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## Note

### Using Community Benefits To Bridge the Divide Between Minnesota's Nonprofit Hospitals and Their Communities

Meredith Gingold\*

#### INTRODUCTION

In the first two years of the Patient Protection and Affordable Care Act (ACA), the nation's top seven hospitals, as ranked by *U.S. News & World Report*, collected an additional \$4.5 billion in revenue per year.<sup>1</sup> During the same period, their direct spending on charity care—free treatment for low-income patients—dropped by \$142 million.<sup>2</sup> This trend occurred locally in Minnesota as well; the Mayo Clinic's revenue grew by over \$1 billion since the full implementation of the ACA,<sup>3</sup> yet the growth in its delivery of community benefits, a larger category encompassing things like charity care, training for doctors and residents, and community health improvement efforts, was just over \$30 million—approximately 3% of the growth in revenue.<sup>4</sup> There are clear disparities in these numbers that tell an important story.

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1. Dan Diamond, *How Hospitals Got Richer off Obamacare*, POLITICO (July 17, 2017, 5:00 AM), <https://www.politico.com/interactives/2017/obamacare-non-profit-hospital-taxes> [<https://perma.cc/UG8V-9PBK>].

2. *Id.*

3. *Id.*

4. In 2013, the Mayo Clinic dedicated \$139,816,947 of its operating expenses to community benefits. In 2015, it dedicated \$170,085,455. To arrive at the above numbers, I conducted my own calculations based on the data found at the following website: *Mayo Clinic Hospital Rochester*, CMTY. BENEFIT INSIGHT, <http://www>

As of 2014, 60% of United States hospitals were exempt from federal, state, and local taxes because they are nonprofits.<sup>5</sup> The community benefit standard requires nonprofit hospitals to demonstrate that they serve their community in return for their various tax breaks.<sup>6</sup> While these tax exemptions encourage nonprofit hospitals to give back to their communities in return for the tax exemptions that they receive, any giving is voluntary.<sup>7</sup> There is a tremendous amount of variation in the percentages of nonprofit hospitals' budgets that are spent on community benefits, and current community benefit spending levels nationally are nowhere near the value of the tax exemptions that nonprofit hospitals receive.<sup>8</sup> These tax exemptions cost federal, state, and local governments \$24.6 billion in 2011,<sup>9</sup> and that number is rising,<sup>10</sup> yet community benefit giving levels are falling.<sup>11</sup>

"There is an expectation that nonprofits provide sufficient community benefit to justify their tax-exempt status,"<sup>12</sup> but the community benefits that nonprofit hospitals offer exceed the value of their tax exemptions in only 62% of hospitals.<sup>13</sup> This number is likely inflated because the community benefit standard is often not a true measure

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.communitybenefitinsight.org/?page=search.view.hospital&id=1464&year=2013&show=amounts [https://perma.cc/9YDD-MQ4W].

5. Bradley Herring, Darrell Gaskin, Hossein Zare & Gerard Anderson, *Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits*, 55 J. HEALTH CARE ORG. PROVISION & FIN. 1, 1 (2018).

6. See Tara Fugate, *What Is Community Benefit Spending and Why Does It Matter for Not-for-Profit Hospitals?*, MINN. NURSES ASS'N, <https://mnnurses.org/what-is-community-benefit-spending-and-why-does-it-matter-for-not-for-profit-hospitals> [https://perma.cc/7XG9-F556].

7. See Daniel B. Rubin, Simone R. Singh & Gary J. Young, *Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice*, 36 ANN. REV. PUB. HEALTH 545, 548 (2015) ("A key consideration underlying this controversy is the fact that federal and most state and local exemption standards lack explicit criteria regarding what is expected of tax-exempt hospitals in terms of their management practices and community benefit activities.").

8. *Id.*

9. Sara Rosenbaum, David A. Kindig, Jie Bao, Maureen K. Byrnes & Colin O'Laughlin, *The Value of the Nonprofit Hospital Tax Exemption Was \$24.6 Billion in 2011*, 34 HEALTH AFFS. 1125, 1125 (2015), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1424> [https://perma.cc/J964-LVUE].

10. See *id.* at 1128 ("[T]otal tax benefits increased nominally at an average annual rate of 7.7% between 2002 and 2011, yielding substantial cumulative value.").

11. See THOMAS DELEIRE, KAREN JOYNT & RUTH McDONALD, *IMPACT OF INSURANCE EXPANSION ON HOSPITAL UNCOMPENSATED CARE COSTS IN 2014*, at 1-2 (2014), [https://aspe.hhs.gov/system/files/pdf/77061/ib\\_UncompensatedCare.pdf](https://aspe.hhs.gov/system/files/pdf/77061/ib_UncompensatedCare.pdf) [https://perma.cc/4KMB-8YF7].

12. Herring et al., *supra* note 5.

13. *Id.*

of the amount a nonprofit hospital contributes to its community due to the wide array of activities that nonprofit hospitals can count as community benefits.<sup>14</sup>

Because of these shortcomings, a number of cities and states have taken steps toward recouping the money lost to nonprofit hospitals in tax exemptions. Pittsburgh's mayor sued the University of Pittsburgh Medical Center over its nonprofit status but eventually dropped the suit in 2014 in hopes of settling out of court.<sup>15</sup> After a 2015 ruling in New Jersey determined that nonprofit hospitals can be required to pay property taxes,<sup>16</sup> hospitals in New Jersey have begun negotiating settlement agreements with their localities.<sup>17</sup> In 2011, Massachusetts General Hospital, often ranked as the best hospital in the United States, negotiated a payment in lieu of taxes (PILOT) of just over \$2.5 million on what would have otherwise been a \$55 million tax payment.<sup>18</sup> These instances show that the interaction between nonprofit hospitals, their communities, and their tax exemptions is a pressing issue that is coming up across the country.

Local reformers in Minnesota should look to community benefits as a tool for building trust between communities surrounding Minnesota's nonprofit hospitals and the hospitals themselves. A system that creates real benefits for the communities that surround Minnesota's nonprofit hospitals must (1) ensure that what nonprofit hospitals can

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14. See *id.* at 7 (“[W]e believe that a comparison which uses charity care alone as the sole community benefit to compare with the value of the tax exemption serves as a reasonable lower bound for community benefits.”); Diamond, *supra* note 1 (“A POLITICO review of community benefit activities reported by these top hospitals found that the organizations counted activities like sponsoring races and hosting lectures toward their community benefit spending.”).

15. See Associated Press, *Pittsburgh, UPMC Drop Lawsuits over Nonprofit Status*, KDKA 2 CBS PITT. (July 29, 2014, 1:58 PM), <https://pittsburgh.cbslocal.com/2014/07/29/pittsburgh-upmc-drop-lawsuits-over-nonprofit-status>.

16. See Justin Zaremba, *Hospital Settles Tax Dispute After Its Nonprofit Status Questioned*, NJ.COM (Sept. 24, 2017), <https://www.nj.com/morris/2017/09/pequannock-settles-tax-dispute-with-atlantic-medic.html> [<https://perma.cc/VL8Y-UH75>].

17. Atlantic Health and the town of Pequannock, New Jersey, reached a settlement agreement where Atlantic Health would pay the town “a community service contribution of \$237,500 annually through 2021, in addition to \$25,000 from 2016 through 2021 to support the township’s public health initiatives.” This lawsuit and the subsequent settlement came after one of Atlantic Health’s hospitals in another town did not meet the legal test to operate as a nonprofit and Pequannock began to assess taxes on its hospital. *Id.*

18. CITY OF BOS., FISCAL YEAR 2016 PAYMENT IN LIEU OF TAX (PILOT) PROGRAM RESULTS (2016), [https://www.boston.gov/sites/default/files/embed/fy16\\_pilot\\_results\\_for\\_web.pdf](https://www.boston.gov/sites/default/files/embed/fy16_pilot_results_for_web.pdf) [<https://perma.cc/2QDN-6M95>].

count as community benefits provides actual benefit to the community, *and* (2) create a mandatory minimum amount of community benefit nonprofit hospitals must give.

In Part I, this Note examines the history of U.S. nonprofit hospitals and their tax exemptions, both on a federal and state level. Part I also investigates the actual workings of tax exemptions in tandem with the evolving nature of the nonprofit hospital in the United States and the communities that they serve. It also introduces the ways that Minnesota has customized the community benefit standard for its nonprofit hospitals.

In Part II, this Note argues that the community benefit standard, as it exists now, does not adequately encourage nonprofit hospitals to give back to their communities. First, this Part will show that nonprofit hospitals' tax exemption schemes as they exist now are inequitable—they, rightfully, take away a financial burden from some hospitals that offer a tremendous amount of community benefit while needlessly benefitting other hospitals that offer considerably less community benefit. Part II dives deeper into the meaning of "community benefit," the different kinds of expenditures that hospitals count under this category, and what these numbers reveal about the real nature of tax exemptions for nonprofit hospitals in the United States. Further, this Part explores how some hospitals give back to their communities at levels commensurate with their tax exemptions while others fall short of this mark. This Part also considers the current state actions, including litigation, around the subject to highlight how the current scheme is not working, and then it demonstrates that these trends occur locally in Minnesota as well.

In Part III, this Note proposes that Minnesota should investigate and implement reforms that rebuild trust between local nonprofit hospitals and their communities through true use of the community benefit standard. Specifically, reformers should scrutinize which categories count as community benefit and adjust them in order to reflect actual benefit to a community. Next, reformers should set a minimum amount of community benefits that Minnesota nonprofit hospitals must provide to retain their state and local tax exemptions. This amount should be flexible, based on current amounts of community benefit giving in the state, and specific enough for nonprofit hospitals to follow. In this way, communities surrounding Minnesota's nonprofit hospitals will truly benefit from their presence.

## I. NONPROFIT HOSPITALS' TAX EXEMPT STATUS: INCEPTION AND EVOLUTION

This Part will discuss how the tax-exempt status first granted to nonprofit hospitals reflected their initial role in the community. However, as that role changed with the advancement of modern medicine, the regulations governing tax exemption evolved as well. Because of the nature of nonprofit hospitals today, the tax-exemptions scheme has not evolved to encompass the diversity of nonprofit hospitals and the communities that they serve. This Part highlights that many nonprofit hospitals are integral to their communities and investigates how, locally, Minnesota has begun to adopt its own framework for nonprofit tax exemptions.

### A. HISTORY OF NONPROFIT HOSPITALS

Hospitals in America began as “alms houses” where communities and religious charities would care for the poor and sick for free.<sup>19</sup> The provision of medical care was secondary to the provision of food and shelter, as medical care was rudimentary at the time.<sup>20</sup> As hospitals began to develop in the 1800s, they became places that treated specific populations, like children, or specific diseases, like tuberculosis.<sup>21</sup> By 1890, there were 172 hospitals in the United States.<sup>22</sup>

As technology advanced, the level of care that hospitals could administer increased, and they shifted away from providing free care to providing care to the wealthy who could afford new treatments.<sup>23</sup> This shift led to tremendous growth in the field, and by 1920, there were more than 4,000 hospitals in the United States and an additional 521 mental illness hospitals.<sup>24</sup>

Because of the complexity and expense of medical treatment, hospitals began to favor a nonprofit structure that allowed for more

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19. See *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456, 465 (2015) (discussing the “early origins as charitable alms houses providing free basic medical treatment to the infirm poor”).

20. See PHOEBE LINDSEY BARTON, *UNDERSTANDING THE U.S. HEALTH SERVICES SYSTEM* 251 (4th ed. 2010).

21. *Id.*

22. *Id.*

23. See Cecilia M. Jardon McGregor, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 305 (2007) (discussing the origins and history of support for charity care as directly tied to religious charities).

24. BARTON, *supra* note 20, at 253.

financial stability due to tax benefits.<sup>25</sup> Nonprofit hospitals generate revenue, but their excess revenue is reinvested in the facility's improvement and growth, whereas for-profit hospitals may give some of this revenue to shareholders as dividends and are taxed accordingly.<sup>26</sup>

#### B. THE EVOLUTION OF FEDERAL STANDARDS FOR TAXATION OF NONPROFIT HOSPITALS

Federal regulations for nonprofit hospitals' tax-exempt status have changed as the nature of nonprofit hospitals has changed. This Section will examine how the advent of Medicare and Medicaid impacted IRS rules and how the Patient Protection and Affordable Care Act continued to change the existing rules.

##### 1. Creation of the Community Benefit Standard

Federal law provides that certain hospitals can obtain tax-exempt status as charitable nonprofit organizations.<sup>27</sup> Section 501(c)(3) of the Internal Revenue Code exempts from income taxation "[c]orporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes."<sup>28</sup> Under section 501(c)(3), hospitals, along with certain other "charitable" organizations, can obtain six benefits.<sup>29</sup> These include exemption from federal corporate income tax, state corporate income tax, state sales tax, and local property tax.<sup>30</sup> Additionally, nonprofit hospitals receive better rates for financing debt and tax subsidization of charitable contributions made to them.<sup>31</sup> Congress has not defined the word

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25. See Theodore R. Marmor, Mark Schlesinger & Richard W. Smithey, *A New Look at Nonprofits: Health Care Policy in a Competitive Age*, 3 YALE J. ON REGUL. 313, 322 (1986).

26. See BARTON, *supra* note 20, at 265.

27. See 26 U.S.C. § 501(c)(3).

28. *Id.*

29. See Herring et al., *supra* note 5, at 4.

30. *Id.*

31. *Id.* For a more detailed dive into each of these benefits, see Theodore J. Patton, *The Calamity of Community Benefit: Redefining the Scope and Increasing the Accountability of Minnesota's Nonprofit Hospitals*, 37 HAMLINE L. REV. 1, 4 (2014), which cites JAMES J. FISHMAN & STEPHEN SCHWARZ, *NONPROFIT ORGANIZATIONS: CASES AND MATERIALS* 327, 357 (3d ed. 2006); and Sara Rosenbaum & Ross Margulies, *Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REPS. 283, 283 (2011).

“charitable,”<sup>32</sup> but there is consensus that “the promotion of health is considered to be a charitable purpose.”<sup>33</sup>

Nonprofit hospitals have been able to qualify for tax exemption since 1894.<sup>34</sup> The initial scheme emphasized aid to the poor, where hospitals at that time generally focused, as medicine was not advanced.<sup>35</sup> As the practice of medicine became more sophisticated, hospitals began to accept more paying patients, and in 1953, the Internal Revenue Service (IRS) specified that a hospital would only be recognized as a corporation organized for charitable purposes if it was “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.”<sup>36</sup> Additionally, nonprofit hospitals had to maintain an open staff,<sup>37</sup> furnish services at reduced rates, and utilize earnings for capital improvements.<sup>38</sup> This change meant that nonprofit hospitals could charge patients for their services, but they should not deny care to individuals unable to pay.<sup>39</sup>

With the passage of Medicare and Medicaid in 1965, IRS staff, lobbied heavily by hospitals,<sup>40</sup> came to believe that hospitals would no longer need to cover the health care costs of the poor.<sup>41</sup> A 1969

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32. Cf. Steven T. Miller, Comm’r, Tax Exempt & Gov’t Entities, IRS, Address at the Office of the Attorney General of Texas: Charitable Hospitals: Modern Trends, Obligations and Challenges 6–7 (Jan. 12, 2009) (describing how the community benefit standard is defined).

