⁴⁷ The fact that for-profit hospitals have no legal obligation to provide uncompensated care or charity care softened the impact of the TCJA even more.²⁴⁸ Non-profit hospitals, on the other hand, have seen a decrease in the amount of money they receive for their tax-exempt status and have begun to take resources away from post-ACA efforts or services designed to further the goals of greater access, quality and affordability of health care.²⁴⁹

In order to further the early intervention and population health goals of the ACA and HHS, for-profit hospitals should be legally required to participate in the health care system’s attempts to achieve health equity.²⁵⁰ To do this, everyone must have a “fair and just opportunity to be as healthy as possible,”²⁵¹ which begins by decreasing health disparities²⁵² and improving health outcomes.²⁵³ Right now, the burden is largely on non-profit hospitals to ensure their communities are healthy, because the ACA requires them to

²⁴⁵ See *Requirements for 501(c)(3) Hospitals*, *supra* note 23 (explaining that to be tax-exempt a non-profit hospital must complete the ACA’s CHNA requirement).

²⁴⁶ King, *supra* note 48, at 583.

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ Generally, health equity is a broad goal that encompasses many different social and economic factors, which are often called the “social determinants of health.” Generally, equal access to quality care is the factor that the healthcare system focuses on. FURROW ET AL., *supra* note 132, at 9.

²⁵¹ *Id.*

²⁵² These are “population-level health differences that [are] linked to a history of social, economic, or environmental disadvantage.” *Id.*

²⁵³ This requires decreasing the burden of illness, injury and mortality on lower-income populations, as well as improving access to care and the quality of care received. *Id.*

report their charity care and community benefit investments through the CHNA, and to implement an effective plan to address community health needs. While for-profit hospitals are not banned from addressing those same needs, many may choose not to provide, or provide significantly less, preventative care and “wraparound services,”²⁵⁴ either because they are not legally required to, or because they believe their money is better invested elsewhere. If for-profit hospitals do choose to assess community needs, their analyses may not be as detailed as the CHNA that is required by the IRS. Thus, they may not be as effective at ensuring the hospital remains accountable to all of its community members, and that the preventative care provided is accessible to all within the community—including surrounding low-income populations who may not necessarily be “treatable” at for-profit hospitals.

Communities and the government need a way to ensure that for-profit hospitals are proactively engaging in the health maintenance of their communities. They can do this by holding for-profit hospitals to the same standards as non-profit hospitals when it comes to community needs, which in turn can be achieved on either the federal or state level through a CHNA. Parts A and B of this section discuss how the government can impose legal obligations on for-profit hospitals by attaching a required CHNA and implementation plan to programs such as Medicaid and CONs, respectively. This approach helps to equalize the burden of for-profits and non-profits when it comes to addressing community needs and preventative care, while still allowing for-profits to maintain their profit-driven business models.

A. The Federal Level

On the federal level, for-profit hospitals can be held accountable to address the needs of their community by conditioning their

²⁵⁴ See Jeff Lagasse, *Wraparound Services Hold Promise for Reducing Health Costs and Improving Outcomes*, HEALTHCARE FIN. (Oct. 9, 2018), <https://www.healthcarefinancenews.com/news/wraparound-services-hold-promise-reducing-health-costs-and-improving-outcomes> (noting that wraparound services include assistance related to “behavioral health, social work, dietetics, . . . patient navigation, pharmacist education, financial counseling and a medical-legal partnership”).

payments for Medicaid patients on the completion of a CHNA and a corresponding implementation plan. This would be a two-step process, in that the federal government would add a stipulation to its state Medicaid funding that would require any hospital receiving such funds to first complete a CHNA.²⁵⁵ The states then, in order to receive federal matching funds²⁵⁶ and funds for DSH payments,²⁵⁷ would ensure that the hospitals receiving its Medicaid payments were compliant with the CHNA requirement. Importantly, the CHNA reporting and enforcement would still rest with the federal government, as it currently does for non-profit hospitals.²⁵⁸ The states need only perform a surface level analysis of the hospital system they are providing funds to, in order to ensure compliance with the federal CHNA requirement.

