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Note

HOSPITAL TAX-EXEMPTION AND THE COMMUNITY BENEFIT STANDARD: CONSIDERATIONS FOR FUTURE POLICYMAKING

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*366 I. Introduction

The Boston Globe recently reported that in 2007, ten of Massachusetts' leading hospital companies received approximately $638 million in tax incentives and state borrowing discounts, exceeding the value of “community benefits” (i.e., indigent care and other charity work) they provided by more than $264 million that same year. [1] Without further analysis, this discrepancy appears at odds with a general principle of nonprofit tax-exemption; specifically, that “the government's loss of tax revenues is

offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare." [2] However, during this same year the largest of these companies provided care to Medicare patients at a loss of approximately $400 million, care to Medicaid patients at a loss of nearly $145 million, and care to self-pay patients at a loss of over $40 million. [3] Additionally, the company continues to invest significant resources in community-based partnerships aimed at addressing health disparities; programs that improve the health of women through emergency shelter, social support, and educational opportunities; community workforce development programs; and services for homeless adults and veterans. [4] Should these unreimbursed costs and other community services be considered as part of the tax-exemption calculus? If so, to what extent? Certainly not limited to Massachusetts, this question continues to spur significant debate over the extent to which nonprofit hospitals "deserve" their tax-exempt status.

A. The Issue

The issue of hospital tax-exemption is particularly important given the over 50 million citizens without health insurance in the United States. [5] Historically, the uninsured have relied on the charity of private hospitals (i.e., not government owned) for care. [6] These private hospitals are largely nonprofit; ***367** in fact, "[o]f the 630,000 beds in Medicare-certified community hospitals in the United States in 2003, 68 percent were located in nonprofit hospitals, 16 percent were located in for-profit hospitals, and 15 percent were located in government (nonfederal) facilities." [7] Moreover, the American Hospital Association notes that there are over 5,700 hospitals in the United States, more than 2,900 of which are nonprofit, non-governmental facilities. [8] Given both shrinking reimbursement by government and private payers, and increasingly competitive markets, the cost of unreimbursed care continues to mount and nonprofit hospitals are finding it more difficult to cross-subsidize indigent care (i.e., charity care) using revenues garnered from paying patients. [9] As such, a perception exists that many nonprofit hospitals do not warrant their tax-exempt status, since their direct charity care figures do not equal the financial benefit these entities receive from said exemption.

B. Roadmap

This note does not purport to analyze or recommend new constructs upon which charitable exemption should be based; rather, it offers a pragmatic discussion of elements that should be included when considering tax-exemption as applied to nonprofit hospitals. To facilitate such a discussion, Part II addresses the evolution of tax-exemption for nonprofit hospitals, criticism of the current standard, as well as State, Internal Revenue Service ("IRS"), and Congressional responses to the issue. Part III suggests that any future standard should exclude a mandatory charity care percentage, yet include bad debt, the unreimbursed cost of Medicare, and hospital "community-building" activities. Finally, Part IV recommends that the locus of control for defining the standard should remain with the IRS.

*368 II. Background

A. Evolution of the Community Benefit Standard

1. The Early Years

The history of American hospital tax-exemption has been widely addressed in legal scholarship. [10] Hospitals are not per se tax-exempt under the Internal Revenue Code, rather receipt of such benefits is grounded in an organization's designation as "charitable" under § 501(c)(3). [11] Generally speaking, qualification for exemption under this section requires that a hospital: 1) be organized and operated exclusively for charitable purposes; 2) not use any part of its net earnings for the benefit of any private person; and 3) adhere to certain statutory limitations regarding legislative lobbying and participation in political campaigns. [12] One might expect these requirements to include the provision of free health care services; however, charitable is a term of art

never expressly defined by Congress. [13] As such, a hospital's nonprofit status under §501(c)(3) was historically dependent upon an IRS finding that it was "engaged in relief of the poor or distressed . . . ." [14]

In 1956, the IRS announced a substantive rule of charitable purpose. [15] Specifically, Revenue Ruling 56-185 permitted nonprofit hospitals to charge patients, but conditioned tax-exemption on the provision of charity care "to the extent of [the hospital's] financial ability." [16] The ruling went on to note that a low charity care record is not dispositive; however, the requirement is not met simply because the hospital expects, but does not receive, full payment for services. [17] Although the Ruling did not provide a formula for assessing a hospital's charity care and the IRS has never taken an official position on how much actual charity care was required, "if a hospital lacked a substantial charity care program, auditing agents almost always recommended denial or revocation of exempt status." [18]

***369** The substantive test established in Revenue Ruling 56-185 remained until 1969, when the IRS announced Revenue Ruling 69-545, presently referred to as the "community benefit standard." [19] Written while Congress was considering Medicare and Medicaid legislation, it has been asserted that this Ruling was a direct response to complaints from the hospital industry that the combination of private insurance and the new public insurance programs would reduce the overall demand for charity care, making it difficult for hospitals to satisfy the IRS's exemption requirement. [20] The new Ruling stated that the general law of charity considered promotion of health a charitable purpose; therefore, "[a] nonprofit organization whose purpose and activity are providing hospital care is promoting health and may . .. qualify as organized and operated in furtherance of a charitable purpose." [21]
Revenue Ruling 69-545 further identified five key factors to be considered when determining whether a hospital qualifies for exemption under section 501(c)(3), namely, does the hospital: (1) operate an emergency room open to all persons regardless of ability to pay; (2) provide care to all persons able to pay directly or through insurance; (3) serve a public interest; (4) maintain an open medical staff; and (5) use surplus revenues to improve the quality of care, facilities, medical training, education, and research. [22] Determinations were to be made after consideration of "all of the relevant facts and circumstances in each case," with the absence of particular factors, or the presence of others, not necessarily being determinative. [23]

2. The Later Years

Academics have suggested that the IRS began to undermine its standard almost immediately after adoption. [24] In 1973, Sound Health Association ("Sound Health"), a "staff model" nonprofit Health Maintenance Organization ("HMO") was denied tax-exemption under section 501(c)(3). [25] Under this model, Sound Health employed salaried clinicians, contracted with secondary providers, and administered nearly all services at ***370** its own clinic. [26] Moreover, it provided services to both members and nonmembers regardless of their ability to pay. [27] Despite this structure and clear Congressional preference for such organizations, [28] a final IRS ruling declared that Sound Health's members would receive preferential treatment and that a prepayment feature for members did not further a public charitable purpose. [29] However, the Tax Court disagreed noting that the provision of medical care is a charitable activity and that the tests applied to determine hospital exemption are relevant to HMOs. [30] The court went on to hold that there was no significant preferential treatment resulting in private benefit to the organization's "insiders," and that membership was "not so limited that the community as a whole [would] not benefit." [31]