33. See Rev. Rul. 69-545, 1969-2 C.B. 117.

34. Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 8–9 n.20 (1995).

35. BARTON, *supra* note 20.

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

37. “Open staff” essentially means that any doctor can practice at a hospital, even if not a direct employee of the hospital. See JANET E. GITTERMAN & MARVIN FRIEDLANDER, HEALTH CARE PROVIDER REFERENCE GUIDE 12 (2004), <https://www.irs.gov/pub/irs-tege/eotopic04.pdf> [<https://perma.cc/S38R-NF8S>].

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

39. *Id.*

40. See M. Gregg Bloche, *Tax Preferences for Nonprofits: From Per Se Exemption to Pay-for-Performance*, 25 HEALTH AFFS. w304, w304–05 (2006) (stating that industry lobbyists argued that the need for free care had largely disappeared, but nonprofit hospitals still produced community benefits aside from free care, so they should still receive tax exemptions).

41. See John D. Colombo, *The Role of Access in Charitable Tax Exemption*, 82 WASH. U. L.Q. 343, 348–49 (2004).

revenue ruling created the community benefit standard,<sup>42</sup> which revised the tax-exempt policy for hospitals to include health promotion<sup>43</sup> as a charitable purpose.<sup>44</sup> This change meant that hospitals could qualify for tax-exempt status even if they did not offer free care to patients unable to pay, also known as “charity care.”<sup>45</sup> This ruling gave a list of factors that might distinguish tax-exempt hospitals from their for-profit counterparts, but the list was non-exhaustive and broad.<sup>46</sup> The factors included but were not limited to: (1) an emergency room open to all; (2) a board of directors drawn from the community; (3) an open staff; (4) treatment of those who utilize public programs to pay medical bills; and (5) use of surplus funds to improve facilities, patient care, medical training, education, or research.<sup>47</sup> These rulings evolved some, but the community benefit standard remained intact.<sup>48</sup> Today, hospitals are not required to provide a certain amount of care for the poor in order to maintain their tax-exempt status.<sup>49</sup>

## 2. The Affordable Care Act’s Impact on Community Benefit Requirements

The Patient Protection and Affordable Care Act (ACA) changed some rules affecting nonprofit hospitals’ tax-exempt status but overall did not make sweeping changes to the community benefit standard

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42. Rev. Rul. 69-545, 1969-2 C.B. 117. For criticism detailing the lack of “community” in the community benefit standard, see Susannah C. Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 40–44 (2014).

43. *What Is Health Promotion?*, WORLD HEALTH ORG. (Aug. 20, 2016), <https://www.who.int/news-room/q-a-detail/health-promotion> [<https://perma.cc/368W-K6L2>].

Health promotion enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people’s health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure.

*Id.*

44. Rev. Rul. 69-545, 1969-2 C.B. 117. For further discussion on the definition of charity care, see *infra* Part II.A.1.

45. See Tahk, *supra* note 42, at 40.

46. Rev. Rul. 69-545, 1969-2 C.B. 117.

47. *Id.*

48. Further rulings held that tax-exempt hospitals need not provide emergency care to qualify for tax-exempt status. Rev. Rul. 83-157, 1983-2 C.B. 94.

49. This understanding came from IRS internal guidance for field agents about auditing tax-exempt hospitals. I.R.S., Field Serv. Advisory 200110030 (Feb. 5, 2001), 2001 WL 234018. For discussion of this guidance, see generally Douglas M. Mancino, *The Impact of Federal Tax Exemption Standards on Health Care Policy and Delivery*, 15 HEALTH MATRIX 5 (2005).

laid out by the IRS.<sup>50</sup> Section 9007 of the ACA requires that nonprofit hospitals (1) work with their community to determine community health needs and then work to meet those needs; and (2) implement consumer protection regarding billing, collection, and financial assistance.<sup>51</sup>

As part of the first requirement, the ACA requires that nonprofit hospitals complete a Community Health Needs Assessment (CHNA) at least once every three years.<sup>52</sup> As a part of the CHNA, the ACA requires nonprofit hospitals to (1) collect input from a broad cross-section of the community served, (2) make each assessment public, and (3) adopt implementation strategies for each assessment.<sup>53</sup> Hospitals must widely publicize the CHNA.<sup>54</sup> Hospitals that fail to meet these requirements must pay a \$50,000 excise tax<sup>55</sup> and can lose their federal tax exemptions.<sup>56</sup>

There are many shortcomings to this new standard. The ACA does not give further guidance on the process for conducting a CHNA,<sup>57</sup> nor does it state to what degree the public must be involved in the assessment.<sup>58</sup> An additional critique of the CHNA is that the

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50. PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 239 (2011) (explaining that the ACA was comparatively limited, “compared, that is, with the health-care systems of other democracies or to the ideal remedies that many reluctant supporters of the legislation would have preferred”).

51. Pub. L. No. 111-148, § 9007, 124 Stat. 119, 855–56 (2010). *See generally* Julia James, *Nonprofit Hospitals’ Community Benefit Requirements*, HEALTH AFFS. (Feb. 25, 2016), <https://www.healthaffairs.org/doi/10.1377/hpb20160225.954803/full>; DONNA C. FOLKEMER, LAURA A. SPICER, CARL H. MUELLER, MARTHA H. SOMERVILLE, AVERY L.R. BROW, CHARLES J. MILLIGAN, JR. & CYNTHIA L. BODDIE-WILLIS, HILLTOP INST., HOSPITAL COMMUNITY BENEFITS AFTER THE ACA: THE EMERGING FEDERAL FRAMEWORK (2011), <https://mdsoar.org/bitstream/handle/11603/13345/Hospital-Community-Benefits-after-the-ACA-The-Emerging-Federal-Framework-pdf.pdf> [<https://perma.cc/4ZB3-HVK9>].

52. § 9007, 124 Stat. at 856.

53. *Id.*

54. I.R.C. § 501(r)(3)(B)(ii).

55. *Id.* § 4959.

56. *See* Amy Clary, *How States Keep Community at the Center of Hospitals’ Community Health Needs Assessments*, NAT’L ACAD. FOR ST. HEALTH POL’Y (Apr. 12, 2019), <https://www.nashp.org/how-states-keep-community-at-the-center-of-hospitals-community-health-needs-assessments> [<https://perma.cc/2UGQ-ZWF9>]; I.R.S., UIL 501.03-00, Final Adverse Determination Letter (Feb. 14, 2017), <https://www.irs.gov/pub/irs-wd/201731014.pdf> [<https://perma.cc/9RV8-9N9J>]; Michael Wyland, *Hospital Loses IRS Tax Exemption for Noncompliance with ACA*, NONPROFIT Q. (Aug. 17, 2017), <https://nonprofitquarterly.org/hospital-loses-irs-tax-exemption> [<https://perma.cc/9RV8-9N9J>].

57. *See* FOLKEMER ET AL., *supra* note 51, at 5.

58. *See id.*

definition hospitals can use for “community” is too flexible to be meaningful.<sup>59</sup> Earlier drafts had included provisions for geographical components or target populations,<sup>60</sup> but advocates argued that hospitals are in the best position to define their communities.<sup>61</sup> The final regulations include provisions that prohibit hospitals from excluding medically underserved communities from their definition of community,<sup>62</sup> but critics question whether this is enough to make hospitals take a hard look at the communities that surround them.<sup>63</sup> Finally, as hospitals are only required to adopt implementation strategies, not make measurable progress, there has been a wide range in the progress on CHNA goals actually made.<sup>64</sup>

The second main change the ACA requires is that nonprofit hospitals must adopt certain financial policies to maintain their tax-exempt status. Specifically, hospitals are limited in their ability to charge uninsured patients at inflated rates,<sup>65</sup> they may not engage in extraordinary collection actions<sup>66</sup> against patients without making a reasonable effort to determine if that person is eligible for financial aid,<sup>67</sup> and hospitals must have written financial assistance policies that are well publicized.<sup>68</sup> While these regulations make important changes to the ways that nonprofit hospitals may operate, they still do not require

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59. See Tahk, *supra* note 42, at 79 (noting that nonprofit hospitals define their communities in different ways, which leads to different amounts of community benefits given by these hospitals).

60. Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20,523, 20,529 (Apr. 5, 2013).

61. *Id.*

62. *Id.*

63. See generally Tahk, *supra* note 42.

64. See Geri Rosen Cramer, Simone R. Singh, Stephen Flaherty & Gary J. Young, *The Progress of US Hospitals in Addressing Community Health Needs*, 107 AM. J. PUB. HEALTH 255, 255–56 (2017) (“This assessment suggested that many hospitals have been slow to take definitive action to address the needs identified from CHNAs, possibly because they are having difficulty prioritizing needs.”).

65. I.R.C. § 501(r)(5)(A).

66. “Extraordinary collection actions” (ECAs) are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care that is covered under a hospital’s financial aid policy that involve things like selling the debt to another party, reporting adverse information to credit agencies, or instituting a legal or judicial process. See *Billing and Collections – Section 501(r)(6)*, IRS (Sept. 19, 2020), <https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6> [<https://perma.cc/NR6J-NVUV>].

67. I.R.C. § 501(r)(6).

68. Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,151, 38,151–53 (June 26, 2012).

nonprofit hospitals to provide any set amount of charity care or community benefit.<sup>69</sup>

### C. THE NATURE OF NONPROFIT HOSPITALS TODAY

The nonprofit hospitals of today are a far cry from the original charity care hospitals that the foundations of the tax-exempt status for nonprofit hospitals envisioned. This change in nonprofit hospitals can be attributed to four main reasons: (1) technology is more widely used, (2) more patients have insurance, (3) hospitals increasingly rely on patients with insurance, and (4) Medicare and Medicaid compensate hospitals for care they provide to populations these programs cover.<sup>70</sup> These changes have led to nonprofit hospitals that are unrecognizable when compared to the alms houses of the early 1900s: lavish compensation for top executives,<sup>71</sup> glamorous campuses that resemble luxury hotels,<sup>72</sup> and aggressive and expensive advertising campaigns<sup>73</sup> to attract patients to rapidly consolidating medical behemoths.<sup>74</sup> Yet, nonprofit hospitals still benefit from generous tax exemptions that were put in place when these hospitals looked quite different.<sup>75</sup>

The tax exemptions that nonprofit hospitals receive have increased tremendously since the days of alms houses. This trend can be seen by the sharp increase in the value of tax exemptions for

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69. See Tahk, *supra* note 42, at 47.

70. See Bloche, *supra* note 40.

71. See Alia Paavola, *Top 5 Nonprofit Hospitals for Executive Pay*, BECKER'S HOSP. REV. (June 26, 2019), <https://www.beckershospitalreview.com/compensation-issues/top-5-nonprofit-hospitals-for-executive-pay.html> [<https://perma.cc/72H8-UHLR>] (stating that on average, the top executives at the 82 largest nonprofit health systems were paid \$3.5 million annually in fiscal year 2017).

72. See *Is This a Hospital or a Hotel?*, N.Y. TIMES (May 28, 2014), <https://www.nytimes.com/interactive/2014/sunday-review/hotel-hospital-quiz.html> [<https://perma.cc/KP4E-LRHY>] (emphasizing the similarities between hospitals and luxury hotels with a fun, interactive quiz).

73. See Robin J. Larson, Lisa M. Schwartz, Steven Woloshin & H. Gilbert Welch, *Advertising by Academic Medical Centers*, 165 ARCHIVES INTERNAL MED. 645, 645 (2005) (characterizing advertising by the nation's top academic medical centers as "plac[ing] the interests of the medical center before the interests of the patients"); Brooke Murphy, *6 Nonprofit Hospitals with TV Ads Valued at More than \$1.2M in 2016*, BECKER'S HOSP. REV. (May 26, 2017), <https://www.beckershospitalreview.com/hospital-management-administration/these-6-nonprofit-hospitals-spent-the-most-on-tv-ads-in-2016.html> [<https://perma.cc/95T7-7BW2>].

74. See Reed Abelson, *When Hospitals Merge To Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), <https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html> [<https://perma.cc/UJ52-YV>].

75. See *infra* Part I.C.

nonprofit hospitals between 2002 and 2011, the most recent year with comprehensive data. The Joint Committee on Taxation estimated that the total value to nonprofit hospitals from federal, state, and local tax exemptions in 2002 was \$12.6 billion,<sup>76</sup> with the exemptions from state and local taxes accounting for about half of that number.<sup>77</sup> A 2018 study that used the same methodology as the 2002 study calculated that nonprofit hospitals' tax exemptions amounted to \$24.6 billion in 2011.<sup>78</sup> This dramatic increase in the value of nonprofit hospitals' tax exemptions in such a short period of time shows how the nature of nonprofit hospitals has changed alongside the value of their tax exemptions.

As the value of federal, state, and local nonprofit hospital tax exemptions grows, hospitals have grown tremendously as well—from a \$28 billion industry in 1970 to \$571 billion in 2004<sup>79</sup> despite the number of hospitals decreasing as hospitals have consolidated.<sup>80</sup> Health care itself is expected to make up 20% of U.S. gross domestic product by 2026.<sup>81</sup> In Minnesota, hospitals' net income totaled \$14.3 billion between 1997 and 2016.<sup>82</sup>

Further, the nature of nonprofit hospitals is changing. Nonprofit hospitals are more likely to be “profitable” than for-profit hospitals (77% compared to 61%).<sup>83</sup> A 2016 study showed that seven of the ten most profitable hospitals in the United States are nonprofit

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76. CONG. BUDGET OFF., NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 3 (2006), <https://www.cbo.gov/sites/default/files/109th-congress-2005-2006/reports/12-06-nonprofit.pdf> [<https://perma.cc/GKU4-5H6E>].

77. *Id.*

78. Rosenbaum et al., *supra* note 9.

79. Patton, *supra* note 31, at 6.

80. BARTON, *supra* note 20, at 272–74.

81. Off. of the Actuary, *CMS Office of the Actuary Releases 2017-2026 Projections of National Health Expenditures*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 14, 2018), <https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2017-2026-projections-national-health-expenditures> [<https://perma.cc/59WZ-H742>].

82. NAT'L NURSES UNITED & MINN. NURSES ASS'N, MINNESOTA'S MOST—AND LEAST—EXPENSIVE HOSPITALS 3 (2019), [https://mnnurses.org/wp-content/uploads/2019/03/190304\\_MNA\\_Most-LeastExpensive\\_report.pdf](https://mnnurses.org/wp-content/uploads/2019/03/190304_MNA_Most-LeastExpensive_report.pdf) [<https://perma.cc/JS2D-CJC5>].

83. See John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once for the Poor, Strike It Rich*, WALL ST. J. (Apr. 4, 2008, 11:59 PM), <https://www.wsj.com/articles/SB120726201815287955> [<https://perma.cc/4JYJ-4BNE>] (“Nonprofits, which account for a majority of U.S. hospitals, are faring even better than their for-profit counterparts: 77% of the 2,033 U.S. nonprofit hospitals are in the black, while just 61% of for-profit hospitals are profitable, according to the AHD data.”).

hospitals.<sup>84</sup> In 2019, the Mayo Clinic, a nonprofit hospital, saw its operating income—the surplus when revenue exceeds paid expenses—jump 72% as it surpassed \$1 billion for the first time.<sup>85</sup> These statistics show that nonprofit hospitals have changed and grown in many important ways alongside the value of their tax exemption, and their value to their communities has grown as well.