Although this proposed solution may conflict with the *Sebelius* plurality, in the sense that the justices' reasoning to make the expansion optional rested on the idea that the expansion created an entirely new program that cannot be used to condition funds,²⁵⁹ it actually differs from the ACA's changes to Medicaid because it does not impose any more of a burden on states than that program already enforced. Further, as Justice Ginsberg noted in her *Sebelius* concurrence, the Medicaid Act²⁶⁰ explicitly stated that the federal

²⁵⁵ In order for states to receive funds from the federal government to participate in Medicaid, they must meet "core federal requirements." Robin Rudowitz et al., *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (Mar. 21, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/>.

²⁵⁶ "Medicaid is jointly financed by the federal government and states, with the federal government providing matching funds for allowable state Medicaid spending on an open-ended basis." Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, KAISER FAM. FOUND. (Jan. 31, 2017), <https://www.kff.org/medicaid/issue-brief/current-flexibility-in-medicaid-an-overview-of-federal-standards-and-state-options/>.

²⁵⁷ MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, *supra* note 174.

²⁵⁸ *See supra* Part III.A.

²⁵⁹ Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 581 (2012).

²⁶⁰ The Medicaid Act was signed into law on July 30, 1965 by President Lyndon B. Johnson establishing Medicare and Medicaid, the latter creating health insurance for the poor. 1965—*The Medicare and Medicaid Act*, NAT'L HEALTH L. PROGRAM, <https://healthlaw.org/announcement/medicare-and-medicaid-act-1965-2/> (last visited Oct. 2, 2020).

government has the right “to alter, amend, or repeal any provision of [Medicaid],” effectively putting states on notice that the federal requirements could change.²⁶¹

Conditioning Medicaid funds on an assessment and implementation plan to address community needs will be an effective way to target for-profit hospitals and incentivize them to address the health needs of a population they have generally neglected.²⁶² At the same time, for-profit hospitals would still be able to continue to fulfill their mission of profit maximization,²⁶³ since the participation required by for-profits under this proposed solution would simply require them to fulfill the CHNA’s goal of investing in their communities.²⁶⁴ While this could include charity and uncompensated care, it does not necessarily have to, which allows for-profit hospitals to continue to primarily care for insured patients in their hospitals who are capable of paying for their treatment.²⁶⁵

Instead, should for-profits choose to participate in a subsidized program like Medicaid (and most already do),²⁶⁶ they can implement a CHNA plan like that of Medstar.²⁶⁷ Since Medicaid is a system designed to provide health care to the poor and underserved populations of our nation,²⁶⁸ it is likely that a for-profit hospital choosing to accept Medicaid patients is located in a community that has a significant low-income population uniquely vulnerable to poor health outcomes. In fact, in 2018, in the ten states with the highest

²⁶¹ *Sebelius*, 567 U.S. at 639 (Ginsburg, J, concurring).

²⁶² See U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 26 (noting that one of HHS’s strategic healthcare goals is to address barriers to care by improving patient access to healthcare and expanding the choices of care and service that a patient can receive).

²⁶³ See *supra* Part I.B.

²⁶⁴ See Karen Kahn, *How Do Nonprofit and For-Profit Hospitals Differ? It’s Complicated*, NONPROFIT QUARTERLY (Sept. 10, 2019), <https://nonprofitquarterly.org/how-do-nonprofit-and-for-profit-hospitals-differ-its-complicated/>.

²⁶⁵ See Herrera, *supra* note 12.

²⁶⁶ See INST. OF MED., *supra* note 11.

²⁶⁷ See *supra* notes 209–13 and accompanying text.