In the early 1990s, the IRS challenged the charitable exemption of another HMO, Geisinger Health Plan ("Geisinger"). [32] In contrast to Sound Health, Geisinger was organized as a "contractual model" (meaning it maintained provider contracts with third party health professionals) [33] with a limited charity care program. [34] Hoping to capitalize on these differences, the IRS's arguments were again rejected by the Tax Court, which held that Geisinger's membership was unlimited, provided a community

benefit, and was not operated for private benefit. [35] However, on appeal, the Third Circuit reversed finding the community benefit was limited to Geisinger members "since the requirement of subscribership remain[ed] a condition precedent to any service." [36] In addition, the plan's charity care offering in the form of a subsidized dues program was miniscule and would only cover thirty-five people, as compared to approximately 70,000 paying members. [37]

Almost ten years after the Geisinger decision, the Tax Court heard a series of cases concerning the tax-exempt status of three Intermountain Health Care ("IHC") System subsidiary HMOs. [38] In each case, the Tax Court held against a grant of exemption for failure to provide a community ***371** benefit and specifically highlighted the lack of charity care in the HMO's operations. On appeal, the Tenth Circuit affirmed, noting that IHC provided "virtually no free or below-cost health-care services." [39] Professor John Colombo argues that the position taken by the IRS in Sound Health ran counter to the broad language of Revenue Ruling 69-545, and that "simply providing health care to all paying patients was insufficient to warrant exemption." [40] Moreover, the Third Circuit's decision in Geisinger "signaled that the community benefit test . . . was inadequate to distinguish 'charitable' health care from 'non-charitable' health care." [41] These initial cases, coupled with the subsequent IHC rulings, illustrate that something more like "health care plus," arguably a substantial charity care program, is required. [42]

B. Modern Reaction to the Community Benefit Standard

1. The States Weigh In

State income tax laws largely derive from section 501(c)(3) of the Internal Revenue Code; however, state property and sales tax exemptions typically have their own standards. [43] As such, exemption under the Code does not necessarily entail a state property or sales tax exemption. [44] The former is of great importance to hospitals given that they "are often highly capital-intensive businesses with significant property holdings." [45] While most states have historically recognized nonprofit community hospitals as being exempt from property taxes, [46] a series of cases and legislation beginning in 1985 illustrate a growing concern that nonprofit hospitals are not providing charity care sufficient to meet exemption.

In Utah County v. Intermountain Health Care, Inc., the Utah Supreme Court upheld the exemption revocation of several hospitals, noting they had not "demonstrated any substantial imbalance between the value of the services [provided] and the payments it receives apart from any gifts, donations, or endowments." [47] Specifically, the charity care provided by the hospitals was less than one percent of their gross revenues, and was not intentionally ***372** advertised due to fears that patients would take advantage of it. [48] Several years later, the Texas Legislature passed a law setting financial guidelines for charity care provided by tax-exempt hospitals. [49] Although not as stringent as the Texas guidelines, a number of states have also enacted legislation either mandating or making voluntary hospital community benefit reporting (e.g., California, Idaho, Illinois, Indiana, Maryland, and New York). [50] Most recently, publicity generated by the revocation of two Illinois hospitals' state property tax-exemptions, [51] resulted in draft legislation establishing debt collection regulation and strict charity care requirements. [52] While the latter were eventually withdrawn, they would have imposed an obligation on nonprofit hospitals to provide charity care equal to or greater than eight percent of the hospital's total operating costs. [53]

2. The IRS Takes a Hard Look

In response to calls for increased transparency in the nonprofit sector by Senators Max Baucus and Chuck Grassley, [54] the IRS recently revised Form 990, "the primary mechanism used to monitor exempt organizations' compliance with federal tax law." [55] "[C]hanges include[d] an overhaul of ***373** the 'core form' that captures select information regarding exempt organizations' financial status, governance, staffing, and employee compensation, as well as the creation of several schedules which seek

to standardize reporting for information that had previously been provided through filer-designed attachments." [56] Schedule H of Form 990 in particular will require nonprofit hospitals to provide the IRS with detailed information, using standardized definitions, describing their charitable efforts beginning in 2009 (reporting tax year 2008). [57]
Schedule H is organized into six parts, based in large part on voluntary reporting guidelines originally developed by the Catholic Health Association. [58] Specific reporting sections include: 1) charity care and certain other community benefits; 2) community building activities; 3) bad debt, Medicare, and collection practices; 4) management companies and joint ventures; 5) facility information; and 6) supplemental information. [59] Moreover, Schedule H provides clear standards with respect to the types of activities reportable as community benefit and how such activities should be reported (costs rather than charges). [60] Schedule H does not "provide a bright line standard against which the reported data can be assessed to determine whether the reporting hospital should be tax-exempt or should be taxed." [61]

In addition to revising Form 990, the IRS initiated a Hospital Compliance Project in May 2006 to study community benefit and executive compensation. [62] The project consisted of surveying over 500 nonprofit hospitals, classified by community type, revenue size, as well as health insurance coverage and per capita income of the surrounding area. [63] Several key findings from the report were as follows: 1) the average percentage of total revenues spent on combined community benefit was nine percent; 2) community benefit expenditures were not evenly distributed, as nine percent of the hospitals, mainly large and urban hospitals, reported sixty percent ***374** of the community benefit expenditures; 3) uncompensated care was the largest component of community benefit at fifty-six percent, and was greatest for critical access, rural, and small hospitals; 4) medical education and training expenditures represented twenty-three percent of the community benefit, research expenditures represented fifteen percent, and community programs six percent; and 5) aggregate profit margin was five percent, with twenty-one percent of hospitals reporting a deficit. [64] However, the study was not without its limitations given that the data were not independently verified, [65] and the IRS did not limit what could be included within a reportable category. [66] As such, expenditures reported by some hospitals may overstate what will actually be reported on the upcoming Schedule H, due to their inclusion of uncompensated care as charges, bad debt, Medicare shortfalls, and private insurance shortfalls. [67]

3. Congress Takes Aim

The community benefit standard has come under increased scrutiny by federal lawmakers in recent years. Beginning in 2004, the Subcommittee on Oversight of the House Ways and Means Committee held hearings on hospital pricing, which included discussions related to charity care and the differences in services offered by nonprofit versus for-profit hospitals. [68] A year later, the full Committee held hearings specifically related to nonprofit hospital tax-exemption, [69] which subsequently resulted in two research reports by the Congressional Budget Office entitled, Nonprofit Hospitals and the Provision of Community Benefits and Nonprofit Hospitals and Tax Arbitrage. The former addresses the type and amount of community benefit provided by nonprofit hospitals, [70] while the latter examines the use of tax-exempt bonds by nonprofit hospitals. [71] Despite this interest by the House Committee on Ways and Means, Senator Chuck Grassley, ranking member of the Senate Finance Committee, has been the most vocal in his concern that nonprofits may not be deserving of their tax-exempt status.