#### D. NONPROFIT HOSPITALS ARE OFTEN INTEGRAL TO THE COMMUNITIES THEY SERVE

Any consideration of nonprofit hospitals must take notice that hospitals, for-profit and nonprofit, are often integral parts of the communities that they serve, and when they close, the communities they leave behind lack access to care.<sup>86</sup> For many poorer cities, hospitals have emerged as anchor institutions<sup>87</sup> while other sectors in the cities struggle to stay afloat.<sup>88</sup> Recently, hospital closures are likely to occur

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84. See Ge Bai & Gerard F. Anderson, *A More Detailed Understanding of Factors Associated with Hospital Profitability*, 35 HEALTH AFFS. 889, 889 (2016), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1193>.

85. Christopher Snowbeck, *Mayo Clinic's Operating Income Jumped 72% in 2019, Surpassing \$1 Billion*, STAR TRIB. (Feb. 25, 2020, 10:06 PM), <https://www.startribune.com/mayo-clinic-s-operating-income-jumped-72-in-2019-surpassing-1-billion/568171112> [<https://perma.cc/QRX2-4ES5>] (“Financial results released Tuesday show that for the year, Mayo attracted revenue of about \$13.8 billion and paid expenses of about \$12.8 billion, leaving \$1.06 billion of income from clinic operations.”).

86. See, e.g., Joseph P. Williams, *Code Red: The Grim State of Urban Hospitals*, U.S. NEWS & WORLD REP. (July 10, 2019, 11:23 AM), <https://www.usnews.com/news/healthiest-communities/articles/2019-07-10/poor-minorities-bear-the-brunt-as-urban-hospitals-close> (describing how the closure of inner-city hospitals disproportionately hurts poor and minority patients); Manny Ramos, *Westlake Hospital Closing Approved Unanimously by State Review Board*, CHI. SUN TIMES (Apr. 30, 2019, 9:21 PM), <https://chicago.suntimes.com/news/2019/4/30/18619458/westlake-hospital-closing-approved-unanimously-by-state-review-board> [<https://perma.cc/E62Y-W5P2>] (describing another hospital closing in Cook County, Illinois); Mike Elk, *Private Equity's Latest Scheme: Closing Urban Hospitals and Selling Off the Real Estate*, AM. PROSPECT (July 11, 2019), <https://prospect.org/health/private-equity-s-latest-scheme-closing-urban-hospitals-selling-real-estate> [<https://perma.cc/F5JX-3AHD>] (describing how a private equity firm bought an urban hospital in Philadelphia and will now close the hospital to sell the land).

87. See Jaime Rosenberg, *Health Systems Take On Role as Anchor Institutions, Enhance Community Development*, AM. J. MANAGED CARE (July 25, 2018), <https://www.ajmc.com/newsroom/health-systems-take-on-role-as-anchor-institutions-enhance-community-development> [<https://perma.cc/A8PF-UMJE>] (“Anchor institutions are enterprises, such as universities and hospitals, that are rooted in their local communities by mission, invested capital, or relationships to customers, employees, and vendors.”).

88. Diamond, *supra* note 1.

in poor, segregated neighborhoods.<sup>89</sup> Also, with increased closure of hospitals in rural areas, rural residents are forced to travel farther to obtain care.<sup>90</sup> Even when hospitals manage to stay open, they often face cutbacks that signal to residents the possibility of a closure in the near future.<sup>91</sup> When hospitals close, that means worse health care for the residents who relied on those hospitals, including longer emergency room wait times and longer ambulance rides.<sup>92</sup> This decrease in services disproportionately impacts disadvantaged groups such as the elderly, homeless, and uninsured.<sup>93</sup>

Recently, the COVID-19 pandemic has intensified the burden on nonprofit hospitals nationwide and the risk to disadvantaged communities' access to healthcare. Hospitals, which already operate on a thin margin, have been forced to stop all but the most urgent non-COVID care, resulting in a decrease in revenue while expenses remain high.<sup>94</sup> According to a July 2020 American Hospital Association analysis, median margins of all hospitals, not just nonprofit hospitals, are projected to drop seven percent in the second half of 2020, though those

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89. See Michelle Ko, Jack Needleman, Kathryn Pitkin Derose, Miriam J. Laugesen & Ninez A. Ponce, *Residential Segregation and the Survival of U.S. Urban Public Hospitals*, 71 MED. CARE RSCH. & REV. 243, 245 (2013).

90. See generally Dan Diamond, *Tax-Exempt Mayo Clinic Grows, but Rural Patients Pay a Price*, POLITICO (Nov. 16, 2017, 5:04 AM), <https://www.politico.com/story/2017/11/16/mayo-clinic-rural-health-care-244955> [<https://perma.cc/5NEZ-BWTV>]; Jeremy Olson, *Making Childbirth Safer for Rural Minnesota Moms*, STAR TRIB. (Dec. 7, 2019, 7:31 PM), <http://www.startribune.com/making-childbirth-safer-for-rural-minnesota-moms/565845542> [<https://perma.cc/J5FU-JDYR>]; Jeremy Olson, *Childbirth Deaths and Complications Are More Likely in Rural America*, STAR TRIB. (Dec. 4, 2019, 8:44 PM), <https://www.startribune.com/childbirth-deaths-and-complications-are-more-likely-in-rural-america/565808792> [<https://perma.cc/E2X7-AHSJ>] (detailing how the Mayo Clinic closed a hospital in Albert Lea, Minnesota, requiring residents to travel twenty-three miles to the next closest hospital to get care).

91. See Andrea Waxman, *St. Joseph Hospital's Future Raises Questions*, URB. MILWAUKEE (Apr. 27, 2019, 2:13 PM), <https://urbanmilwaukee.com/2019/04/27/st-joseph-hospitals-future-raises-questions> [<https://perma.cc/MH9K-SSCF>].

92. See Catherine Ho, *Report: Berkeley Hospital Closure Would Mean Longer ER Waits, Ambulance Rides*, S.F. CHRON. (Dec. 17, 2018, 5:50 PM), <https://www.sfchronicle.com/business/article/Report-Berkeley-hospital-closure-would-mean-13473268.php> [<https://perma.cc/GML8-MSLX>].

93. See generally JASON COBURN, AMANDA FUKUTOME, MARISA RUIZ ASARI, JENNIFER JARIN & VAUGHN VILLAVERDE, *RAPID HEALTH IMPACT ASSESSMENT: PROPOSED CLOSURE OF ALTA BATES CAMPUS BERKELEY, CA* (2018).

94. See KAUFMAN HALL, *THE EFFECT OF COVID-19 ON HOSPITAL FINANCIAL HEALTH 2* (2020), [https://www.aha.org/system/files/media/file/2020/07/KH-COVID-Hospital-Financial-Health\\_FINAL.pdf](https://www.aha.org/system/files/media/file/2020/07/KH-COVID-Hospital-Financial-Health_FINAL.pdf) [<https://perma.cc/BH6Z-4N5W>].

drops would have been even higher without CARES Act funding.<sup>95</sup> Hospitals across the country are already closing due to COVID-19-related financial crises.<sup>96</sup> This, in turn, exacerbates the impact on poor, segregated communities and other disadvantaged groups who already struggle to access quality care.

For example, in Albert Lea, Minnesota, a city of 18,000 residents, the local hospital, owned by the Mayo Clinic, is slowly losing many of its services.<sup>97</sup> The intensive care unit closed in October 2017, the surgery unit closed in January 2018,<sup>98</sup> and its birthing unit has already moved maternity services to another hospital in Austin, Minnesota.<sup>99</sup>

These closures will force residents to travel twenty-three miles to receive the same care they could have received in their hometown.<sup>100</sup> In St. Paul, St. Joseph's Hospital, a nonprofit hospital, has 105 inpatient mental health beds—a substantial percentage of the roughly 1,300 beds in Minnesota.<sup>101</sup> Yet, the hospital operated at a \$50 million loss last year.<sup>102</sup> Instead of completely closing the hospital,<sup>103</sup> it has become a COVID-only hospital,<sup>104</sup> while its emergency room and

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95. *Id.* at 4.

96. See Emily Barone, *Rural U.S. Hospitals Are on Life Support as a Third Wave of COVID-19 Strikes*, TIME (Oct. 20, 2020, 12:18 PM), <https://time.com/5901656/coronavirus-hospital-closures> [<https://perma.cc/F2NK-77TM>] (stating that hospitals in St. Paul, Chicago, Houston, and Philadelphia have recently closed or are set to do so soon).

97. Diamond, *supra* note 90.

98. *Id.*

99. See *Mayo Clinic Closes Hospital, Clinics in Southwest Minnesota*, ALBERT LEA TRIB. (Dec. 5, 2019, 7:59 PM), <https://www.albertleatribune.com/2019/12/mayo-clinic-closes-hospital-clinics-in-southwest-minnesota> [<https://perma.cc/BL8N-P8V7>].

100. Diamond, *supra* note 90.

101. Ed. Bd., *St. Joseph's Hospital's Woe Spotlight Strained Mental Health Care Capacity, Raise Broader Questions about Nonprofits' Obligations*, STAR TRIB. (Feb. 21, 2020), <https://www.startribune.com/st-joseph-s-hospital-s-woes-spotlight-strained-mental-health-care-capacity-raise-broader-questions-about-nonprofits-obligations/568092172> [<https://perma.cc/A5VR-FGKC>].

102. *Id.*

103. Jeremy Olson, *M Health Fairview To Cut Staff, Consider Trims to Hospitals*, STAR TRIB. (Nov. 23, 2019), <https://www.startribune.com/m-health-to-cut-staff-consider-trims-to-hospitals/565346742> [<https://perma.cc/N5JM-PVGS>] (disclosing the potential that St. Joseph's Hospital may have to close).

104. Jeremy Olson, *Fairview Cuts Include Bethesda, St. Joseph's Hospitals; 900 Jobs To Be Lost*, STAR TRIB. (Oct. 6, 2020), <https://www.startribune.com/fairview-cuts-will-include-two-hospitals-affect-900-jobs/572641022> [<https://perma.cc/8RF3-JYQC>].

specialties such as neurology and bariatrics will be relocated.<sup>105</sup> Inpatient mental health care will continue through at least 2021.<sup>106</sup> Fairview Health, which operates St. Joseph's Hospital, will operate at a \$250 million loss in 2020—exacerbated by the pandemic—and will close sixteen clinics in Minnesota and western Wisconsin.<sup>107</sup> These closures result in less access to needed care across the region.

Thus, any conversation about nonprofit hospitals' tax exemptions needs to take into account the integral role nonprofit hospitals often play in their communities, the ways they have been impacted by the pandemic, and the void that would be left behind if they were forced to close. Local communities should keep these factors in mind when seeking to regulate nonprofit hospitals.

#### E. MINNESOTA-SPECIFIC STANDARDS FOR NONPROFIT HOSPITALS' TAX EXEMPTION

States often mirror federal tax exemption laws in their own statutes, and some build on these rules or offer further definitions of terms.<sup>108</sup> This trend can be seen by looking at the Minnesota state constitution, Minnesota state statutes, local agency reporting, legislative actions, and a local agreement between Minnesota nonprofit hospitals and the Attorney General.<sup>109</sup>

##### 1. Minnesota State Constitution & Minnesota State Statutes

In addition to federal tax exemptions, states exempt nonprofit hospitals from paying state taxes as well.<sup>110</sup> Minnesota's state constitution contains the tax exemptions. Article X, section I states:

Taxes shall be uniform upon the same class of subjects and shall be levied and collected for public purposes, but public burying grounds, public school houses, *public hospitals*, academies, colleges, universities, all seminaries of learning, all churches, church property, houses of worship, *institutions of purely public charity*, and public property used exclusively for any public purpose, shall be exempt from taxation except as provided in this section.<sup>111</sup>

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105. *Reimagined St. Joseph's Hospital Will Become Community and Equity-Focused Health Campus*, FAIRVIEW, <https://www.fairview.org/future/st-josephs-hospital> [https://perma.cc/7UT9-73A2].

106. Olson, *supra* note 103.

107. *Id.*

108. *See infra* Part I.E.1; *see also infra* Part I.B.

109. *See infra* Part I.E.1.

110. *Compare supra* text accompanying notes 26–31, with *supra* text accompanying note 105.

111. MINN. CONST. art. X, § 1 (emphasis added).

Because Minnesota's state constitution contains its own tax-exempt provision,<sup>112</sup> localities within Minnesota may be restricted in the initiatives they can take toward nonprofit hospitals.

Further, Minnesota's nonprofit hospital tax exemptions are codified in state law.<sup>113</sup> According to Minnesota law, all institutions of public charity, including hospitals, are exempt from paying property taxes,<sup>114</sup> sales taxes,<sup>115</sup> and corporate income taxes.<sup>116</sup> The property tax exemption applies provided that the land is not "used principally by such hospital as a recreational or rest area for employees, administrators, or medical personnel."<sup>117</sup>

Minnesota nonprofit hospitals must report (1) services provided at no cost or for a reduced fee, (2) teaching and research activities, and (3) other community or charitable activities.<sup>118</sup> The Minnesota Commissioner of Health oversees the reporting of community benefits and compiles an annual report detailing each hospital's community benefit activities.<sup>119</sup> Again, these laws show how deeply engrained in state law these tax exemptions for nonprofit hospitals are.

## 2. Report & Legislative Actions

The Minnesota Department of Health (MDH) released a report on nonprofit hospitals' provision of community benefits in 2007 at the request of the Minnesota legislature.<sup>120</sup> This report focused on the value of uncompensated care and community benefits that Minnesota nonprofit hospitals gave in return for their tax exemptions.<sup>121</sup> The report recommended that hospitals be required to have a written charity care policy, that debt collection be standardized across the state, and that community benefit reporting be public and standardized.<sup>122</sup> In 2007, Senator Linda Berglin introduced a bill based on these recommendations, but the bill was never enacted.<sup>123</sup>

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112. *See id.*

113. MINN. STAT. § 272.02 subdiv. 4 (2020).

114. *Id.* subdiv. 7.

115. *Id.* § 297A.70 subdiv. 7(a) (2020).

116. *Id.* § 290.05 subdiv. 2 (2020).

117. *Id.* § 272.02 subdiv. 37 (2020).

118. *Id.* § 144.698 subdiv. 1(5) (2020).

119. *Id.* § 144.699 subdiv. 5 (2013).

120. MINN. DEP'T OF HEALTH, MINNESOTA HOSPITALS: UNCOMPENSATED CARE, COMMUNITY BENEFITS, AND THE VALUE OF TAX EXEMPTIONS, at iii-v (2007).

121. *Id.*

122. *Id.* at v.