²⁶⁸ Nat’l Fed’n of Indep. Bus. v. *Sebelius*, 567 U.S. 519, 634 (2012). (Ginsburg, J, concurring).

percentage of for-profit hospitals²⁶⁹ Medicaid recipients ranged from 4–30% of the population.²⁷⁰ After the ACA’s Medicaid expansion became optional, six out of those ten states chose not to expand,²⁷¹ likely leaving a significant portion of the population in those states unable to obtain insurance and thus afford care.

Because of the decision to make the Medicaid expansion optional and the TCJA’s effective repeal of the individual mandate, the number of uninsured individuals is rising,²⁷² leaving our most vulnerable populations at risk once again. Despite these changes, the original goals of the ACA and the HHS strategic plans remain the same, and hospitals are still expected to participate in the creation of a system that is affordable, accessible, and of high quality.²⁷³ Before legislation altered the function of the ACA, non-profit hospitals were carrying out efforts to achieve these goals through their CHNAs by ensuring their implementation plans focused on “preventive community health engagement and outreach.”²⁷⁴ After the legislative changes were made, non-profit hospitals were burdened once again with bearing the costs of uncompensated and charity care and were forced to put preventive outreach measures to the wayside.²⁷⁵ Because providing uncompensated care is both a legal requirement for all non-profit hospitals and is an acceptable

²⁶⁹ *Hospitals by Ownership Type*, *supra* note 19.

²⁷⁰ *Total Monthly Medicaid and CHIP Enrollment (2019)*, KAISER FAM. FOUND., <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/> (last visited Nov. 17, 2020).

²⁷¹ *Medicaid Expansion Enrollment (2017)*, KAISER FAM. FOUND., <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/> (last visited Oct. 2, 2020).

²⁷² *See* Keith, *supra* note 43 (stating that in 2018 the uninsured rate increased for the first time since the ACA was enacted in 2010, rising 0.5%, or by about 1.9 million people).

²⁷³ *See* U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 229.

²⁷⁴ *See supra* notes 205–08 and accompanying text; *see also* King, *supra* note 118, at 583–84 (explaining that the TCJA shifts federal tax breaks from non-profit hospitals to for-profits hospitals, cutting non-profit resources which in turn led non-profits to cut non-legally mandated services, such as preventive community health engagement).

²⁷⁵ *See* King, *supra* note 48, at 583–84 (noting that in the “face of financial difficulties” preventive community health engagement would be “the first [charitable activity] to be dropped or simply forgotten”).

way to fulfill their CHNA requirements, non-mandated services, such as population health and preventative care, were the first to go to when it came time to siphon resources in order to address the increasing uninsured population.²⁷⁶

For-profit hospitals that choose to provide and receive compensation for care provided to low-income individuals through Medicaid should be required to participate in a federal CHNA to ensure that all hospitals are caring for and addressing the long term health needs of their communities' most vulnerable residents.²⁷⁷ Through a conditional CHNA, for-profits would be required to address the needs of their community and, more broadly, shoulder more responsibility towards achieving the system's health equity goal. The Assessment would require for-profits to bear the cost of uncompensated care, directly or indirectly. They could either provide uncompensated or charity care to the extent needed by the community, or more realistically, they could provide community services to help decrease health disparities, which would improve the health of the community and prevent the community's non-profits from bearing uncompensated and charity care costs beyond their means.²⁷⁸ It is important to highlight that at its core, this approach is a choice. If community health outreach and preventative care promotion is an avenue that for-profit hospitals are not willing to take, they can choose not to receive state Medicaid funding. The

²⁷⁶ *Id.* at 533, 582.

²⁷⁷ The modern healthcare system supports the idea that "health systems and community stakeholders" should collaborate to "address the social factors that have created great health disparities between low-income and more-affluent neighborhoods." See Steven R. Johnson, *Hospitals Address Social Determinants of Health Through Community Cooperation and Partnerships*, MODERN HEALTHCARE (June 2, 2018, 1:00 AM), <https://www.modernhealthcare.com/article/20180602/TRANSFORMATION03/180609978/hospitals-address-social-determinants-of-health-through-community-cooperation-and-partnerships> (discussing how hospitals should use their community benefit investments "to tackle more preventive and upstream issues," such as addressing the social determinants of health, rather than just focusing on clinical initiatives).