***375** In May 2005, Senator Grassley conducted an inquiry into nonprofit hospital charity care policies, compensation policies, and types of community benefit provided, by sending letters to ten of the largest U.S. nonprofit hospitals requesting that they account for their charitable activities in light of their tax-exempt status. [72] Results of Senator Grassley's survey demonstrated that nonprofit hospitals generally have no consistent methodology for measuring community benefit. [73] As a result, the Senator sought a staff report to aid Finance Committee members in the development of proposals to address the issue. [74] The staff report was released in July 2007 and recommended development of specific standards for hospitals seeking exemption under section

501(c)(3) including, but not limited to, quantitative standards for charity care; limitations on charges billed to uninsured patients; transparency and accountability requirements; and sanctions for failure to comply with requirements under the Section. [75]

In May 2009, pursuant to the Senate Finance Committee's efforts to develop health care reform legislation, Committee Chairman Senator Max Baucus and Senator Grassley distributed a number of policy options for the Committee's consideration. [76] Among the options proposed was a recommendation to "codify organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of section 501(c)(3) tax-exempt status." [77] Specifically, hospitals would be required to: 1) conduct regular community needs assessments; 2) meet minimum charity care levels; 3) provide services regardless of a patient's inability to pay; and 4) "follow certain procedures before instituting collection actions against patients." [78] Exemptions would be allowed for "[c]ertain hospitals that are critical to the communities they serve or which have an independent basis for tax exemption," such as classification as an educational or research organization; however, those not meeting the enumerated requirements would face intermediate sanctions designed to encourage compliance. [79]

***376** On September 22, 2009, the Chairman's Mark was released entitled, America's Healthy Future Act of 2009. [80] The Mark included requirements for community needs assessments, financial assistance policies, charge limitations, collection policies, as well as reporting and disclosure; however, a charity care standard and a broad sanctions scheme were left out. [81] In response, Senator Grassley noted that a mandatory charity percentage requirement would likely "become a ceiling, not a floor" and, therefore, additional study was necessary to devise a formula that maximizes nonprofit hospital expenditures for charitable purposes. [82] According to Steven T. Miller, Commissioner, Tax Exempt and Government Entities at the IRS, "Senator Grassley continues to discuss the possibility of introducing legislation in this area." [83]

III. Moving Forward

A. Why Does the Community Benefit Standard Matter?

A 2006 Congressional Budget Office report estimated that the value of major tax-exemptions provided to nonprofit hospitals through federal, state, and local governments was approximately $12.6 billion in 2002. [84] This figure consists of $2.5 billion in federal corporate income tax-exemptions, $1.8 billion in federal tax-exempt-bond financing, $1.8 billion in charitable contributions (federal), $500 million in state corporate income tax exemptions, $2.8 billion in state and local sales tax exemptions, and $3.1 billion in local property tax exemptions. [85] Moreover, according to recent IRS data concerning public charity tax filings, "nonprofit hospitals accounted for revenues of $451.3 billion (41.6% of total public charity revenues) and assets of $551.6 billion (28.5% of total public charity assets)." [86] Given these figures, it is no surprise that one would question the extent to which nonprofit hospitals are earning their charitable status. Nevertheless, in recent years, legal scholarship [87] and congressional efforts [88] have, for the reasons ***377** explained below, incorrectly suggested legislation aimed at increasing nonprofit hospital responsibility in order to maintain tax-exempt status.

B. Is There Really Any Difference Between Nonprofit and For-Profit Hospitals?

Despite being bound by section 501(c)(3)'s qualifications for tax-exemption, most notably the non-distribution constraint, [89] a perception exists that nonprofit hospitals are no different than their for-profit counterparts, and therefore are undeserving of exemption. As such, numerous studies have considered whether ownership type influences financial performance, patient outcomes, and likelihood of providing certain services.

1. Financial Indicators

In 2006, the National Bureau of Economic Research conducted a meta-analysis of empirical literature investigating the effect of hospital ownership on financial performance (e.g., cost, revenue, profit margin, and efficiency). [90] Their analysis found that diverse results among the literature could be explained largely by "differences in authors' underlying theoretical frameworks, assumptions about the functional form of the dependent variables, and model specifications." [91] Those studies using weaker methods and functional forms tended to predict greater divergence in financial performance among ownership types; however, combined estimates suggested for-profit hospitals generate greater revenue, albeit modest in terms of economic significance, than their nonprofit counterparts. [92] Moreover, a summary of several studies on gross uncompensated care data illustrates little difference between nonprofit and for-profit hospitals, as well as "little difference between pre-and post-conversion levels of charity care in nonprofit to for-profit conversion transactions." [93]

***378 2. Quality Indicators**

Regarding the effect of hospital ownership on quality of care, a vast body of literature provides conflicting evidence. [94] Based on a quantitative review of studies conducted since 1990, researchers indicate that divergent results are largely based on analytic methods. [95] Specifically, study features such as "disease or outcome studied, whether or not the study adjusted for patient comorbidities, and data sources" tend to explain the differences among attempts to compare patient outcomes between nonprofit and for-profit hospitals. [96] Moreover, researchers "found no systematic differences in estimated ownership effects between studies that did and did not examine ownership conversions," and "regions covered explained little of the variation in studies of patient outcomes . . . ." [97]