123. Patton, *supra* note 31, at 11.

In 2011, facing a challenging fiscal climate, the Minnesota legislature approved budget language that would have required nonprofit hospitals in the state to align their community benefit giving with the goals and priorities of the State Health Improvement Plan.<sup>124</sup> The Minnesota Hospital Association opposed granting the state health department control over community benefit activities of nonprofit hospitals, stating that they were duplicative of federal requirements under the ACA.<sup>125</sup> In 2012, the provisions were repealed.<sup>126</sup>

### 3. 2012 Agreement

In 2012, Minnesota's attorney general executed voluntary agreements with each of Minnesota's nonprofit hospitals.<sup>127</sup> These agreements included provisions that required hospitals to adopt a charity care policy and annually review their charity policy and debt collection practices.<sup>128</sup> Nonprofit hospitals must publicize their charity care policy and offer payment plans before pursuing extraordinary collection actions<sup>129</sup> measures.<sup>130</sup> Each nonprofit hospital agreed to cooperate with the inquiries of the Attorney General.<sup>131</sup>

While the agreement did not require a minimum amount of community benefits, it did require hospitals to annually report the community benefits provided to the Minnesota Hospital Association.<sup>132</sup> Some see this as an issue because the Minnesota Hospital Association, a non-governmental advocacy group, is the one receiving these reports, allowing hospitals to "essentially self-define how they're serving the community."<sup>133</sup> While Minnesota's requirements do not differ

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124. GAYLE D. NELSON, MARTHA H. SOMERVILLE, CARL H. MUELLER & CYNTHIA L. BODDIE-WILLS, HILLTOP INST., HOSPITAL COMMUNITY BENEFITS AFTER THE ACA: POLICY IMPLICATIONS OF THE STATE LAW LANDSCAPE 4 (2013), <https://mdsoar.org/bitstream/handle/11603/13098/Hospital-Community-Benefits-after-the-ACA-Policy-Implications-of-the-State-Law-Landscape-pdf.pdf> [<https://perma.cc/U542-5V75>].

125. *Id.*

126. *Id.*

127. *See generally* HILLTOP INST., MINNESOTA COMMUNITY BENEFIT REQUIREMENT (2016), [https://hilltopinstitute.org/wp-content/uploads/hcbp/hcbp\\_docs/HCBP\\_CBL\\_MN.pdf](https://hilltopinstitute.org/wp-content/uploads/hcbp/hcbp_docs/HCBP_CBL_MN.pdf) [<https://perma.cc/3CG4-9Z5M>].

128. Patton, *supra* note 31, at 11.

129. For a definition of extraordinary debt collection, see *Billing and Collections – Section 501(r)(6)*, *supra* note 66.

130. HILLTOP INST., *supra* note 127.

131. *Id.*

132. *Id.*

133. Diamond, *supra* note 90.

much from the federal requirements,<sup>134</sup> they demonstrate how states' nonprofit tax exemptions evolve to reflect local nuances.

Thus, the inception and evolution of nonprofit hospitals' tax-exempt status is firmly rooted in the way that hospitals operated before medical care became so advanced. As medicine evolved and with the passage of Medicare and Medicaid, the IRS rules changed to reflect a broader understanding of the benefits that nonprofit hospitals provide their communities.<sup>135</sup> However, nonprofit hospitals today are a far cry from their predecessors.<sup>136</sup> Nonprofit hospitals are integral to their communities, and some nonprofit hospitals are struggling.<sup>137</sup> States, like Minnesota, often step in to work out more detailed standards for community benefits with their own nonprofit hospitals, but with varying success.<sup>138</sup> This current system is complicated and disjointed due to the nature of its inception and evolution.

## II. THE COMMUNITY BENEFIT STANDARD DOES NOT INCENTIVIZE NONPROFIT HOSPITALS TO BENEFIT THEIR COMMUNITIES

The theory that all nonprofit hospitals deserve their tax exemptions has become increasingly questionable in recent years.<sup>139</sup> Government officials, like Republican Senator Chuck Grassley, Senate Finance Committee Chairman, have rung alarm bells about nonprofit hospitals' tax exemptions.<sup>140</sup> Government audits have found disturbing practices by nonprofit hospitals. For example, an audit by former Minnesota Attorney General Mike Hatch<sup>141</sup> revealed an array of unscrupulous practices in Minnesota's nonprofit hospitals including discriminatory pricing, excessive executive compensation, and aggressive debt collection practices.<sup>142</sup> These findings have prompted

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134. Compare *supra* Part I.B, with *supra* Part I.E.

135. See *supra* Part I.B.

136. See *supra* Part I.C.

137. See *supra* Part I.D.

138. See *supra* Part I.E.

139. See, e.g., Beth Kutscher, *Growing Tax Breaks for Nonprofit Hospitals Questioned*, MOD. HEALTHCARE (June 20, 2015), <https://www.modernhealthcare.com/article/20150620/MAGAZINE/306209968/growing-tax-breaks-for-nonprofit-hospitals-questioned> [<https://perma.cc/9BNV-HHJA>].

140. Press Release, Chuck Grassley, Sen., U.S. Cong., Grassley Renews Probe of Non-Profit, Tax-Exempt Hospitals (Feb. 25, 2019), <https://www.grassley.senate.gov/news/news-releases/grassley-renews-probe-non-profit-tax-exempt-hospitals> [<https://perma.cc/T2YA-MYHG>].

141. *Charities and Charitable Giving—Proposals for Reform: Hearing Before the S. Comm. on Fin.*, 109th Cong. 224 (2005) (statement of Minn. Att'y Gen. Mike Hatch).

142. 3 OFF. OF THE MINN. ATT'Y GEN., COMPLIANCE REVIEW OF FAIRVIEW HEALTH SERVICES' MANAGEMENT CONTRACTS WITH ACCRETIVE HEALTH INC. 1 (2012).

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scholars to examine nonprofit hospitals' tax-exempt status and have prompted state and local governments to examine what hospitals were giving their communities in return for these tax exemptions.<sup>143</sup>

This Part will discuss how the community benefit standard, in its current form, does not adequately incentivize many nonprofit hospitals to benefit their communities.<sup>144</sup> The standard is inequitable and complex.<sup>145</sup> Its complicated terminology precludes a clear picture of exactly which hospitals are giving how much of what types of community benefits.<sup>146</sup> Further, this Part will explore how nonprofit hospitals and for-profit hospitals are increasingly similar, calling into question why nonprofit hospitals deserve tax exemptions while for-profit hospitals do not.<sup>147</sup> Additionally, the amount of free and discounted care nonprofit hospitals give varies tremendously depending on certain characteristics, but their tax exemptions remain uniform.<sup>148</sup> Adding additional complications, the absence of a federal standard for what counts as charity care results in different hospitals' individual definitions and leads to inequitable application of the federal standard.<sup>149</sup>

This Part will also show that community benefits, uncompensated care, and charity care given by nonprofit hospitals to their communities oftentimes do not add up to the value of their tax exemptions.<sup>150</sup> Nonprofit hospitals use the complex terminology of this regulatory scheme to make it seem like they are giving more to their communities than they are.<sup>151</sup> Finally, the amounts of community benefit are simply inequitable.<sup>152</sup>

Next, this Part will demonstrate how lack of tax revenue from nonprofit hospitals has hurt communities surrounding the hospitals.<sup>153</sup> This trend is demonstrated by the varying ways numerous states and localities have attempted to recoup some of the taxes they do not receive from nonprofit hospitals that do not seem deserving of these tax exemptions.<sup>154</sup>

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143. James, *supra* note 51, at 1.

144. *See infra* Part II.

145. *See infra* Part II.A.

146. *See infra* Part II.A.1.

147. *See infra* Part II.A.2.

148. *See infra* Part II.A.3.

149. *See infra* Part II.B.

150. *See infra* Part II.B.

151. *See infra* Part II.B.1.

152. *See infra* Part II.B.2.

153. *See infra* Part II.B.3.

154. *See infra* Part II.C.

Further, this Part will show how community benefits can and should be a bridge between nonprofit hospitals and the often poor, unhealthy communities that surround them.<sup>155</sup> Finally, this Part will demonstrate that the above trends occur locally with Minnesota nonprofit hospitals as well.<sup>156</sup> Overall, this Part aims to show that the current system does not achieve the goals that community benefits were established to accomplish.<sup>157</sup>

A. THE COMMUNITY BENEFIT STANDARD IS COMPLEX, VARIABLE, AND INEQUITABLE

Examining what “community benefit” means, which kinds of hospitals receive tax exemptions in return for community benefits, and how differences in hospital policies can make one patient eligible for free or discounted care at one hospital but not another, reveals that systems granting tax exemptions for nonprofit hospitals as they currently stand are inherently complex, variable, and inequitable.

1. Complex Terminology Precludes a Clear Picture of Hospitals’ Contributions

There are many important terms to understand when looking into forms of spending that nonprofit hospitals claim benefit their surrounding communities. “Community benefit” used to be defined simply as relief for the poor,<sup>158</sup> but now it is more expansive. Hospitals report eight different categories of community benefit on their taxes each year.<sup>159</sup> These include charity care, Medicaid shortfalls, shortfalls from certain other government programs, training a hospital’s own doctors and residents, research, community health improvement efforts, subsidized health services, and donations to community groups.<sup>160</sup> These categories include a wide array of “programs and services that are generally thought to be provided at low or negative margin and are intended to improve access by disadvantaged groups or to address important health care matters for a defined population.”<sup>161</sup>

*Charity care*, one category of community benefit, is medical care that is provided without expectation of payment, as enumerated by a

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155. See *infra* Part II.D.

156. See *infra* Part II.E.

157. See *infra* Part II.

158. FISHMAN & SCHWARZ, *supra* note 31, at 356.

159. See *infra* note 163.

160. *Id.*

161. Joel Weissman, *Uncompensated Hospital Care: Will It Be There If We Need It?*, 276 JAMA 823, 825 (1996).

hospital's financial assistance policy (FAP).<sup>162</sup> Another term often used when referring to the benefits that nonprofit hospitals give in return for tax-exempt status is *uncompensated care*.<sup>163</sup> Uncompensated care is the sum of the charity care that a hospital gives and its bad debt.<sup>164</sup> *Bad debt* refers to care for which a hospital expected to be paid but was not.<sup>165</sup> Hospitals can still pursue patients who received care and have not yet paid their medical bills, so this bad debt is money that a hospital could have pursued but chose not to or pursued unsuccessfully.<sup>166</sup> To be clear: bad debt does not fall into the definition of "community benefit," but hospitals often argue that it should and try to count it in this category.<sup>167</sup> For example, while hospitals in Minnesota provided \$270 million of uncompensated care in 2016, only \$118.3 million was charity care; the remaining \$151.7 million was bad debt.<sup>168</sup> Thus, uncompensated care is not a good measurement of the benefit that a nonprofit hospital is actually bringing to their community because it counts categories that do not truly reflect free care intentionally given to benefit the community. This complex terminology surrounding the community benefit standard precludes a clear picture of what exactly nonprofit hospitals do to benefit their communities in return for the tax exemptions that they receive.

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162. James, *supra* note 51, at 2.

163. See Erica Valdovinos, Sidney Le & Renee Y. Hsia, *In California, Not-for-Profit Hospitals Spent More Operating Expenses on Charity Care Than For-Profit Hospitals Spent*, 34 HEALTH AFFS. 1296, 1297 (2015).

164. *Id.*

165. *Id.*

166. AM. HOSP. ASS'N, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET (2010), <https://www.aha.org/system/files/content/00-10/10uncompensatedcare.pdf> [<https://perma.cc/JLV3-GW7C>].

167. AM. HOSP. ASS'N, ESTIMATES OF THE FEDERAL REVENUE FOREGONE DUE TO THE TAX EXEMPTION OF NON-PROFIT HOSPITALS COMPARED TO THE COMMUNITY BENEFIT THEY PROVIDE (2019) [hereinafter AHA REVENUE FOREGONE], <https://www.aha.org/system/files/media/file/2019/05/estimate-federal-revenue-forgone-due-to-tax-exemption-non-profit-hospitals-compared-to-community-benefit-they-provide-2016-report.pdf> [<https://perma.cc/9SK7-4ZTG>]; AM. HOSP. ASS'N, RESULTS FROM 2016 TAX-EXEMPT HOSPITALS' SCHEDULE H COMMUNITY BENEFIT REPORTS 5 (2019) [hereinafter RESULTS FROM HOSPITALS' SCHEDULE H], <https://www.aha.org/system/files/media/file/2019/05/aha-2016-schedule-h-community-benefits-report.pdf> [<https://perma.cc/RW3A-V5J4>] (stating that patients who create bad debt would likely have been given charity care if they had applied for financial assistance).

168. HEALTH ECON. PROGRAM, MINN. DEP'T OF HEALTH, CHARTBOOK SECTION 6: UNINSURANCE AND THE SAFETY NET 42 (2017), <https://www.health.state.mn.us/data/economics/chartbook/docs/section6.pdf> [<https://perma.cc/4NRA-VBQE>].

## 2. For-Profit and Nonprofit Hospitals Are Incredibly Similar in Operation and Levels of Community Benefit Spending

In the 1969 community benefit standard guidance from the IRS, several of the determining factors that were supposed to differentiate nonprofit hospitals from for-profit hospitals are now shared by both (e.g., open medical staffs, participation in Medicaid and Medicare, and open emergency rooms).<sup>169</sup> Indeed, it is often difficult to tell whether a hospital is for-profit or nonprofit without examining their taxes.<sup>170</sup> More nonprofit hospitals are “profitable” than for-profit hospitals (77% compared to 61%),<sup>171</sup> and seven of the ten most profitable hospitals in the United States are nonprofit hospitals.<sup>172</sup> Hence, nonprofit and for-profit hospitals are similar when it comes to some determinants from IRS guidance and overall profitability.

Further, for-profit hospitals also offer community benefits, though at a lower amount than the benefits provided by nonprofit hospitals, yet they are not compensated for these services with tax exemptions.<sup>173</sup> Only 20% of nonprofit hospitals’ charity care exceeds the amount of charity care given by for-profit hospitals.<sup>174</sup> In California, nonprofit hospitals dedicate just 0.5% more of their operating expenses to charity care than their for-profit counterparts, and they give the same amount of uncompensated care as for-profit hospitals.<sup>175</sup> Thus, for-profit and nonprofit hospitals provide similar community benefits, yet only one type of hospital is given tax exemptions in return, calling into question whether nonprofit hospitals deserve these tax exemptions over for-profit hospitals.

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169. Patton, *supra* note 31, at 14–15.

170. Michael Ollove, *Some Nonprofit Hospitals Aren’t Earning Their Tax Breaks, Critics Say*, PEW (Feb. 7, 2020), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/07/some-nonprofit-hospitals-arent-earning-their-tax-breaks-critics-say> [<https://perma.cc/7RV7-7N5P>] (“If you look at the practices of nonprofit hospitals, they are nearly indistinguishable from for-profit hospitals.”).

171. Carreyrou & Martinez, *supra* note 83 (“Nonprofits, which account for a majority of U.S. hospitals, are faring even better than their for-profit counterparts: 77% of the 2,033 U.S. nonprofit hospitals are in the black, while just 61% of for-profit hospitals are profitable, according to the AHD data.”).

172. Bai & Anderson, *supra* note 84, at 889.

173. CONG. BUDGET OFF., *supra* note 76, at 1–3, 18 fig.1; *see also* Gary J. Young, Chia-Hung Chou, Jeffrey Shouou-Yin, Daniel Lee & Eli Raver, *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519, 1522–24 tbls.2 & 3 (2013) (displaying detailed tables showing incremental amounts that nonprofit hospitals put toward various categories of community benefits as compared to for-profit hospitals).