²⁷⁸ When uninsured populations rise, for-profit hospitals are usually unaffected by the costs of that uncompensated care. See King, *supra* note 48, at 583 (noting that when indigent patients need health care, non-profits, as compared to for-profits, are the "insurers of last resort," and "predominately bear" the burden of providing that care).

hospital would only be required to complete and implement a CHNA if it decided to accept state Medicaid funding. Regarding the proposed solution's dual approach, the federal aspect is particularly important in that it ensures for-profits meet CHNA requirements in those states that do not require CONs.²⁷⁹

B. The State Level

On the state level, the proposed solution for ensuring that for-profit hospitals are held accountable for their communities' needs is similar to the federal solution described above. Currently, thirty-six states and Washington, D.C. have CON laws in place, requiring any hospital that wishes to purchase or expand on a building, or purchase equipment for their facility, to first obtain approval by the state.²⁸⁰ In determining whether approval is warranted, the state relies on the opinion of a health planning agency, which decides whether the hospital's plans are warranted "based on a set of criteria and community needs."²⁸¹ The hospital must demonstrate a community need if it hopes to receive a CON from a state health planning agency.²⁸² Though the specifics of CON laws vary widely by state, the community need aspect remains a cornerstone of these laws. After all, the purpose of a CON is to ensure care is provided to communities that actually need it.²⁸³ As such, states should be encouraged to require hospitals, whose plans are within a community identifying a need for health care, to complete a CHNA and an implementation plan before a CON will be approved.

Since this is the state level aspect of the dual approach, the states should be free to implement the federal CHNA regulated by the IRS or use the federal CHNA as a guide in creating an equivalent assessment with which hospitals must comply.²⁸⁴ Ultimately, the

²⁷⁹ Four of the ten states with the largest percentage of for-profits do not have certificates of need. Two additional states do have certificates of need, but they do not apply to hospitals. NAT'L CONF. OF STATE LEG., *supra* note 56.

²⁸⁰ *Id.*

²⁸¹ *Id.*

²⁸² *See id.*

²⁸³ *See id.*

²⁸⁴ The point of the state level proposed solution is to keep the enforcement of the CHNA implementation plans with the states, which is why application of

purpose of the state CHNA should remain the same as its federal counterpart: ensuring that hospitals remain accountable for community engagement.²⁸⁵ While this requirement would be applicable to both non-profit and for-profit hospitals,²⁸⁶ the effects of its implementation would force for-profits to engage more actively with the disadvantaged populations in their communities—something non-profits already do based on their charitable status and federal CHNA requirements.²⁸⁷ Similar to the federal proposed solution, the condition of a completed CHNA in order to obtain a CON would still allow for-profit hospitals to choose when they participate in addressing the needs of the community, because there is no legal requirement that hospitals buy new buildings or expand on existing ones. Despite that choice, the attachment of a CHNA to a CON may actually prompt more engagement from for-profit hospitals because growth is often necessary for such organizations to maximize their profits.²⁸⁸

Importantly, the incentives that a CON, even with a conditional CHNA, provides to for-profits neatly overlaps with the underlying purpose of a CON and a CHNA. Namely, that the community has an expansive, engaged and effective healthcare system that will accurately address its needs. In that sense, the proposed solution

the IRS's CHNA that is reported to the federal government should not be applied. See discussion *supra* Part III.A.

²⁸⁵ *Clinical to Community Connections*, ASS'N OF STATE AND TERRITORIAL HEALTH OFFS., <https://www.astho.org/Programs/Access/Community-Health-Needs-Assessments/> (last visited Nov. 17, 2020).