3. Behavioral Indicators

An article by Professor Jill Horwitz demonstrates that, "hospital types differ in their provision of medical services because they are more or less profit-seeking . . . ." [98] In other words, hospitals provide services based on their overall goals and objectives. With respect to consistently profitable services such as open-heart surgery, for-profits are more likely than nonprofits to offer such services. [99] For consistently unprofitable services, such as psychiatric emergency care, data illustrate the exact opposite, in that for-profits are less likely than nonprofits to provide such services. [100] Finally, concerning services with variable profitability such as home health care, "for-profit responsiveness to financial incentives is strong and quick--likely because for-profits are relatively more profit-seeking . . . ." [101] Criticism is often leveled at nonprofit hospitals for this type of market behavior, as if they are undeserving of their tax-exempt status "merely because the market requires that sound business strategies be employed by all entities seeking to survive, if not thrive." [102]

***379 4. Implications**

The above assessment demonstrates that traditional measures of comparison show little difference between for-profit and nonprofit hospitals. However, managerial behaviors have been shown to differ. [103] For example, nonprofit hospitals may be more likely to cross-subsidize unprofitable services, thereby improving access in their communities. These behavioral indicators not only demonstrate commitment to a purpose far more beneficent than simply the "promotion of health" as proscribed in Revenue Ruling 69-545, [104] they also provide substantial support to justify nonprofit hospitals' "deservedness" of tax-exempt status.

C. Mandatory Charity Care Percentages

As discussed in Part II, the IRS and the Tax Court have implicitly required something more than the broad dictates of Revenue Ruling 69-545, something akin to "health care plus" as described by Professor Colombo. [105] Moreover, several states have

enacted legislation requiring hospitals to provide fixed percentages of charity care. [106] While credible arguments exist to support such a requirement, [107] this theory of tax-exemption is wrong for a number of reasons.

First, an underlying rationale for awarding a hospital tax-exempt status is to relieve the government of a financial burden that would otherwise require the appropriation of public funds. [108] This purpose should not presume that free care be the basis of exemption, as community health can be promoted through any number of activities. Expressed another way, solely focusing on the amount of charity care provided by a hospital "bears no logical relationship to the needs of a particular community." [109] For example, ***380** suppose Hospital A spends $20 million dollars providing free care to indigent patients, and Hospital B spends $20 million dollars subsidizing a burn unit and emergency mental health services. While the benefit of free care may be directly observable, assessing the absolute value of cross-subsidized service cannot easily be determined (e.g., Hospital B may be located in a community where access to a burn unit or emergency mental health services is compromised due to geographic availability.).

Second, requiring a fixed amount of charity care may excessively burden smaller or independent hospitals located in rural or lower socio-economic areas. [110] For example, disproportionate share hospitals may already face heightened financial risk given the number of indigent patients they care for. [111] Were these facilities mandated to provide a larger percentage of charity care, many would struggle further, or perhaps be forced to close. [112] By contrast, multi-hospital systems may be able to avoid community benefit disclosure at individual hospitals by reporting community benefit at an aggregate level, which makes it difficult to determine the amount of charity care provided to particular communities, [113] and may even conceal lower levels of charity care provided in more affluent settings. [114]

Finally, as the IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report illustrates, there is no consistently applied formula used by hospitals to assess their community benefit activities. [115] Even in states where community benefit reporting has been made mandatory, requirements vary. [116] While the new IRS Form 990 will allow for collection of this information using a standard set of definitions, significant "methodological concerns remain that may influence the analytic value and comparability" of this information. [117] Specifically, differences in provider type (i.e., size, structure, and scope) and variations in cost accounting methods may have direct implications for assessing the provision of charity care. [118]

***381** Concerning differences in provider type, the IRS identifies filing organizations by Employer Identification Number. [119] Data will be reported by multi-hospital systems, as well as individual hospitals, which "will make it difficult to compare activities across various provider types and may complicate efforts to analyze Schedule H filings in concert with other data sources, such as Medicare Cost Reports and Medicaid DSH reporting." [120] While Schedule H eliminates the use of charge-based accounting practices in assessing the value of community benefit, filers continue to have flexibility in determining the cost of services (e.g., cost-to-charge ratios, internal cost accounting systems, etc.). [121] These differences in costing methods "are likely to yield varying estimates of costs and the validity of some approaches may ultimately be disputed." [122]

Given the foregoing reasons, and the fact that the IRS has historically avoided a mechanical formula for determining whether a nonprofit hospital has met its responsibility under the community benefit standard, it is reasonable to assert that a fixed percentage requirement for charity care could not presently be applied consistently across the industry.

D. Medicare Shortfall, Bad Debt, and Community-Building Activities

1. The Current State of Affairs

The community benefit standard allows nonprofit hospitals some degree of latitude in determining what services and activities constitute community benefit. As a result, significant variation exists in the type and amount of benefits reported. [123] The U.S. Government Accountability Office ("GAO") recently reviewed guidance provided to nonprofit hospitals from five sources, including government agencies (i.e., Centers for Medicare & Medicaid Services) and health care industry groups (i.e., the American Hospital Association, the Catholic Health Association, VHA (formerly Voluntary Hospitals of America), and the Healthcare Financial Management Association). [124] The GAO's review found that consensus existed among sources to include charity care, the unreimbursed cost of Medicaid and other means-tested government programs, and the costs associated with a number of "other activities" (e.g., health professions education, medical research, subsidized health services, etc.) in a definition of community ben- ***382** efit. [125] However, debate continues over the inclusion of bad debt, the unreimbursed cost of Medicare, and costs associated with "community building activities" (e.g., housing programs, leadership development for community members, workforce development, etc.) in this definition. [126]

2. Bad Debt & Medicare Shortfall

Bad debt is generally defined as uncollectible patient accounts. [127] For example, if a patient's bill is $5,000, and the hospital only expects to collect $500, the bad debt amount is $4,500. Similarly, the unreimbursed cost of Medicare, referred to as a "shortfall," is defined as the difference between a hospital's cost to care for a Medicare beneficiary and the reimbursement received. [128] For example, if it costs a hospital $5,000 to care for a Medicare patient, yet the diagnosis-related group ("DRG") payment is only $4,500, the shortfall amount is $500. Both bad debt and shortfall are shown on hospital financial statements in an amount equal to the charges being written off. [129] Of the twenty-three states that have enacted mandatory charity care reporting, fifteen allow for reporting of bad debt and/or Medicare shortfall. [130]