174. Herring et al., *supra* note 5, at 9.

175. Valdovinos et al., *supra* note 163, at 1298–99.

### 3. Charity Care Varies Depending on Hospitals' Definitions

Additionally, what counts as charity care on a nonprofit hospital's tax forms is largely determined by what a hospital itself defines as charity care.<sup>176</sup> The Medicare Provider Reimbursement Manual instructions for hospitals defines charity care as the care that a hospital chooses to provide for free or a discounted rate in their FAP.<sup>177</sup> There are no federal requirements that mandate eligibility criteria or substance of a FAP.<sup>178</sup> Therefore, what one hospital may consider charity care, another hospital may charge a patient for, and if that second hospital is not paid for that care, the same amount could be bad debt.<sup>179</sup>

This lack of guidance is significant because of the way that FAPs impact the way a nonprofit hospital serves its community through the current community benefit standard. Bad debt, rather than charity care, increases when a hospital cares for more poor patients.<sup>180</sup> This statistic suggests that hospitals do not adjust their FAPs to reflect their patient populations and instead charge patients who are unable to pay. Further, hospitals often do not notify patients if they are eligible for free or discounted care,<sup>181</sup> even though they are required to do so.<sup>182</sup> One study showed that forty-five percent of nonprofit hospitals billed patients for services that would have been covered under a

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176. MARCO A. VILLAGRANA, EDWARD C. LIU, MARGOT L. CRANDALL-HOLLIICK & JOSEPH S. HUGE, CONG. RSCH. SERV., HOSPITAL CHARITY CARE AND RELATED REPORTING REQUIREMENTS UNDER MEDICARE AND THE INTERNAL REVENUE CODE (2018), <https://fas.org/sgp/crs/misc/IF10918.pdf> [<https://perma.cc/LB2K-6AG9>] (“The Medicare Provider Reimbursement Manual instructions for the S-10 worksheet define charity care as resulting ‘from a hospital’s policy to provide all or a portion of services free of charge to patients who meet the hospital’s charity care policy or financial assistance policy (FAP).’”).

177. *Id.*

178. See Tahk, *supra* note 42, at 46. For more information about FAP requirements, see generally *Financial Assistance Policy and Emergency Medical Care Policy – Section 501(r)(4)*, IRS (Sept. 19, 2020), <https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4> [<https://perma.cc/GJ7U-CV22>].

179. See Tahk, *supra* note 42, at 46–48.

180. Valdovinos et al., *supra* note 163, at 1301.

181. See Sayeh S. Nikpay & John Z. Ayanian, *Hospital Charity Care—Effects of New Community-Benefit Requirements*, 373 NEW ENG. J. MED. 1687, 1689–90 (2015) (“Only 44% of hospitals regularly notified patients of their potential eligibility for charity care before initiating deb collection . . .”).

182. *Financial Assistance Policies*, IRS (Feb. 2, 2021), <https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps> [<https://perma.cc/7UAY-7YTH>].

FAP.<sup>183</sup> This disconnect means that hospitals are, perhaps intentionally, missing a key opportunity to provide benefit to their communities. Instead of offering free or discounted care, they charge patients who may be able to receive the same care at a free or discounted rate at another hospital. Because there is no requirement that nonprofit hospitals offer charity care in any specific way,<sup>184</sup> some nonprofit hospitals fail to use free or discounted care, a key component of community benefits, to truly benefit the patients who seek care there and the community at large. This is all part of a larger scheme where many hospitals get more than they receive when it comes to tax exemptions and community benefits.

B. MANY NONPROFIT HOSPITALS RECEIVE MORE BENEFITS FROM TAX EXEMPTIONS THAN THEY PROVIDE

There are no bright-line numerical thresholds for determining whether a hospital meets the legal requirements for nonprofit status.<sup>185</sup> Further, there is no requirement that hospitals provide a specified amount of community benefit or charity care.<sup>186</sup> However, there is a general consensus that nonprofit hospitals should be giving back in levels commensurate with what they receive.<sup>187</sup> This Section shows that many nonprofit hospitals do not give back at these levels.<sup>188</sup>

Additionally, nonprofit hospitals use the complex terminology surrounding the community benefit standard to tout high but misleading numbers to gain unwarranted praise.<sup>189</sup> Finally, this Section will demonstrate that the amounts of community benefits given by nonprofit hospitals vary by factors that are not compensated for by the tax exemption scheme in its current form.<sup>190</sup>

1. The Numbers Do Not Add Up

Some research suggests that while overall, nonprofit hospitals give community benefits equal to or exceeding the value of their tax exemptions, the amount of community benefits that hospitals give is

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183. Jordan Rau, *Patients Eligible for Charity Care Instead Get Big Bills*, KAISER HEALTH NEWS (Oct. 14, 2019), <https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills> [<https://perma.cc/4S8Z-4ZFA>].

184. See *supra* note 49 and accompanying text.

185. VILLAGRANA ET AL., *supra* note 176.

186. *Id.*

187. See Herring et al., *supra* note 5, at 1–2.

188. See *infra* Part II.B.1.

189. See *infra* Part II.B.2.

190. See *infra* Part II.B.3.

not equally distributed, while the tax exempt status is.<sup>191</sup> For example, in 2005, Minnesota's nonprofit hospitals received \$482 million in tax exemptions and provided only \$80 million in charity care.<sup>192</sup> Nationally, the value of community benefits given exceeds the value of the tax exemption received for only 62% of nonprofit hospitals.<sup>193</sup> Furthermore, as community benefits are a broad category that encompasses many expenditures that may not actually benefit a hospital's surrounding community,<sup>194</sup> it is likely that fewer than 62% of nonprofit hospitals are contributing actual benefits to their communities at rates commensurate with their tax exemptions.

While nonprofit hospitals do not report the value of their tax exemptions, they are required to report the amount of community benefits they give annually in Schedule H of IRS Form 990.<sup>195</sup> For example, while the Mayo Clinic reports that it delivered community benefits totaling 11.9% of its total operating expenses in 2017,<sup>196</sup> nowhere does Mayo have to say what percentage of the total operating expenses the tax exemptions amounted to. Researchers estimate that nonprofit hospitals' tax exemptions average about 6% of their total operating expenses, but this number likely varies widely.<sup>197</sup>

Further, because it is difficult to assess nonprofit property and there is little incentive to assess it because it will not be taxed, federal, state, and local governments are often unaware of the amounts that they are forfeiting.<sup>198</sup> Thus, while there is transparency around what hospitals report as community benefits, there is a lack of transparency

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191. See, e.g., Geoffrey Propherter, *Property Tax Exemptions for Nonprofit Hospitals: What Are They Worth? Do They Earn Them? Evidence from New York City*, 39 PUB. BUDGETING & FIN. 3 (2019) (studying property tax expenditure for nonprofit hospitals in New York City).

192. MINN. DEP'T OF HEALTH, *supra* note 120, at iii-iv.

193. Herring et al., *supra* note 5, at 1.

194. See *supra* Part II.A.1.

195. See *infra* note 261.

196. See *Mayo Clinic Hospital 2018 IRS Form 990: Return of Organization Exempt from Income Tax*, GUIDESTAR 36 (Nov. 15, 2019), <https://www.guidestar.org/profile/41-1754276> [<https://perma.cc/35QD-S5S9>] (click "Show Form 990" hyperlink; then click "2018 Form 990" hyperlink).

197. Herring et al., *supra* note 5, at 1.

198. Ronald W. Rakow, *Payments in Lieu of Taxes*, LINCOLN INST. LAND & POL'Y (Jan. 2013), <https://www.lincolninst.edu/publications/articles/payments-lieu-taxes> [<https://perma.cc/4MJ3-NXFN>]; Oliver L. Riskin-Kutz, *For Seventh Year in a Row, Harvard Fails To Meet PILOT Program Recommendation*, HARV. CRIMSON (Mar. 8, 2019), <https://www.thecrimson.com/article/2019/3/8/boston-pilot-tax> [<https://perma.cc/5BR3-TJKD>].

around tax benefits received by nonprofit hospitals. Oftentimes, the benefits received and the benefits given do not add up.

## 2. Nonprofit Hospitals Tout High, but Misleading, Uncompensated Care Spending

Nonprofit hospitals will use the complex terminology that surrounds the community benefit standard to suggest that they are giving back to their communities at higher levels than their actual tax returns reflect. Data from the American Hospital Association suggests that nonprofit hospitals in the United States consistently give back to their communities in amounts far exceeding their tax exemptions.<sup>199</sup> The analysis states that hospitals received about \$9 billion in federal tax exemptions in 2016, but gave back about \$95 billion in community benefits.<sup>200</sup> While these numbers cast hospitals in a flattering light, they also are overly generous in their calculations—they do not include any state or local tax exemptions,<sup>201</sup> and they include both bad debt and Medicare shortfalls in community benefit calculations, when those are not categories that nonprofit hospitals count on their tax forms as a community benefit.<sup>202</sup> Finally, this report refuses to state the amount of charity care that hospitals give, instead deciding to create a category called “financial assistance and certain other community benefits” which they say hospitals dedicate an average of 10% of their expenses to.<sup>203</sup>

Locally, the Minnesota Hospital Association’s Community Benefit Report has similar shortfalls. Specifically, the Minnesota report claims that in 2017, Minnesota nonprofit hospitals gave \$5.2 billion in community contributions.<sup>204</sup> In reality, the amount that actually qualifies on their taxes as community benefit spending is \$1.67 billion.<sup>205</sup> The

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199. See AHA REVENUE FOREGONE, *supra* note 167.

200. *Id.* at 1.

201. *Id.*

202. RESULTS FROM HOSPITALS’ SCHEDULE H, *supra* note 167, at 5 (“Medicare reimbursement shortfalls occur when the Federal government reimburses the hospitals less than their costs for treating Medicare patients.”). Medicaid shortfalls, not Medicare shortfalls, count on tax forms as a community benefit. Herring et al., *supra* note 5, at 7 (explaining that Medicare costs are not considered to be community benefits on the IRS schedule because Medicaid has historically had lower reimbursement rates than Medicare).

203. RESULTS FROM HOSPITALS’ SCHEDULE H, *supra* note 167, at 3.

204. MINN. HOSP. ASS’N, MINNESOTA’S HOSPITALS: SUPPORTING MENTAL HEALTH AND COMMUNITY WELLNESS 1 (2019).

205. *State Analysis*, CMTY. BENEFIT INSIGHT, [http://www.communitybenefitinsight.org/?page=state\\_analysis.home](http://www.communitybenefitinsight.org/?page=state_analysis.home) [<https://perma.cc/HKY9-CPKH>] (select “Minnesota” and the year from the drop-down menu).

Minnesota Hospital Association number includes Medicare shortfalls, which are not counted as a community benefit, bad debt, and taxes and fees that they claim benefit their community but again, are not considered community benefits by the IRS.<sup>206</sup> Conspicuously, the report never even mentions the fact that these nonprofit hospitals receive tax exemptions. Thus, not only are some nonprofit hospitals not giving back to their communities in levels commensurate with their tax benefits, but they are manipulating the numbers and using complex terminology to make themselves look more generous than they really are, generating unwarranted praise.<sup>207</sup>

### 3. Amounts of Community Benefits, Uncompensated Care, and Charity Care Given Are Inequitable

Because there is no standard for how much a nonprofit hospital must give to its community in community benefits each year, there is a wide variation in community benefits, uncompensated care, and charity care that often falls disproportionately on certain hospitals.<sup>208</sup> This distribution raises concern over the fairness of tax exemptions if all nonprofit hospitals qualify for the same tax exemptions, but levels of charity care, uncompensated care, and overall community benefit spending vary greatly among them.<sup>209</sup>

There are many trends that demonstrate the disparities in benefits that a nonprofit hospital gives to its community each year. For example, the amount of charity care a hospital gives increases if the hospital has an emergency department, if they are a teaching hospital, and if they have a trauma center.<sup>210</sup> Urban public hospitals<sup>211</sup> account for one-third of uncompensated care in the United States—double their portion of the hospital market.<sup>212</sup> Major teaching hospitals provide

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206. MINN. HOSP. ASS'N, *supra* note 204, at 4, 14–19.

207. See Rick Pollack, *Community Benefits Go Far Beyond Charity Care*, AM. HOSP. ASS'N (Jan. 16, 2018), <https://www.aha.org/news/blog/2018-01-16-community-benefits-go-far-beyond-charity-care> [<https://perma.cc/Z5LF-JD6M>].

208. Patton, *supra* note 31, at 176 (explaining that oftentimes, charitable hospitals in some of the poorest urban neighborhoods in Minnesota provide significant levels of charity care).

209. Valdovinos et al., *supra* note 163, at 1302 (suggesting that “some not-for-profit institutions might not be pulling their weight” and “the hospitals that spend the highest proportion of their budgets on charity care may be at a disadvantage”).

210. See *id.* at 1301 tbl.4.

211. Public hospitals are nonprofit hospitals that are funded completely by the government and donations. TARESSA FRAZE, ANNE ELIXHAUSER, LAUREL HOLMQUIST & JAYNE JOHANN, *PUBLIC HOSPITALS IN THE UNITED STATES*, 2008, at 1 (2010).

212. BARTON, *supra* note 20, at 264.

three times the amount of uncompensated care relative to their share of the market.<sup>213</sup>

However, while these statistics make intuitive sense, other statistics do not—nonprofit hospitals with the highest net incomes tend to devote the smallest proportion of their earnings to free care, while hospitals with the lowest earnings spend the most on charity care.<sup>214</sup> These statistics show how much variation there is in the amount that nonprofit hospitals are giving back to their communities, all in return for the same type of tax exemptions.

Locally, in Minnesota, the ten largest providers of uncompensated care accounted for over half of the uncompensated care throughout the state's 128 hospitals in 2005.<sup>215</sup> This holds true in 2017, with the ten highest-contributing hospitals providing 50.8% of uncompensated care in the state.<sup>216</sup> Additionally, in Minnesota, charity care is more likely in urban than in rural hospitals, but still not uncommon in rural hospitals.<sup>217</sup> These statistics show how national disparities in community benefit giving between nonprofit hospitals occur locally in Minnesota too. It is only natural that cities and counties would take action to try to recover some of this lost tax revenue.

#### C. LOCALITIES ATTEMPT TO RECOUP SOME TAXES FROM NONPROFIT HOSPITALS

States and cities, recognizing that they are giving up significant amounts of revenue to nonprofit institutions, including hospitals, are trying different strategies to make up some of this revenue. States have denied exemptions for hospital property that had never before been taxed, initiated investigations to determine whether or not nonprofit hospitals are fulfilling their charitable obligations, and attempted ballot initiatives to require that all nonprofit organizations, including hospitals, be subject to property taxes. This Section recounts some of these efforts and demonstrates the lengths that state and local governments will go to in order to recoup some of the taxes that nonprofit entities do not have to pay.

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213. *Id.*

214. Lisa Rapaport, *Nonprofit Hospitals with Healthiest Finances Offer Little Charity Care*, REUTERS (Feb. 17, 2020), <https://www.reuters.com/article/us-health-hospitals-charity/nonprofit-hospitals-with-healthiest-finances-offer-little-charity-care-idUSKBN20B1WS> [<https://perma.cc/Q3Q2-AGF8>].