²⁸⁶ Presently, non-profit hospitals are only required to complete a CHNA to obtain their tax-exempt status under the federal government. See *Requirements for 501(c)(3) Hospitals*, *supra* note 31 (detailing the four requirements that a hospital must meet to remain tax-exempt post-ACA, which includes the completion and implementation of a CHNA). That CHNA is not currently taken into consideration when a non-profit is looking to obtain a certificate of need from their state. See NAT'L CONF. OF STATE LEG., *supra* note 56 (explaining that when a state health planning agency considers a certificate of need, its approval is based on a set of criteria and community need. However, the determination of need is not a CHNA, and does not place the same burden on health care facilities to implement the needs assessment).

²⁸⁷ See Rev. Rul. 56-185, 1956-1 C.B. 202.

²⁸⁸ Profit maximization is the goal that drives for-profit hospitals. King, *supra* note 48, at 548–49.

provides a benefit to the for-profit hospital, the state and the non-profit hospitals. If a for-profit hospital chooses to apply for a CON in a community showing need and chooses to implement a CHNA, it can maximize its profits through expansion. A state can continue to apply its existing CON laws, either denying or approving a hospital's plan based on community need. If the state health planning agency approves a plan, it will not only be able to achieve the goal of ensuring geographically underserved populations receive adequate care through the CON application process,²⁸⁹ the planning agency will also be confident that the hospital will continue to fulfill its community health obligations through imposition of a CHNA implementation plan. The state proposed solution benefits non-profits in the same way as the federal proposed solution.²⁹⁰ While non-profits must continue to provide mandated community benefits and uncompensated care,²⁹¹ requiring for-profits to implement a CHNA plan before they can expand or add to their hospital will shift some of the burdens of uncompensated and charity care off of non-profits, finally encouraging for-profits to address the needs of the most vulnerable members of their community.

CONCLUSION

The solutions proposed herein would enable the federal and state governments to incentivize for-profit hospitals to contribute to the healthcare system's health equity goals, and help alleviate the crushing burden that non-profits currently face when caring for the poor. Neither the federal nor the state aspect of the proposed solution prevent for-profits from continuing to fulfill their profit maximization goals. Rather, it conditions two important sources of state funding and regulation, Medicaid and a CON, respectively, on the completion of a CHNA. While Medicaid and a CON are both

²⁸⁹ See NAT'L CONF. OF STATE LEG., *supra* note 56 (noting that the purpose of a state CON program is to "help distribute care to disadvantaged populations or geographic areas that new and existing medical centers may not serve").

²⁹⁰ See *supra* Part IV.A.

²⁹¹ See Rev. Rul. 56-185, 1956-1 C.B. 202 (noting that the IRS defines "charitable" under section 501(c)(3) to require a hospital to operate for those unable to pay for care and to accept all patients in need of care regardless of ability to pay if that hospital is to remain tax-exempt).

voluntary endeavors for for-profit hospitals, both generally provide enough benefits that the completion and implementation of a conditional CHNA is likely. Incentivizing for-profits in this way motivates them to participate in the effort to improve the health equity of the population, which is critical for “improving community health” and is one of the “most effective and cost-efficient approach[es] to healthcare.”²⁹² Ultimately, this proposal will help put into action a central theme of the ACA, the view that “health care [is] an essential public good to which everyone should have access.”²⁹³

²⁹² King, *supra* note 48, at 584; *see also* Thomas Beaton, *How Preventive Healthcare Services Reduce Spending for Payers*, HEALTH PAYER INTELLIGENCE (Aug. 29, 2017), <https://healthpayerintelligence.com/news/how-preventive-healthcare-services-reduce-spending-for-payers> (showing how working with community groups and identifying community factors can help hospitals reduce costs).

²⁹³ Importantly, the idea that health care is a right cannot be achieved without “creating a legal obligation to provide care or to ensure access to an adequate supply of providers.” FURROW ET AL., *supra* note 132, at 358.