Regarding bad debt, the Catholic Healthcare Association ("CHA"), VHA, and the Healthcare Financial Management Association ("HFMA") recommend exclusion of this loss in a definition of community benefit. [131] CHA and VHA maintain that "hospitals have the responsibility to better identify patients eligible for charity care, and thus distinguish charity care from bad debt." [132] Likewise, HFMA encourages hospitals to design charity care policies that provide direction for assessing eligibility when patients provide insufficient information to make a formal determination. [133] In contrast, the American Hospital Association ("AHA") recommends inclusion of bad debt in a definition of community benefit, asserting that low-income patients represent the majority of uncollectible accounts and would qualify for charity care were the appropriate documentation available. [134] The IRS and the Centers for Medicare and Medicaid Services ("CMS") have not taken ***383** a position on the issue; however, both utilize reporting instruments that permit hospitals to estimate the amount of bad debt attributable to low-income patients. [135]

Concerning treatment of Medicare shortfalls, CHA and VHA recommend exclusion of shortfall losses in a definition of community benefit, citing concerns over hospital inefficiency, as opposed to underpayment. [136] Further, because nonprofit and for-profit hospitals compete to attract Medicare patients, service to this population is not a differentiating feature. [137] By comparison, AHA recommends inclusion of shortfall losses in a definition of community benefits citing Medicare's lack of full compensation for hospital costs and the large number of low-income beneficiaries. [138] HFMA recommends that individual hospitals consider their specific financial status when deciding whether to include shortfall losses in a reporting of community benefit. [139] The IRS has not taken a position on the issue; however, Schedule H requires that hospitals report Medicare revenue and cost information separate from traditional community benefit activities, and allows them to explain what portion of these costs they feel should be included as community benefit. [140] Similarly, CMS has not officially taken a position, [141] but it does collect information on hospitals' unreimbursed costs. [142]

a. Bad debt

Inclusion of bad debt in a definition of community benefit is of great significance to nonprofit hospitals given that many report losses in substantial amounts as compared to charity care. [143] Based on 2004 data, hospital-specific bad debt was estimated to be between $26 billion and $30 billion annually, with research suggesting a two to four percent increase in hospitals' bad debt expense, as a percentage of revenue, by 2012. [144] Further, it is often impossible to disentangle bad debt from charity care, as more than ninety percent of hospitals state that at least some portion of their bad debt consists of accounts that could be classified as charity care had the patients ***384** been properly identified. [145] As such, a compromise position exists whereby a lesser amount of bad debt could be included in a nonprofit hospital's accounting of charity care. Moreover, this inclusion could be made contingent upon the provider's adoption of systems to better address "administrative inefficiencies." The following provides two examples of how this lesser amount could be determined, and then considers a number of "payer identification" processes.

(I) Amount determination.

First, bad debt figures could be included in a definition of charity care, calculated as costs rather than charges. Not only does the AHA advocate this position, [146] but also cost information is being requested on Schedule H. [147] This inclusion would alleviate the potential for bias that exists when using charge data to make comparisons among hospitals, particularly those with different payer mixes. [148] For example, comparisons of DRGs across hospitals often show "similar costs per case but different markup rates reflected in their charges." [149] A variety of methods have been used to calculate the true "cost" of hospital services, including total Medicare allowed charges, Medicare payment, and cost-to charge ratios ("CCR"). [150] The latter, favored by most researchers, requires an analysis of hospital cost reports and claims data to determine the relationship between Medicare-allowable costs and hospital charges. [151] While all of the aforementioned methods have limitations, research suggests that departmental CCRs are most representative of a hospital's true cost. [152] These costs could be further limited to "variable costs," as opposed to being calculated on a fully allocated basis, which would include an apportionment of the hospital's "fixed costs." Variable costs represent those costs that change according to output ***385** and are saved if the hospital does not provide a service (e.g., medications, disposable supplies, etc.). [153] Fixed costs represent those costs that do not change according to output, and are not saved if the hospital does not provide a service (e.g., bricks and mortar, equipment, salaried labor costs, etc.). [154] This conservative methodology would ensure the highest degree of credibility, as the majority of hospital service costs are fixed. [155]

Second, the Taxation and Health Law Sections of the American Bar Association ("ABA") note that separation of charity care from bad debt is often problematic due to audit guidelines, which may be interpreted to require proof of charity care eligibility that is impractical for hospitals to produce. [156] For example, a poor patient presenting in an emergency department is not always in a position to provide income or asset documentation sufficient to determine his or her eligibility for charity care, nor does this patient have incentive to do so after receiving treatment. [157] Therefore, the ABA recommends that the IRS consider a flexible standard that allows hospitals to "recognize the amount of charity care they have provided which, after reasonable efforts, cannot be documented with certainty as charity care without unreasonable cost." [158] One such method would be to presumptively include a percentage of bad debt that corresponds to the number of persons within a hospital's service area that might generally be eligible for free care based on the hospital's charity care policy. [159]

(II) Improved processes.

Initially, nonprofit hospitals could be required to adopt and publish charity care policies in accordance with IRS-devised guidelines. While no single "approved" model exists, a number of recommendations have been made both within and without

government. [160] For example, the Senate Finance ***386** Committee staff has recommended a minimum eligibility threshold of less than one hundred percent of the federal poverty level, citing the percentage as "a common standard for nonprofit hospitals." [161] In addition, they suggested extensive publication of charity policies, written in plain English and in multiple languages as necessary within a community. [162] More recently, HFMA published a "model" policy that did not mandate a specific minimum eligibility threshold, but suggested services be made available on a sliding fee scale according to financial need, using federal poverty guidelines. [163] The policy further recommended an application process considering patients' personal and financial information; the use of credit scoring or other publicly available data to determine ability to pay; the use of reasonable efforts to determine alternative public or private funding; consideration of patients' available assets and other available resources; and review of the patients' outstanding accounts receivable and payment history. [164] A number of other "presumptive financial assistance" criteria (e.g., food stamp eligibility, residence in low income/subsidized housing, etc.) are also recommended when supporting documentation is insufficient. [165]

Next, adoption of HFMA Principles and Practices Board Statement 15, "which provides instructions for record keeping, valuation, and disclosure of charity care and bad debts on audited financial statements," [166] could allow nonprofit hospitals to better distinguish between charity care and bad debt. Board Statement 15 exists as a sample policy for presumptively enrolling patients in hospital charity-care programs [167] and revised Form 990 requests information regarding whether hospitals have adopted the Statement. [168] This consistency makes it more likely that nonprofit hospitals will begin to adopt the Statement as a "best practice" standard for accounting and reporting uncompensated care.