215. MINN. DEP'T OF HEALTH, *supra* note 120, at iii.

216. I calculated this figure using the dataset at *Standard Hospital Data Sets 2017 Uncompensated Care*, MINN. DEP'T HEALTH, <https://www.health.state.mn.us/data/economics/hccis/data/stnddrpts.html> [<https://perma.cc/66N7-F5E4>].

217. See HEALTH ECON. PROGRAM, *supra* note 168, at 43.

These actions show how the lack of taxes from nonprofit hospitals clearly harms some state and local governments enough to prompt legal action. Pittsburgh's mayor sued the University of Pittsburgh Medical Center, disputing its nonprofit status, but eventually dropped the suit in 2014 in hopes of settling out of court,<sup>218</sup> and it appears one agreement has been reached.<sup>219</sup> In 2019, another suit by the Pennsylvania attorney general alleged that the Pittsburgh Medical Center was not fulfilling its obligation as a public charity,<sup>220</sup> but the lawsuit was dismissed.<sup>221</sup>

After a 2015 ruling in New Jersey determined that the Morristown Medical Center, a nonprofit hospital, had to pay property taxes because it was not fulfilling its obligations for receiving an exemption, towns all over New Jersey have begun negotiating settlement agreements with their local hospitals.<sup>222</sup> In 2011, Massachusetts General Hospital, often ranked as the best hospital in the United States, negotiated a payment in lieu of taxes (PILOT) of just over \$2.5 million on what would have otherwise been a \$55 million tax payment.<sup>223</sup> Additional Minnesota reform efforts are described above.<sup>224</sup> These individual efforts by state and local governments are laudable and demonstrate that there are clear issues with the current community benefit standard—nonprofit hospitals are not giving the community benefits that they promised in return for the tax benefits they receive.

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218. Associated Press, *supra* note 15; Brian O'Neill, *Pittsburgh's Biggest Nonprofits Need To Pay Their Fair Share*, PITT. POST-GAZETTE (Sept. 15, 2019), <https://www.post-gazette.com/opinion/brian-oneill/2019/09/15/Pittsburgh-nonprofits-fair-share-Bill-Peduto-Darlene-Harris-UPMC-Highmark-CMU-Pitt/stories/201909150030> [<https://perma.cc/C5GA-W5C9>].

219. *County Approves Agreement with UPMC Lock Haven*, EXPRESS (Oct. 30, 2020), <https://www.lockhaven.com/news/local-news/2020/10/county-approves-agreement-with-upmc-lock-haven> [<https://perma.cc/N9QZ-JW2W>].

220. Press Release, Josh Shapiro, Att'y Gen., Commonwealth of Pa., Attorney General Josh Shapiro Announces Legal Action Against UPMC for Violating Pennsylvania's Charity Laws (Feb. 7, 2019), <https://www.attorneygeneral.gov/taking-action/press-releases/attorney-general-josh-shapiro-announces-legal-action-against-upmc-for-violating-pennsylvanias-charities-laws> [<https://perma.cc/CG7H-95ET>].

221. Kris B. Mamula, *UPMC Lawsuit Against Attorney General Is Dismissed*, PITT. POST-GAZETTE (Apr. 25, 2019), <https://www.post-gazette.com/business/legal/2019/04/24/UPMC-lawsuit-against-attorney-general-is-dismissed/stories/201904240167> [<https://perma.cc/3PBX-QX55>].

222. Justin Zaremba, *Hospital Settles Tax Dispute After Its Nonprofit Status Questioned*, NJ.COM (Sept. 24, 2017), <https://www.nj.com/morris/2017/09/pequannock-settles-tax-dispute-with-atlantic-medic.html> [<https://perma.cc/EAT6-CXNB>].

223. CITY OF BOS., *supra* note 18.

224. See *supra* Part I.E.

D. COMMUNITY BENEFITS SHOULD BRIDGE THE GAP BETWEEN NONPROFIT HOSPITALS AND THEIR SURROUNDING COMMUNITIES

Oftentimes, major nonprofit hospitals are seen as inaccessible to the communities that surround them—perpetuating health inequities and a divide between the hospitals and the communities that they claim to serve in their Community Health Needs Assessment (CHNA). For example, the Cleveland Clinic, a nonprofit hospital, located in a poor and unhealthy neighborhood in Cleveland, attracts wealthy international patients while alienating its African-American neighbors, who refer to it as “[t]he plantation.”<sup>225</sup> The Cleveland Clinic is exempt from paying tens of millions of dollars in taxes that could go toward its community in return for a “loosely defined commitment to reinvest in its community.”<sup>226</sup> While the Cleveland Clinic’s CHNA defined the communities that surround it as “highest need,”<sup>227</sup> the Cleveland Clinic dedicated less than 2% of their expenses toward charity care in 2016.<sup>228</sup>

A five-minute walk from the Johns Hopkins nonprofit hospital in downtown Baltimore, residents of the Madison-East End neighborhood have a lower life expectancy than residents in Bangladesh, Turkmenistan, and North Korea.<sup>229</sup> Oftentimes, poor communities surrounding hospitals tend to lack grocery stores with healthy food and places to play or exercise outside safely.<sup>230</sup> These anecdotes show a clear need for nonprofit hospitals to benefit the communities that surround them.

Community benefits could be the bridge between a nonprofit health care provider and its community, but in many cases, the current system does not create that outcome. The work that nonprofit hospitals count toward their community benefits often does not directly benefit their surrounding community. Activities like sponsoring races and hosting lectures are counted, whereas what communities really

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225. Dan Diamond, *How the Cleveland Clinic Grows Healthier While Its Neighbors Stay Sick*, POLITICO (July 17, 2017, 5:00 AM), <https://www.politico.com/interactives/2017/obamacare-cleveland-clinic-non-profit-hospital-taxes> [<https://perma.cc/6TZE-TZW3>].

226. *Id.*

227. *Id.*

228. *The Cleveland Clinic Foundation 2018 IRS Form 990: Return of Organization Exempt from Income Tax*, GUIDESTAR 59 (Nov. 12, 2019), <https://www.guidestar.org/profile/41-1754276> [<https://perma.cc/K7P5-FTUJ>] (click “Show Form 990” hyperlink; then click “2018 Form 990” hyperlink).

229. Diamond, *supra* note 1.

230. *Id.*

need are very different offerings.<sup>231</sup> Nonprofit hospitals spend far less on community health improvement and contributions to local community groups than they do other types of community benefits.<sup>232</sup> In 2012, nonprofit hospitals reported dedicating the largest portion of community benefit spending to medical education for their own doctors and residents (36%) followed by offsetting losses<sup>233</sup> from Medicaid (32%).<sup>234</sup> While these expenses arguably help a hospital by training its staff and compensating them for care they perform, it is harder to see how these actions directly benefit the community that surrounds a hospital.<sup>235</sup>

Further, some hospitals actively work against additional requirements for them to give back to their communities.<sup>236</sup> In 2016, the Mayo Clinic lobbied heavily against the reauthorization of a 2% provider tax in Minnesota that pays for care for low-income Minnesotans,<sup>237</sup> even when the Minnesota Hospital Association expressed support for this tax.<sup>238</sup> Though the tax passed, it lapsed at the end of

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231. Diamond, *supra* note 225.

232. Rosenbaum et al., *supra* note 9, at 1226 (“Hospitals allocated just \$2.7 billion (4 percent of total community benefit spending) to community health improvement and slightly less than \$2.0 billion (3 percent of total community benefit spending) to cash and in-kind contributions to community groups.”).

233. Additionally, it is important to note that Medicaid shortfalls are a bit of a fallacy—they are the difference between the list price of a procedure and the amount that a hospital negotiated with Medicaid to be compensated. However, hospitals hardly ever charge their list price, so this compensation is not a true “shortfall.” Diamond, *supra* note 1.

234. *Id.*

235. Cf. Daniel B. Rubin, Simone Rauschen Singh & Peter D. Jacobson, *Evaluating Hospitals’ Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption*, 103 AM. J. PUB. HEALTH 612, 614 (2013) (suggesting that the proper measure of community benefit is using population health measures, not monetary contributions because money spent “indicate[s] nothing about whether the program created any real benefit”).

236. Diamond, *supra* note 90; Joel Michael, *MinnesotaCare Provider Taxes*, HOUSE RSCH. (2015), <https://www.house.leg.state.mn.us/hrd/pubs/ss/ssmcpt.pdf> [<https://perma.cc/VW4Z-RL2W>].

237. Heather J. Carlson, *Rochester Lawmakers To Fight Extension of Provider Tax*, POST BULL. (Jan. 27, 2017, 12:00 PM), <https://www.postbulletin.com/business/6284006-Rochester-lawmakers-to-fight-extension-of-provider-tax> [<https://perma.cc/6CLK-3TDE>] (“Mayo Clinic has opposed the provider tax since its inception and does not want to see the reinstatement of this hidden tax, which increases the cost of health care.”).

238. *Hospital, Health System Leaders Rally in Support of Provider Tax*, MINN. HOSP. ASS’N (May 3, 2019), <https://www.mnhospitals.org/newsroom/news/id/2240/hospital-health-system-leaders-rally-in-support-of-provider-tax> [<https://perma.cc/NW5P-MM4Z>].

2020,<sup>239</sup> and a special session tax bill passed in May 2019 dropped the rate to 1.8%.<sup>240</sup> It seems clear that at least some nonprofit hospitals work to “do enough to be perceived as nonprofit while engaging in business practices that are corporate in nature.”<sup>241</sup> Community benefits can and should be a real bridge between nonprofit hospitals and their communities, but currently, that does not seem to be the case as illustrated locally in Minnesota.

#### E. THESE TRENDS OCCUR LOCALLY IN MINNESOTA

In 2018, the most recent year with comprehensive data, Minnesota’s sixty-four nonprofit hospitals spent over \$1.6 billion on community benefits, with an average of around \$31 million per facility.<sup>242</sup> However, that number does not tell the whole story, as Minnesota nonprofit hospitals gave out only \$215 million in free and discounted care.<sup>243</sup> The vast amount of community benefit, almost \$897 million, was actually the difference of the cost of care given to patients on Medicaid and the cost the hospital would charge an uninsured patient.<sup>244</sup> Minnesota consistently gives out less uncompensated care than the national average, though this could be because Minnesota has low uninsured rates compared to the national average.<sup>245</sup> In 2016, Minnesota

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239. Peter Callaghan, *The Tax That Pays for MinnesotaCare Is Set To Expire at the End of the Year. So Far, Legislators Can’t Agree on a Plan To Replace It*, MINNPOST (Feb. 6, 2019), <https://www.minnpost.com/state-government/2019/02/the-tax-that-pays-for-minnesotacare-is-set-to-expire-at-the-end-of-the-year-so-far-legislators-cant-agree-on-a-plan-to-replace-it> [<https://perma.cc/2T4Y-EZC5>].

240. *Provider Tax*, MINN. DEP’T REVENUE (Feb. 4, 2021), <https://www.revenue.state.mn.us/provider-tax> [<https://perma.cc/HYM5-BV2W>].

241. Diamond, *supra* note 90.

242. *State Analysis*, *supra* note 205. Because of the way that hospitals report this data, hospital systems report as one, so this average may be skewed higher because of many hospitals reporting together as one.

243. *Id.*

244. *Id.* For example, in 2016, Hennepin County Medical Center paid \$404 million for care they delivered to Medicaid patients, but this spending was offset with \$360 million in payments.

245. In 2018, 4% of Minnesotans were uninsured, whereas 9% of Americans were uninsured. *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND. (2018), <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [<https://perma.cc/BZ6Z-PBQ8>]. Of course, there are disparities in insurance status by age, race, gender, and other factors. HEALTH ECON. PROGRAM, MINN. DEP’T OF HEALTH, CHARTBOOK SECTION 2: TRENDS AND VARIATION IN HEALTH INSURANCE COVERAGE (2019), <https://www.health.state.mn.us/data/economics/chartbook/docs/section2.pdf> [<https://perma.cc/CE9C-A2R5>]. The increase in insurance status may be associated with a drop in uncompensated care rates in Minnesota hospitals. Christopher Nowbeck, *Uncompensated Care Costs at Minnesota Hospitals Plunge Since*

hospitals gave out on average uncompensated care that constituted 1.6% of their expenditures whereas the rest of the country averaged 4.2%.<sup>246</sup>

Further, the amount of community benefit that Minnesota hospitals give is decreasing. Between 2013 and 2015, community benefit spending decreased by 4.8% overall,<sup>247</sup> despite the fact that Minnesota's hospitals increased their net income levels by about 5.5% in that time period.<sup>248</sup> This decrease is magnified when looking at charity care spending, which fell 35.1% in that same period.<sup>249</sup> While this decrease could be due in part to the drop in the uninsured rate during the same period in Minnesota,<sup>250</sup> that same drop likely contributed to higher Medicaid shortfalls, which would have increased community benefit levels.<sup>251</sup> These statistics demonstrate that Minnesota hospitals used to give back to their communities at higher levels, and despite increases in revenue, levels of aid are falling.

This does not mean that Minnesota hospitals have no free care to give. Hennepin County Medical Center, in downtown Minneapolis, offered 1.32% of its operational expenses in charity care in 2018,<sup>252</sup> though this is still less than the amount they spend on educating their health care providers.<sup>253</sup> In contrast, Children's Health Care, also in downtown Minneapolis, spent 0.09% of its operational expenses on

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*Health Law*, STAR TRIB. (Oct. 31, 2016, 7:46 PM), <https://www.startribune.com/uncompensated-care-costs-at-minnesota-hospitals-plunge-since-health-law/399330351> [<https://perma.cc/JJD2-FQJG>].

246. HEALTH ECON. PROGRAM, *supra* note 168, at 37.

247. Fugate, *supra* note 6.

248. NAT'L NURSES UNITED & MINN. NURSES ASS'N, *supra* note 82, at 11.

249. Fugate, *supra* note 6.

250. The uninsured rate, or the rate of individuals in Minnesota without insurance, dropped from 8.2% to 4.3% between 2013 and 2015. *Minnesota's Uninsured Rate Jumps in 2017 Despite Strong Economy*, MINN. DEP'T HEALTH (Feb. 20, 2018), <https://www.health.state.mn.us/news/pressrel/2018/uninsured022018.html> [<https://perma.cc/NNV7-KV3P>].

251. Herring et al., *supra* note 5, at 9 ("Marketplace subsidies and state Medicaid expansions (where they occurred) clearly reduced the number of uninsured and, in turn, likely reduced the amount of hospital charity care (yet also likely increased the amount of unreimbursed Medicaid costs).").

252. *Hennepin HealthCare System Inc 2018 IRS Form 990: Return of Organization Exempt from Income Tax*, GUIDESTAR 41 (Nov. 5, 2019), <https://www.guidestar.org/profile/41-1754276> [<https://perma.cc/3KTX-PVS7>] (click "Show Form 990" hyperlink; then click "2018 Form 990" hyperlink).

253. *Id.* (stating that Hennepin County Medical Center spent 2.2% of their operating expenses on educating health professionals).

charity care in 2018.<sup>254</sup> Again, these statistics show how some nonprofit hospitals give more community benefits than other nonprofit hospitals, despite the fact that they all receive the same types of tax exemptions.

It is important to note that all hospitals in Minnesota are not on an even playing field. Rural hospitals in Minnesota often report a slimmer or negative operating margin due to cutbacks in commercial insurance plans' reimbursements.<sup>255</sup> Thus, it is clear that the overall trends seen in the amount of community benefits, uncompensated care, and charity care that nonprofit hospitals across the country offer exist in Minnesota as well. It follows that reform efforts successful elsewhere could find success in Minnesota too.

Thus, while community benefits could serve as a bridge between nonprofit hospitals and their communities, because of the way the scheme functions, that is not always the case. Because the terminology involved in nonprofit hospitals' tax exemptions is so complex, because nonprofit hospitals differ in so many respects but all receive the same tax exemptions, and because many nonprofit hospitals do not give back to their communities at the levels they should, the community benefit standard is not accomplishing what it should. It is easy for these hospitals to tout high but misleading amounts that they are benefiting their communities, but it is clear that the community benefit standard does not incentivize nonprofit hospitals to benefit their communities in any uniform way.

### III. CHANGES TO THE COMMUNITY BENEFIT STANDARD CAN HELP MINNESOTA NONPROFIT HOSPITALS SERVE THEIR COMMUNITIES IN MORE MEANINGFUL WAYS

There have been many proposals to "fix" the broken system of tax exemptions that nonprofit hospitals currently receive. Some individuals, concerned with the inequality and ineffectiveness of the community benefit standard, have advocated for completely revoking

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254. *Children's Health Care 2018 IRS Form 990: Return of Organization Exempt from Income Tax*, GUIDESTAR 51 (Nov. 10, 2019), <https://www.guidestar.org/profile/41-1754276> (click "Show Form 990" hyperlink; then click "2018 Form 990" hyperlink) [<https://perma.cc/N7PZ-VG3P>]; see *Minneapolis*, CHILD.'S MINN. (2020), <https://www.childrensmn.org/locations/minneapolis> [<https://perma.cc/E78Y-RSGR>] (listing the locations of Children's Minnesota in Minneapolis, Minnesota).

255. MINN. HOSP. ASS'N, MHA ISSUE BRIEF: THE FINANCIAL HEALTH OF MINNESOTA HOSPITALS AND HEALTH SYSTEMS IN FISCAL YEAR 2017, at 6 (2018), <https://www.mnhospitals.org/Portals/0/Documents/news/The-Financial-Health-of-MN-Hospitals-and-Health-Systems-FY2017.pdf> [<https://perma.cc/TZ6Y-83Z2>].

nonprofit hospitals' tax exemptions.<sup>256</sup> Other proposals focus on the CHNA requirement and its potential to set expectations for how nonprofit hospitals should assess and address community needs.<sup>257</sup> Yet others argue that increased accountability will encourage hospitals to truly serve the communities where they belong.<sup>258</sup> Some call for community benefits to focus on population health, not the health of individual patients.<sup>259</sup>

While these proposals will likely make some difference, they do not strike at the core of the problem—the question of whether what nonprofit hospitals currently count as community benefits on their tax forms actually benefit the communities that surround the hospital. Additionally, most reforms are meaningless (except for complete elimination of tax exemptions) if there is not some minimum amount of community benefit required for nonprofit hospitals to maintain their tax exemptions. By considering these two factors, this Note suggests steps that Minnesota should consider that aim to address each.

A. REQUIRING HOSPITALS TO USE AMOUNTS GENERALLY BILLED TO CALCULATE MEDICAID SHORTFALLS WILL PREVENT MINNESOTA HOSPITALS FROM RECOUPING MORE THAN THEY NEED

Community benefits can be the bridge between a nonprofit health care provider and its surrounding community, but the way the current system stands, that is not the outcome.<sup>260</sup> The place to start when looking for a solution is taking a closer look at what nonprofit hospitals can count as community benefits. The eight categories of community benefits are: (1) charity care, (2) unreimbursed costs from Medicaid, (3) unreimbursed costs from other means-tested programs, (4) community health improvement services and operations, (5) health professions education, (6) subsidized health services, not means-

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256. George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 148–55 (2010).

257. Mary Crossley, *Health and Taxes: Hospitals, Community Health and the IRS*, 16 YALE J. HEALTH POL'Y L. & ETHICS 51 (2016).

258. Patton, *supra* note 31, at 7 (“Greater accountability can be accomplished by redefining the community benefit standard to more effectively prioritize specific charitable activities and by empowering the communities served by nonprofit hospitals to shape the services and care available.”).

259. Jessica Berg, *Putting the Community Back into the “Community Benefit” Standard*, 44 GA. L. REV. 375, 377–79 (2010).

260. Haider J. Warraich, *Hospitals Need To Earn Their Tax-Exempt Status*, STAT NEWS (Nov. 27, 2017), <https://www.statnews.com/2017/11/27/hospitals-tax-exempt-status> [<https://perma.cc/JG8S-W3MD>] (explaining how community benefits should force hospital systems to look at the people who live around them).

tested, (7) unfunded research, and (8) cash and in-kind contributions for community benefit.<sup>261</sup> This Note will propose taking a closer look at unreimbursed costs from Medicaid and other means-tested programs.

“Medicaid shortfall,” also known as unreimbursed costs from Medicaid, is defined as is the difference between the nonprofit hospital’s costs incurred for treating Medicaid patients and the payment received from Medicaid in return.<sup>262</sup> In a recent study, the largest category of community benefits nonprofit hospitals reported is unreimbursed costs from Medicaid, comprising “31% of the total incremental community benefits.”<sup>263</sup> For the Mayo Clinic, it was the largest category of community benefits—comprising more than one-third of the 6.64% of total operating expenses they dedicated to community benefits in 2016.<sup>264</sup> Currently, nonprofit hospitals use the “gross patient charges”<sup>265</sup> minus the amount they were reimbursed by Medicaid in order to calculate the amount of Medicaid shortfall they report as community benefit.<sup>266</sup> This calculation makes sense for practical reasons, but it likely overrepresents the actual amount of money a hospital needs to be fully compensated for the cost of caring for a Medicaid patient.

For example, the American Hospital Association estimates that Medicaid payments to hospitals amounted to 90% of the cost of patient care in 2015,<sup>267</sup> and other estimates find that Medicaid payments covered 93% of the costs of patient care in 2014.<sup>268</sup> Sometimes, with

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261. IRS, INSTRUCTIONS FOR SCHEDULE H (FORM 990) (2020), <https://www.irs.gov/pub/irs-pdf/i990sh.pdf> [<https://perma.cc/W5EV-EQJP>].

262. Herring et al., *supra* note 5, at 2.

263. *Id.* at 7.

264. See *Mayo Clinic Hospital 2018 IRS Form 990: Return of Organization Exempt from Income Tax*, GUIDESTAR 36 (Nov. 15, 2019), <https://www.guidestar.org/profile/41-1754276> [<https://perma.cc/35QD-S5S9>] (click “Show Form 990” hyperlink; then click “2018 Form 990” hyperlink).

265. IRS, *supra* note 261, at 13 (“‘Gross patient charges’ means the total charges at the organization’s full established rates for the provision of patient care services before deductions from revenue are applied.”).

266. *Id.* at 14.

267. AM. HOSP. ASS’N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET 2 (2016), <https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt.pdf> [<https://perma.cc/NUL4-U2AV>].

268. Peter Cunningham, Robin Rudowitz, Katherine Young, Rachel Garfield & Julia Foulz, *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, KAISER FAM. FOUND. (June 6, 2016), <https://www.kff.org/medicaid/issue-brief/understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes> [<https://perma.cc/H2CP-AXS4>] (click “Issue Brief” hyperlink).

additional payments, hospitals are overcompensated for the care they give to patients on Medicaid.<sup>269</sup> Further, some suspect that the marginal costs of Medicaid patients are lower than Medicaid payments, otherwise nonprofit hospitals would likely refuse to see these patients.<sup>270</sup> Thus, if there are Medicaid shortfalls at all, they are likely smaller than what nonprofit hospitals are reporting.

These data lead to natural questions about whether the Medicaid shortfall amount that nonprofit hospitals currently consider community benefit actually benefits the community at all. In 2011, a plurality opinion of the Illinois Supreme Court opined that nonprofit Illinois hospitals should not count Medicaid shortfalls as community benefit because hospitals voluntarily participate in these programs, which advance the hospital's financial interest.<sup>271</sup> In fact, Illinois courts of appeals have held that Medicaid shortfalls are not considered charity for purposes of assessing eligibility for a state property tax exemption.<sup>272</sup> Other states do not consider Medicaid shortfall as an element of state-defined community benefits.<sup>273</sup> Clearly, some states have come to the conclusion that Medicaid shortfalls do not make a hospital more charitable or contribute more benefit to its community.

Additionally, the current method of calculation for Medicaid shortfalls is erroneous. Hospitals hardly ever charge full established rates for a service, as they often negotiate substantial discounts with private insurers for the amount they will be reimbursed for care.<sup>274</sup> So, counting the difference between this full amount, "gross patient

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269. *Id.*

270. *Id.*

271. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131, 1151 (Ill. 2010).

272. *Riverside Med. Ctr. v. Dep't of Revenue*, 795 N.E.2d 361, 367 (Ill. App. 2003) ("Riverside argues, however, that its charity care is not limited to the provision of free care. It points out that it also provides discounted care to patients through Medicare, Medicaid and private insurance. Specifically, Riverside claims to give this care at 50% of actual cost. We are unpersuaded by the argument. Although Riverside does give discounts, these discounts are given pursuant to contract."); *Alivio Med. Ctr. v. Dep't of Revenue*, 702 N.E.2d 189, 190-93 (Ill. App. 1998) (denying charitable real estate exemption to medical center where, *inter alia*, most of the center's revenue was derived from patient fees and the majority of those fees were Medicaid payments). For more information about the impact of the *Provena* case in Illinois, see generally Antonio Senagore, *Are Nonprofit Hospitals Charitable Institutions? The Charitable Use Real Property Tax Exemption After Provena*, 99 ILL. B.J. 96 (2011).

273. Melvin A. Lamboy-Ruiz, James N. Cannon & Olena V. Watanabe, *Does State Community Benefits Regulation Influence Charity Care and Operational Efficiency in U.S. Non-Profit Hospitals?*, 158 J. BUS. ETHICS 441, 445 n.12 (2019).

274. Herring et al., *supra* note 5, at 1.

charges,”<sup>275</sup> and the amount reimbursed by Medicaid as a community benefit is inaccurate because nonprofit hospitals would not be reimbursed by private insurers at the level of the gross patient charge. The care that was given surely benefits the individual Medicaid patient,<sup>276</sup> but the faulty, inflated collection calculus does not help the community at all.

While some may argue that Medicaid shortfalls should not be considered a community benefit at all,<sup>277</sup> some hospitals truly need to be compensated for the difference between the amount Medicaid will reimburse and the cost of care. “Disproportionate share hospitals”—hospitals that care for a large number of patients eligible for Medicare and Medicaid or hospitals that receive more than 30% of their net inpatient care revenue from state and local governments as compensation for indigent care<sup>278</sup>—qualify for supplemental payments from Medicaid.<sup>279</sup> While these payments total 108% of the costs of treating Medicaid patients, when the costs of treating uninsured patients is considered, these payments cover only 89% of the combined costs of uninsured and Medicaid patients.<sup>280</sup> Thus, eliminating Medicaid shortfalls for hospitals like disproportionate share hospitals would fail to account for the real benefits that these hospitals are giving to their communities by treating patients with Medicaid coverage.

The solution to this problem is to use the “amount generally billed” method to calculate the price against which Medicaid reimbursements should be compared.<sup>281</sup> This method uses the payment amounts from Medicare, Medicaid, and all private health insurers for a certain treatment in the past year divided by the number of claims to calculate what a hospital generally billed for that treatment in the

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275. See *supra* note 265.

276. See generally Crossley, *supra* note 257 (arguing that the community benefit standard incentivizes nonprofit hospitals to act in ways that benefit individual patients, not communities).

277. Nation, *supra* note 256, at 150–51 (arguing that current community benefits activities are “an inefficient, deceitful non-democratic approach that undermines the basic foundations of our democracy”).

278. *Disproportionate Share Hospital*, CTMS FOR MEDICARE & MEDICAID SERVS. (Sept. 2, 2020, 5:03 PM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh> [<https://perma.cc/55BD-SAVL>].

279. Robert Nelb, James Teisl, Allen Dobson, Joan E. DaVanzo & Lane Koenig, *For Disproportionate-Share Hospitals, Taxes and Fees Curtail Medicaid Payments*, 35 HEALTH AFFS. 2277, 2277 (2016).

280. *Id.* at 2277–78.

281. *Limitation on Charges – Section 501(r)(5)*, IRS (Sept. 19, 2020), <https://www.irs.gov/charities-non-profits/limitation-on-charges-section-501r5> [<https://perma.cc/6SVG-D5H9>].

past year.<sup>282</sup> This measure is a more accurate amount than the gross patient charges, as it reflects what a hospital actually charges for the care it gives. Further, the amount generally billed method is already in place for determining what hospitals can charge patients under their FAP,<sup>283</sup> so it will not be difficult for hospitals to calculate, as it is not new to them.

There are drawbacks to the amounts generally billed method as well,<sup>284</sup> but, as it more accurately reflects the value of the service that a hospital provides to an individual patient, it more accurately reflects the true benefit that a hospital is giving to a community by caring for a patient on Medicaid. This same method should also be applied to other means-tested programs, whose shortfalls nonprofit hospitals also receive community benefit credit for, as hospitals could shift a service from one category to another if the requirements were not uniform for calculating shortfall.<sup>285</sup>

Thus, Medicaid shortfalls and shortfalls from other means-tested programs are currently not a good measure of actual benefit to a community, as they are not calculated to properly demonstrate the cost that a nonprofit hospital is not compensated for when it agrees to care for a patient on a means-tested program. By changing the way that these shortfalls are calculated, these numbers will be a more accurate representation of the benefit a nonprofit hospital actually brings to its community through these services. However, this change will not matter if there is not a minimum amount of community benefits required.

#### B. MINNESOTA NONPROFIT HOSPITALS SHOULD BE REQUIRED TO CONTRIBUTE A MINIMUM AMOUNT OF COMMUNITY BENEFITS

What should and should not count as a community benefit only matters if someone is keeping track of which nonprofit hospitals offer community benefits and whether nonprofit hospitals are held

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282. *Id.*

283. Sara Rosenbaum, *Additional Requirements for Charitable Hospitals: Final Rules on Community Health Needs Assessments and Financial Assistance*, HEALTH AFFS. (Jan. 23, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150123.044073/full> [<https://perma.cc/JUS9-DEW3>] (“[I]n the case of emergency medical care and other medically necessary care, organizations are barred from charging persons eligible for financial assistance more than amounts generally billed to insured patients.”).

284. Cunningham et al., *supra* note 268 (explaining how the amounts generally billed standard likely overestimates the actual cost of a medical procedure, as it considers the amounts of all claims hospitals have been allowed by health insurers, and hospitals receive considerable overpayment from private insurers, amounting to 144% of the cost of patient care).