Finally, hospitals could begin referring to "external sources, such as zip codes in conjunction with per-capita income data, credit reports, and migrant worker status," in making charity care determinations; a practice that may help estimate the portion of bad debt more accurately attributed to charity care. [169] As an example, BJC HealthCare recently conducted an extensive analysis of zip code data and found that two-thirds ($85 million) of ***387** its $125 million in bad debt was attributed to patients that would have been eligible for charity care under the organization's existing policy, raising the system's total community benefit (as a percentage of overall expenses) nearly three percent. [170] Many facilities are also using screening software, directly integrated with existing information systems, to determine self-pay patients' eligibility for charity or public funding upon admission or after scheduling. [171] Features range from eligibility verification and bill estimation, to identification of alterative sources of financial assistance and enhanced third-party payer connectivity. However, these applications can require significant investment in information technology, and may not be realistic options for all facilities. [172]

b. Medicare shortfall.

Although participation in Medicare is voluntary, caring for Medicare beneficiaries is a condition for tax-exemption under Revenue Ruling 69-645, [173] and very few hospitals can elect not to participate in the public program given the large percentage of care provided to older patients. [174] These considerations make clear why inclusion of Medicare shortfall in a definition of community benefit is of great importance to nonprofit hospitals. Again, a compromise position exists, whereby a lesser amount of Medicare shortfall could be included in a nonprofit hospital's accounting of charity care, expressed as variable and/or fixed costs, rather than charges. [175] Several practical arguments militate in favor of this position.

Foremost, Medicare was not designed as a complete benefit. Beneficiaries are responsible for deductibles, coinsurance, and copayments under "Part A" (i.e., inpatient hospital coverage), [176] and monthly premiums, annual deductibles, and coinsurance for most services under "Part B" (i.e., physician and outpatient coverage). [177] As the program has no limit on beneficiaries' coinsurance responsibility, those with chronic health conditions ***388** or high medical costs can be subject to major cost-sharing expenses. [178] Given these requirements and limitations on benefits, nearly half of Medicare beneficiaries' health care

costs go uncovered. [179] This has led the Taxation and Health Law Sections of the ABA to acknowledge the position that a hospital's entire Medicare shortfall could count as charity care, given the "elderly constitute a clearly-recognized charitable class." [180] Moreover, the AHA has stated that because many Medicare beneficiaries are of limited means, they would likely qualify for a hospital's charity care program. [181] These positions are reinforced by the nearly 8.8 million Medicare beneficiaries designated "dual-eligible" for Medicaid. [182]

Additionally, Medicare payment rates "are set by law rather than through a negotiation process as with private insurers." [183] Specifically, the Medicare Payment Advisory Commission ("MedPAC") makes annual payment update recommendations to Congress. [184] This update considers both provider-specific factors (e.g., adequacy of current payments, impact of scheduled policy changes, and anticipated changes in provider costs), as well as the "perspective of the economy-wide gains achieved by the firms and workers who pay taxes that fund Medicare." [185] While MedPAC's use of fixed payments in consideration of the taxpayer's burden is noble, the inability to negotiate reimbursement rates leaves hospitals ill-equipped to respond to budget deficits brought on by changes in patient demand, staffing, etc. [186]

Between 2000 and 2008, Medicare payments also fell significantly relative to costs, and underpayments to hospitals rose from $1.3 billion to $22 billion. [187] As a result of this increasing burden, the nationally recognized ***389** Mayo Clinic has implemented a two-year pilot program to assess the financial effect of not accepting Medicare patients. [188] While MedPAC asserts that annual reimbursement updates provide enough funding to cover the costs of an efficient provider, [189] aggregate Medicare margins (payments less costs, expressed as a percentage of payments) [190] have reached a ten-year low, dropping from 6.3% in 1999, to-6.9% in 2009. [191] In response, MedPAC states that hospitals facing financial pressure remain able to constrain costs, and that "[o]ver time, aggregate hospital cost growth has moved in parallel with margins on private-payer patients." [192] That being said, MedPAC's arguments do not, by themselves, necessitate exclusion of shortfalls in a definition of charity care.

Finally, CHA has suggested that the provision of services to Medicare beneficiaries is not a factor that differentiates nonprofit hospitals from their for-profit counterparts; as such, the former should not include Medicare losses in a definition of community benefit. [193] However, this position ignores two key arguments. First, nonprofit hospitals are required to serve Medicare beneficiaries as a condition of tax-exemption, [194] whereas for-profit hospitals may elect not to participate in the program. [195] Second, Professor Horwitz's research on managerial behaviors and their impact on access are illustrative of the differences in ownership types; namely, nonprofit hospitals are more likely to provide certain community services regardless of their profitability. [196] These motivations should be highlighted and rewarded, despite the fact that for-profit hospitals voluntarily choose to provide services to Medicare patients.

***390 3. Community-Building Activities**

Although there is a general consensus within the industry to define community-building activities as "community benefit," the IRS has not yet taken a position. [197] However Schedule H does allow hospitals to report a number of community building activities (physical improvements and housing; economic development; community support; environmental improvements; leadership development and training for community members; coalition building; community health improvement advocacy; and workforce development). [198] Despite the IRS's need for additional data on the impact of community building activities, [199] and suggestions that these activities "represent a relatively small proportion of total operating expenses for hospitals," [200] hospital efforts in this area should not only be included in a definition of community benefit, they should be recognized, rewarded, and encouraged.

First, organizations "created to aid low and moderate income families by lessening neighborhood tensions, eliminating prejudice and discrimination, and combating community deterioration may qualify for exemption under section 501(c)(3) of the [Internal Revenue] Code." [201] Such organizations might include those formed to develop home construction or renovation programs for sale to low-income families; ameliorate the housing needs of minority groups; or formulate plans to combat neighborhood blight within a particular area in a city. [202] Given that the aforementioned community building activities are encouraged by the Code's tax-exemption scheme, it seems reasonable to argue that they should be deemed charitable regardless of the providers' underlying organizational purpose.

Second, a significant body of research exists demonstrating that social determinants can be responsible for systematic disparities in health across diverse populations. [203] Social determinants are generally defined as "factors in the social environment that influence health . . . [including] income ***391** distribution, discrimination, access to education, and housing policies." [204] More broadly, they represent "the conditions in which people are born, grow, live, work and age . . .." [205] To illustrate the extent of these disparities, there would have been 886,202 fewer deaths in the United States between 1991 and 2000 if African-American and Caucasian mortality rates were equalized. [206] In contrast, medical advances saved only 176,633 lives during this same period. [207] While countless others could be provided, this example is indicative of the notion that traditional interventions alone have not sufficiently addressed the root causes of morbidity and mortality.