285. Herring et al., *supra* note 5, at 7.

accountable when they do not meet a minimum standard. Some scholars call for a mandate that a certain percentage of the tax benefits that the nonprofit hospital receives must be given in charity care or community benefits.<sup>286</sup> Lawmakers also have called for investigating the value of community benefits that nonprofit hospitals give.<sup>287</sup>

A Minnesota community benefit reform proposal should set a minimum amount of community benefits that nonprofit hospitals must give to their community in return for their tax exemptions. These proposals should be modeled on existing successful state laws, offer multiple options to fit different nonprofit hospitals, be strict and specific, and should be based on current levels of community benefit giving to ensure the best compliance and highest increase in community benefits that nonprofit hospitals in Minnesota can offer.

First, Minnesota community benefit reformers should look to the states that already regulate nonprofit hospitals' community benefits for guidance and inspiration. By the end of 2015, thirty-four states enacted regulations related to nonprofit hospitals provision of community benefits.<sup>288</sup> Some states go further: Illinois,<sup>289</sup> Nevada,<sup>290</sup>

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286. Patton, *supra* note 31, at 15 ("Under the proposed reasonableness test, the cost of community care provided by any nonprofit hospital should equate to *at least* half the value of its tax exemptions.").

287. Press Release, U.S. Senate Comm. on Fin., Grassley Releases Staff Discussion Draft of Potential Non-Profit Hospital Reforms, Solicits Public Comment (July 18, 2007), <https://www.finance.senate.gov/ranking-members-news/grassley-releases-staff-discussion-draft-of-potential-non-profit-hospital-reforms-solicits-public-comment> [<https://perma.cc/7R6V-AEP2>].

288. Cory E. Cronin, *Hospitals' Choices and the Institutional Environment: The Role of Community Benefit in the Health Care Sector* 172 (Aug. 2015) (Ph.D. dissertation, Case Western Reserve University) (OhioLink).

289. 35 ILL. COMP. STAT. 5/223 (2018) ("[A] taxpayer . . . is entitled to a credit against the taxes imposed under subsections (a) and (b) of Section 201 of this Act in an amount equal to the lesser of the amount of real property taxes paid during the tax year on real property used for hospital purposes during the prior tax year or the cost of free or discounted services provided during the tax year pursuant to the hospital's charitable financial assistance policy, measured at cost.").

290. Nevada requires that nonprofit and for-profit hospitals that have at least 100 beds and are located in a county that has at least two licensed hospitals annually provide care for indigent inpatients in an amount that represents at least 0.6% of the hospital's net revenue for the preceding fiscal year. NEV. REV. STAT. § 439B.320 (2020). If the amount of treatment a hospital provides to indigent patients is less than 0.6% of its net revenues for the previous year, the county will deduct the shortfall from payments otherwise owed to the hospital. *Id.* § 439B.340(2)(c).

Pennsylvania,<sup>291</sup> Texas,<sup>292</sup> and Utah<sup>293</sup> each require nonprofit hospitals to give a certain minimum amount of community benefit in return for state tax exemptions.<sup>294</sup>

Second, similar to the Texas regulatory scheme, Minnesota should offer different options to fit the needs of each nonprofit hospital. Specifically, in Texas, the tax code requires nonprofit hospitals to choose between four amounts of community benefits that they must offer.<sup>295</sup> Hospitals can either offer an amount they determine is reasonable per their CHNA, charity care and government-sponsored indigent health care equal to at least 4% of their net patient revenue, charity care and government-sponsored indigent health care equal to 100% of their hospital or system's tax-exempt benefits, or charity care and community benefits equal to 5% of net patient revenue.<sup>296</sup> The law provides exceptions for disproportionate share hospitals, rural hospitals, and hospitals that do not charge for any care.<sup>297</sup> Similar to Texas, any Minnesota reform should offer a flexible yet meaningful standard for nonprofit hospitals to follow.

Third, Minnesota's community benefit reformers should make regulations mandatory, strict, and specific to ensure the best

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291. Pennsylvania's Institutions of Purely Public Charity Act requires that in order to be deemed an "institution of purely public charity," a hospital must do all of the following: advance a charitable purpose, operate free from any private profit motive, donate a substantial portion of its services to benefit the community, "benefit a substantial and indefinite class of persons who are legitimate subjects of charity," and relieve government of some of its burden. 10 PA. CONS. STAT. § 375(a)–(f) (2020). "To fulfill the requirement of section 375(d)(1) that a hospital 'donate or render gratuitously a substantial portion of its services to benefit the community,' a hospital must satisfy one of seven standards. Six of these seven standards specify a minimum level of community benefits." HILLTOP INST., COMMUNITY BENEFIT STATE LAW PROFILE: PENNSYLVANIA (2016), [https://www.hilltopinstitute.org/wp-content/uploads/hcbp/hcbp\\_docs/HCBP\\_CBL\\_PA.pdf](https://www.hilltopinstitute.org/wp-content/uploads/hcbp/hcbp_docs/HCBP_CBL_PA.pdf) [<https://perma.cc/5N48-RMFT>].

292. TEX. TAX CODE ANN. § 11.1801 (2019).

293. As a condition of property tax exemption, Utah requires a nonprofit hospital to contribute annual "gifts to the community" (community benefits) in an amount exceeding the value of its annual property tax liability in the absence of the exemption. 2 PROP. TAX DIV., UTAH STATE TAX COMM'N, PROPERTY TAX EXEMPTIONS STANDARDS OF PRACTICE 31 (2020), <https://propertytax.utah.gov/standards/standard02.pdf> [<https://perma.cc/4A9P-KXZZ>].

294. HILLTOP INST., COMMUNITY BENEFIT STATE LAW PROFILES: A 50-STATE SURVEY OF STATE COMMUNITY BENEFIT LAWS THROUGH THE LENS OF THE ACA 106 (2016), <https://hilltopinstitute.org/wpcontent/uploads/publications/CommunityBenefitStateLawProfiles-50StateSurveyOfStateCommunityBenefitLawsThroughLensOfACA-June2015.pdf> [<https://perma.cc/C5DQ-GVFN>].

295. TEX. TAX CODE ANN. § 11.1801(a)(1)–(4).

296. *Id.*

297. *Id.* § 11.1801(b).

compliance and highest increase in community benefit. Recent studies show that state laws mandating community benefits are associated with increased amounts of community benefit giving by nonprofit hospitals.<sup>298</sup> One study found that in states where community benefit regulations were in place, the amount of charity care given by nonprofit hospitals increased by 20.2%, and the amount of compensated care decreased in nonprofit hospitals by 5.7%.<sup>299</sup> Further, the efficiency of operations increased by 1.5%.<sup>300</sup> The increase in community benefits does not change whether the community benefit requirements are provisional<sup>301</sup> or reporting<sup>302</sup> requirements, and both types together do not incrementally enhance amounts of charity care. Another study found that in states with community benefit regulations of any type, nonprofit hospitals spent an additional \$8.42 per \$1,000 of their total operating expenses on community benefit spending.<sup>303</sup> Thus, Minnesota reformers targeting community benefits should look to existing successes in other states to model our law.

Additionally, there is some evidence that the more specific state laws are, the more community benefits nonprofit hospitals will provide.<sup>304</sup> For example, in a 2004 study, Texas nonprofit hospitals—which faced strict minimum-standard laws—were providing three times more charity care and two times more uncompensated care than hospitals in states with less specific, more process-oriented regulations.<sup>305</sup> Additional evidence from Indiana suggests that nonprofit hospitals in states with relatively strict reporting requirements

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298. Angela Chen, *The Provision of Charity Care by Nonprofit Hospitals* 23–24 (2016) (B.S. thesis, University of Pennsylvania), [https://repository.upenn.edu/cgi/viewcontent.cgi?article=1003&context=joseph\\_wharton\\_scholars](https://repository.upenn.edu/cgi/viewcontent.cgi?article=1003&context=joseph_wharton_scholars) [<https://perma.cc/Q4LN-L8CC>].

299. Lamboy-Ruiz et al., *supra* note 273, at 442.

300. *Id.*

301. Provision requirements can take the form of a prescribed set of persons that must be offered charity care, prescribed types or amounts of uncompensated services offered, and/or charity care requirements for facility investment or expansion. *Id.*

302. Reporting requirements can range from a statement of commitment to community benefit reporting to detailed information regarding the provision of uncompensated care, often including detailed charity care costs and even patient information. *Id.*

303. Emily K. Johnson, Rose Hardy, Tatiane Santos, Jonathan Leider, Richard Lindrooth & Gregory J. Tung, *State Laws and Nonprofit Hospital Community Benefit Spending*, 25 J. PUB. HEALTH MGMT. & PRAC. E9, E9 (2019).

304. Chen, *supra* note 298.

305. Janet P. Sutton & Jeffrey Stensland, *Promoting Accountability: Hospital Charity Care in California, Washington and Texas*, 15 J. HEALTH CARE FOR POOR & UNDERSERVED 237, 238–39, 243 (2004).

provide larger volumes of uncompensated care.<sup>306</sup> Thus, the more specific and strict a community benefit minimum threshold is, the more effect it can be expected to have.

There are drawbacks to this solution. First, it could lead to an overall decrease in community benefits as hospitals offering more community benefits than the minimum drop their levels to offer only the minimum amount required. In Texas, the minimum community benefits law led to an overall decrease in the amount of charity care nonprofit hospitals gave, as hospitals giving more than 4% dropped their levels to 4% to comply with this minimum.<sup>307</sup> However, only 20% of hospitals were giving charity care below 4% before the law was passed,<sup>308</sup> suggesting that this trend could have been avoided had the minimum threshold been set at a more appropriate level. Other, more dated, analyses suggest that this 20% number exists in other states as well.<sup>309</sup>

Thus, fourth, Minnesota community benefit reformers should base minimum community benefit requirements on current levels of community benefit giving to ensure the best compliance and highest increase in community benefits. Structuring the Minnesota community benefit requirements this way will avoid the pitfall of mass decrease in charity care, as illustrated by Texas. When setting a local or a national threshold, it will be key to take into account current levels of community benefits in order to prevent overall levels from decreasing with the institution of a minimum level. In Minnesota in 2015, nonprofit hospitals dedicated an average of 6.2% of their total operating expenses to community benefits.<sup>310</sup> Thus, any minimum threshold would have to take that average into account when considering what minimum threshold would adequately incentivize Minnesota nonprofit hospitals to offer community benefits commensurate with their tax exemptions.

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306. Fred Joseph Hellinger, *Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements*, 34 J. HEALTH POL. POL'Y & L. 37, 56 (2009).

307. See, e.g., Valdovinos et al., *supra* note 163, at 1302.

308. Frances A. Kennedy, Laurie L. Burney, Jennifer L. Troyer & J. Caleb Stroup, *Do Non-Profit Hospitals Provide More Charity Care When Faced with a Mandatory Minimum Standard? Evidence from Texas*, 29 J. ACCT. & PUB. POL'Y 242, 253 (2010).

309. Michael A. Morrissey, Gerald J. Wedig & Mahmud Hassan, *Do Nonprofit Hospitals Pay Their Way?*, 15 HEALTH AFFS. 132, 133, 142 (1996).

310. MINN. DEP'T OF HEALTH, HOSPITAL COMMUNITY BENEFIT SPENDING IN MINNESOTA, 2013 TO 2015, at 8 (2018).

Further, it makes sense for Minnesota reformers to implement state-level regulations instead of aiming at a national standard.<sup>311</sup> Both the Minnesota Attorney General<sup>312</sup> and Minnesota Department of Health<sup>313</sup> are already involved in efforts to reform and report on community benefit spending in Minnesota, so they would be the best parties to administer state-level regulations. Additionally, enforcement at a national level would be more complicated than at a state level and could paint local needs with too uniform of a national brush. Current IRS enforcement options are limited to: (1) do nothing, or (2) move to revoke the hospital's tax-exempt status.<sup>314</sup> Something like intermediate sanctions would likely increase the effectiveness of this proposal, as they would allow for accountability and flexibility.<sup>315</sup>

Thus, Minnesota should institute a minimum level of community benefits that nonprofit hospitals must provide in order to be exempt from state and local taxes. This minimum level should be modeled on existing successful state laws, should offer multiple options to fit different nonprofit hospitals, should be strict and specific to ensure the best compliance, and should be set at a level that adequately incentivizes Minnesota nonprofit hospitals to offer community benefits at levels commensurate with the value of the tax exemption that they receive.

In summation, Minnesota should take note of the work that states are already doing to encourage nonprofit hospitals to provide higher levels of charity care and community benefits in return for their tax exemptions. Reformers should look closely at the specific elements that are considered to benefit communities in order to ensure that they actually help the communities that surround nonprofit hospitals.

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311. For a more detailed proposal for a federal standard implemented by the IRS, see Kim Simmons, Note, *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 (2019).

312. See generally HILLTOP INST., COMMUNITY BENEFIT STATE LAW PROFILE: MINNESOTA (2016), [https://hilltopinstitute.org/wp-content/uploads/hcbp/hcbp\\_docs/HCBP\\_CBL\\_MN.pdf](https://hilltopinstitute.org/wp-content/uploads/hcbp/hcbp_docs/HCBP_CBL_MN.pdf) [<https://perma.cc/H69L-63JA>] (discussing the Minnesota Attorney General's voluntary community benefit requirements with state nonprofit hospitals).

313. See generally MINN. DEP'T OF HEALTH, *supra* note 120 (detailing the Minnesota Department of Health legislature-directed studies on community benefits).

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

315. Rachel Weisblatt, *Uncharitable Hospitals: Why the IRS Needs Intermediate Sanctions To Regulate Tax-Exempt Hospitals*, 55 B.C. L. REV. 687, 708-09 (2014).

A good place to start is reforming the amounts that hospitals can claim in Medicaid shortfall and shortfalls for other means-tested programs by changing the calculation to reflect the discrepancy between generally billed amounts and Medicaid payments, not hospital list prices, which few patients actually pay.

Minnesota should also look to impose measures like the ones already in existence in other states to make sure that nonprofit hospitals are giving back to their communities at levels commensurate with the goal of the community benefit standard. These measures should be flexible to accommodate the diversity of nonprofit hospitals that exist in the state, set at a proper level to facilitate increases in community benefits, and be specific and strict enough to encourage close adherence. If these steps are implemented, Minnesota nonprofit hospitals will begin to rebuild the trust between them and their communities through increased provision of community benefits.

#### CONCLUSION

The inequities inherent in the tax exemptions that the United States gives to nonprofit hospitals are well documented. The historical roots of community benefits, uncompensated care, and charity care illuminate how the nature of health care has changed while tax exemptions for nonprofit hospitals have not evolved in turn. Because of the inequitable distribution of all three types of giving back to the community, a solution is needed to compensate states and localities for the taxes that they forego to nonprofit hospitals, while not hurting the hospitals that are giving significant amounts of free care to needy communities. Changing the way that Minnesota nonprofit hospitals calculate Medicaid shortfalls as community benefits and instituting a mandatory minimum amount of community benefits will ensure that nonprofit hospitals are more deserving of their tax exemptions and that their actions truly benefit the communities they call home.