An emphasis on social determinants of health is not a new phenomenon. In 1974, Canada's Minister of National Health and Welfare suggested that health status could be improved by addressing conditions outside of the traditional health delivery system (i.e., environmental and behavioral threats to health). [208] Several years later, Great Britain's Department of Health and Social Security published a report that called attention to persisting health inequalities among Britain's fully insured population. [209] The controversial [210] "Black Report" suggested these differences were attributable to social inequalities influencing health, and recommended broad policy measures in response. [211] In 2005, the World Health Organization established a Commission on the Social Determinants of Health to collect evidence and to present strategies for the promotion of health equity. [212] The Commission's final report, published in 2008, recommended a number of policies to improve living conditions; address the inequitable distribution of power, money and resources; and establish effective measurements to further understand the problem and assess the impact of improvement efforts. [213]

***392** In the United States, the Department of Health and Human Services ("HHS") published Healthy People 2000, and later Healthy People 2010, a national health promotion and disease prevention agenda. The latter's objectives focus on health determinants that "encompass the combined effects of individual and community physical and social environments and the policies and interventions used to promote health, prevent disease, and ensure access to quality health care." [214] To accomplish these objectives, HHS emphasizes the use of community building activities. Specifically, activities aimed at addressing a physical environment may target either tangible (e.g., physical hazards in schools or worksites) or intangible (e.g., radiation, ozone, etc.) problems, while those aimed at addressing a social environment may target interpersonal interactions within the community, interactions with social institutions, and other broad areas such as housing, public transportation, and violence in the community. [215]

At least one critic has suggested that additional studies are required to determine the exact correlation between mortality and inequality before establishing new policies. [216] However, it is impossible to deny the existence of health disparities and the role that social determinants play in their creation and exacerbation. This position is further supported by the attention social determinants have received both nationally and internationally. Given the extent to which many nonprofit hospitals are integrated into the social fabric of their communities, they are in a unique position to actively engage in community building. As

such, it is reasonable to include costs associated with these labors in a definition of community benefit, despite their generally being considered non-health related charitable activities.

IV. Maintaining IRS Control

Although critics will likely cite the IRS's troubled past, which has been thoroughly documented elsewhere, [217] the Agency is in the best position ***393** to define a modern community benefit standard. First, the IRS has a number of tools to achieve its policymaking objectives. Specifically, it may issue: 1) regulations pursuant to Congressional directive (i.e., formal rulemaking pursuant to the Administrative Procedure Act); 2) regulations under the IRS's general authority to interpret the Code (i.e., informal rulemaking); 3) revenue rulings (i.e., interpretive rules); and 4) private letter rulings applicable only to the requesting party. [218] Each of the aforementioned stem from different authority, are issued according to different processes, warrant different standards of judicial deference and, as a result, differ in their degree of applicability and binding effect. [219] The ability to rely on such an assortment of alternatives allows the IRS to quickly and practically adjust to varying situations, as opposed to waiting on the legislature to reform an unwieldy rule.

In addition, IRS administrators are more likely to have the most sophisticated understanding of complicated tax issues and be in a better position to gather objective information in a less costly manner, as compared to Congress. [220] For example, the Federal Advisory Committee Act ("FACA") requires that nongovernmental entities providing policy advice to an agency be chartered as a federal advisory committee. [221] This adds further transparency to agency policymaking, as committees are responsible for holding public meetings, providing advanced public notice of meetings, recording minutes, making documents relied upon in rendering advice publicly available, and making the product of their work publicly available. [222] Moreover, committees' membership must be "fairly balanced in terms of the points of view represented" and provisions must be established to assure that recommendations are not inappropriately influenced by any special interest. [223] As such, the FACA insulates federal "agencies politically by providing an external, ***394** neutral source of expert policy recommendations that can be difficult for legislators and interest groups to ignore or discredit." [224]

Finally, the flexibility and expertise outlined above is particularly important given legitimate concerns over the quality of Schedule H data, especially in early reporting years. While data is expected in late 2010, the need for aggregation may delay its use, and methodological concerns may complicate meaningful comparisons between providers. [225] In contrast to the IRS, several institutional features make Congress "ill-suited to engage in the experimental, adaptive, trial-and-error approach to policymaking" [226] that may be required to make effective use of this data as it becomes available. Specifically, legislative resources are limited, making continuous monitoring of policymaking difficult. [227] Moreover, revision of legislative policies can be difficult given the need for a congressional majority, as well as "numerous gate keepers and veto-points." [228] As a safeguard, should Congress disapprove of the IRS's policies, it is not without the means to: 1) monitor IRS action through oversight, "watch-dog" committees, or formal investigations; 2) express disapproval of IRS action by denying or reducing appropriations; or 3) amend the current tax code or enact new legislation. [229]

V. Conclusion

Given declining reimbursement and increasingly competitive markets, hospitals will continue to report charity care figures in amounts less than the aggregate tax benefit they receive. Subsequently, many observers will persist in the belief that these hospitals are not meeting their obligation under § 501(c)(3). However, this perception is oversimplified, as the IRS standard for determining hospital tax-exempt status is conditioned upon a community benefit requirement, rather than the provision of free care. While subject to significant criticism by State and Federal lawmakers, and arguably subversion by the IRS and the Tax Court, the broad nature of this standard is perhaps its greatest asset. Not only are hospitals in the best position to assess the needs of their communities, such a standard is also practical given the manner in which the U.S. health care system is

financed. ***395** Therefore, in the event that policymakers elect to revise the tax-exemption standard for hospitals, the following considerations are recommended.

First, the standard should exclude fixed charity care percentages, as charity care bears no logical relationship to community need. Such percentages would have a disproportionate effect on certain facilities, and limited information exists to establish a fair formula for assessing community benefit overall. Second, the standard should include bad debt and the unreimbursed cost of Medicare, provided hospitals report such figures as variable costs and adopt improved processes to better identify patients eligible for charity care. Third, the standard should include and encourage community-building activities, as they are already favored under the Code, and they directly address social determinants of health, which is critical to improving population health and addressing growing health disparities. Finally, any future revisions of the community benefit standard should be left to the discretion of the IRS, given its ability to rely on an assortment of policymaking alternatives, as well as expertise both within and without the Agency.

Despite having ended in mid-2009, the economic recession that began two years ago will likely stifle economic growth over the next several years. [230] This economic challenge is not lost on the health care industry, as Moody's Investors Service reports that the nonprofit health care sector outlook remains negative, and that "hospitals face 'one of the toughest environments in decades"' due to "the federal budget deficit; struggling state budgets; weak employer-sponsored insurance and the nation's unemployment rate . . . ." [231] In addition to this grim economic picture, a recent CMS memorandum failed to provide much hope for hospital finances should the current iteration of health care reform legislation, the Patient Protection and Affordable Care Act ("PPACA"), [232] be enacted. [233] All of these factors, ***396** coupled with significant increases in health care spending projected through 2019, [234] suggest that the issue of nonprofit hospital tax-exemption will remain increasingly relevant and be further scrutinized by lawmakers, industry groups, patient advocates, and the media for years to come.

VI. Addendum

On March 23, 2010, President Barack Obama signed into law the PPACA, [235] which along with the Health Care and Education Reconciliation Act of 2010, [236] signed just seven days later, represents the most comprehensive health care legislation in over forty years. Though largely "health insurance reform" in that it seeks to improve access and affordability, the PPACA amends section 501(c)(3) to require that nonprofit hospitals: 1) conduct a community health needs assessment every three years; 2) maintain a written financial assistance policy; 3) limit charges for emergency care provided to patients eligible for financial assistance so as not to exceed the amount charged to patients with insurance; and 4) make reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in extraordinary collection actions. [237] Hospitals failing to comply with the new requirements may be subject to a $50,000 penalty. [238]

Perhaps more notable, the PPACA mandates that the Secretary of the Treasury and the Secretary of HHS "submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report" that includes information on all hospitals (i.e., nonprofit, for-profit, and government owned) regarding charity care, bad debt, and the unreimbursed cost of Medicaid and Medicare. [239] The Secretaries must also conduct a study on costs associated with nonprofit hospitals' community benefit activities, and provide ***397** an additional report, no later than 2015. [240] Clearly, the PPACA demonstrates Congress' concern with community benefit accountability; however, it also reveals a reluctance to approach the issue in an uncompromising manner (i.e., fixed charity care requirements) and a desire to defer to the expertise of the Department of Treasury and HHS.

Footnotes

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20 Colombo, supra note 18, at 30-31.

21 Rev. Rul. 69-545, 1969-2 C.B. 117, available at http:// www.irs.gov/pub/irs-tege/rr69-545.pdf.

22 Id.

23 Id.

24 See generally Colombo, supra note 18; Mancino, supra note 6.

25 Sound Health Ass'n v. Comm'r, 71 T.C. 158, 172 (T.C. 1978) (In 1973, Sound Health opened its clinic to nonmembers on a fee-for-service basis, and began providing emergency services without regard to the patient's ability to pay. Moreover, Sound Health initiated a subsidy program for nonmembers who failed to meet Medicaid's minimum income requirements, yet still could not afford the Association's dues.).

26 Id.

27 Id.

28 See Health Maintenance Organization Act of 1973, Pub. L. No. 93-222 (codified as amended at 42 U.S.C. § 300e (2006)).

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33 Peter R. Kongstvedt, The Managed Health Care Handbook 38 (Aspen Publishers, 4th ed. 2001) (1985).

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46 Id. at 440.

47 Utah Cnty. By and Through Cnty. Bd. of Equalization v. Intermountain Health Care, Inc., 709 P.2d 265, 274 (Utah 1985) (alteration in original).

48 Id.

49 Colombo, supra note 43, at 442. See also Tex. Health & Safety Code Ann. §§ 311.041-311.048 (West 2010).

50 Cal. Health & Safety Code §§ 127350, 127355 (Deering 2010), Idaho Code Ann. § 63-602D (2010); 210 Ill. Comp. Stat. Ann. 76/15, 76/20 (LexisNexis 2010); Ind. Code Ann. §§ 16-21-9-4-16-21-0-7 (LexisNexis 2010); Md. Code Ann., Health-Gen. § 19-303 (LexisNexis 2010); N.H. Rev. Stat. Ann. §§ 7:32-e-7:32-g (LexisNexis 2010); N.Y. Pub. Health Law § 2803-l (Consul. 2010).

51 In 2004, the Champaign, Illinois County Board of Review recommended revocation of property tax-exemption for Provena Covenant Medical Center in Urbana, Illinois. The Board made a similar recommendation in 2005 for Carle Hospital in Urbana. In both cases, the Board found that the hospitals failed to meet their charity-care obligations. Specifically, both were: 1) charging uninsured patients two to five times what insured patients were charged for the same services; 2) using aggressive collection practices, which included suing patients; 3) providing limited charity care (less than one half of one percent of total revenues in one case); and 4) involved in intimate business relationships with directly related for-profit entities. Provena's exemption was eventually revoked by the Illinois Department of Revenue, a decision that was upheld on appeal to the Illinois Supreme Court. See generally Provena Covenant Med. Ctr. v. Dep't of Revenue, 925 N.E.2d 1131 (Ill. 2010); Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways and Means, 109th Cong., 92-98 (May 26, 2005) (statement of Stan Jenkins, Chairman, Champaign County Board of Review) available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_house_hearings&docid=f:26414.pdf; John Colombo, Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps, 37 Loy. U. Chi. L.J. 493 (2006).

52 See H.R. 5000, 94th Gen. Assem., Reg. Sess. (Ill. 2006); H.R. 4999, 94th Gen. Assem., Reg. Sess. (Ill. 2006).

53 Colombo, supra note 43, at 444.

54 See Press Release, Sen. Grassley Works to Build Confidence in Nonprofits with Greater Transparency (May 29, 2007), available at http:// grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=12581.

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69 See generally Hearing on the Tax-Exempt Hospital Sector Before the H. Comm. on Ways and Means, 109th Cong. (2005) available at http:// frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_house_ hearings&docid=f:26414.pdf.

70 See generally Cong. Budget Office, supra note 7.

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79 Id. at 33-34.

80 America's Healthy Future Act of 2009, S.1796, 111th Cong. (2009), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_ cong_bills&docid=f:s1796pcs.txt.pdf. Chairman's Mark is a “[r]ecommendation by committee (or subcommittee)

chair of the measure to be considered in a markup, usually drafted as a bill." Chairman's Mark/Staff Draft, TheCapitol.Net, http://www.thecapitol.net/glossary/c.htm#Chairman's%20Mark/Staff%20Draft (last visited Mar. 17, 2011).

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