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Taylor N. Armstrong

*Georgia State University College of Law*, [taylorarmstrong@gmail.com](mailto:taylorarmstrong@gmail.com)

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## BEARING HOSPITAL TAX BREAKS: HOW NON-PROFITS BENEFIT FROM YOUR SURPRISE MEDICAL BILLS

Taylor N. Armstrong\*

### INTRODUCTION

Dan Harrison, a father from Atlanta, Georgia, is working to pay off a medical bill he received after taking his seven-year-old daughter to the emergency room.<sup>1</sup> His daughter was having difficulty breathing after coming down with pneumonia, and her pediatrician recommended taking her to the emergency room.<sup>2</sup> Harrison's daughter was covered by his health insurance, and she went to an emergency room that was in-network, meaning one covered by his insurance carrier.<sup>3</sup> Dan paid the \$250 copay, and his daughter received the treatment she needed; however, that was not the end of the financial obligation.<sup>4</sup> Three months after the emergency-room trip, Dan received a \$1,400 bill for services that were not covered by his insurance.<sup>5</sup> Though the services were rendered at an in-network hospital, unbeknownst to Dan, not all of the physicians who treated his daughter were in-network with his provider.<sup>6</sup> Even though Dan did "everything that a reasonable person" would do, he was responsible for paying the extra bill.<sup>7</sup>

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1. Associated Press, *Georgia Lawmakers Work to End 'Surprise Billing' for Patients*, AUGUSTA CHRON. (Feb. 12, 2017, 12:46 AM), <http://chronicle.augusta.com/2017-02-12/georgia-lawmakers-work-end-surprise-billing-patients> [https://perma.cc/EUE5-CWD6].

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Georgia Lawmakers Work to End 'Surprise Billing' for Patients*, *supra* note 1.

Families like the Harrisons carefully plan and budget to make ends meet, but now, across the United States, families are opening their mailboxes to unexpected medical bills.<sup>8</sup> These bills can become financially crippling debts that haunt patients and their families for years to come and result in “lawsuit[s], a damaged credit score, a home foreclosure, or worse.”<sup>9</sup> Due to the trend of rising insurance

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8. Brief for Tenn. Med. Ass’n as Amici Curiae Supporting Petitioners at 17, *HCA Health Servs. of Tennessee v. BlueCross BlueShield of Tennessee, Inc.*, 2016 WL 3357180 (Tenn. 2016) (No. 10-896-11), 2016 WL 6211577, at \*17 (“The ‘surprise’ bill phenomenon is an issue nationwide . . . .”); *see also* Haley Sweetland Edwards, *How You Could Get Hit with a Surprise Medical Bill*, TIME (Mar. 7, 2016), <http://time.com/4246845/health-care-insurance-surprise-medical-bill/> [https://perma.cc/TGU3-AB2U] (describing a patient left with \$106,000 in uncovered medical bills after treatment for a slip and fall); Maggie Fox & Jane Derenowski, *Surprise Medical Bills Found in 22 Percent of ER Visits*, NBC NEWS (Nov. 16, 2016, 5:00 PM, updated Nov. 16, 2016, 7:03 PM), <https://www.nbcnews.com/health/health-care/surprise-medical-bills-found-22-percent-er-visits-n684956> [https://perma.cc/5C3E-HR42] (“A new study published in the New England Journal of Medicine finds that, across the country, 22[%] of people visiting in-network emergency rooms have to deal with bills from out-of-network doctors.”); Elisabeth Ponsot & Daniel Moritz-Rabson, *Americans Who Confronted ‘Surprise’ Medical Bills Share Their Stories*, PBS NEWSHOUR (June 26, 2016, 2:53 PM), <http://www.pbs.org/newshour/updates/americans-who-confronted-surprise-medical-bills-share-their-stories/> [https://perma.cc/H23K-6YCX] (sharing stories of patients left with uncovered medical bills ranging from \$5,000 to \$40,000); Eric Salzman & Anna R. Schechter, *Law Aims to Protect Medicare Patients from Surprise Hospital Bill*, NBC NEWS (Mar. 8, 2017, 3:10 PM), <https://www.nbcnews.com/news/us-news/law-aims-protect-medicare-patients-surprise-hospital-bill-n730686> [https://perma.cc/K3A5-E9KA] (describing a patient left with \$28,000 in uncovered medical bills after treatment for a broken leg); Stephanie Stokes, *Georgia Lawmakers Work to Curb Surprise Medical Bills*, WABE (Feb. 8, 2017), <http://news.wabe.org/post/georgia-lawmakers-work-curb-surprise-medical-bills> [https://perma.cc/D4GT-9QPM] (describing a patient left with \$700 in uncovered costs after an emergency room visit).

9. Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 130 (2017) (“The financial distress mounts after the service has been rendered, with the arrival of involuntarily triggered, surprise out-of-network medical bills or added facility fees. The ordeal continues as the patient tries to sort out the confusing pile of medical bills and insurance statements while unpaid amounts are sold to debt collectors and reported to credit reporting agencies, where the medical bill can become a lawsuit, a damaged credit score, a home foreclosure, or worse.”); *see also* Brief for Tenn. Med. Ass’n, *supra* note 8, at \*17 (“In 2011, the New York Department of Financial Services studied more than 2,000 complaints involving surprise medical bills[] and found the average out-of-network emergency bill was \$7,006.”); Daryl M. Berke, *Drive-by-Doctoring: Contractual Issues and Regulatory Solutions to Increase Patient Protection from Surprise Medical Bills*, 42 AM. J.L. & MED 170, 173 (2016) (“Medical bills from these situations can be crippling.”); Rebecca Lindstrom & Julie Wolfe, *Investigation: 41% of Georgians Report Surprise Medical Bills*, 11ALIVE.COM (May 16, 2016, 8:30 PM), <http://www.11alive.com/news/local/investigation-41-of-georgians-report-surprise-medical-bills/190007567> [https://perma.cc/BL9J-LD42] (“‘Medical debt is the leading cause of bankruptcy,’ said Stephens. ‘[It] can be devastating to a family. I mean thousands of dollars of unexpected medical costs in a year can really have an impact to afford other necessary items.’”); Aimee Picchi, *Most Americans Can’t Handle a \$500 Surprise Bill*, CBS NEWS (Jan. 6, 2016, 5:14 PM), <https://www.cbsnews.com/news/most-americans-cant-handle-a-500-surprise-bill/> [https://perma.cc/GR6J-XTMH] (“[Although] the recession may be long over, many Americans are still living one bill away from financial disaster. . . . In fact, about 63[%] of Americans say they’re unable to

costs throughout the 2000s and underwriting limitations created under the Patient Protection and Affordable Care Act (ACA), insurance companies have been seeking cost-saving strategies, including narrowing insurance networks.<sup>10</sup> While narrower networks reduce insurance premiums, they also increase the likelihood that patients will “find [themselves] out-of-network” and with a surprise medical bill.<sup>11</sup> Many states have passed laws to prohibit surprise bills, but there are many patients beyond the reach of these protections, including those in states without protective laws.<sup>12</sup> To protect patients from this gap, the federal Tax Code may provide a complementary solution to minimal state and federal protections.

This Note addresses the growing issue of surprise medical bills and how the United States Tax Code can be used to prevent many patients from receiving these bills. Part I provides a background on surprise billing and market factors that have led to an increase in the bills as well as current legislative solutions to the problem.<sup>13</sup> Part II

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handle a \$500 car repair or a \$1,000 emergency room bill . . .”).

10. Patient Protection and Affordable Care Act § 1201, 42 U.S.C. § 300gg (2012); Fuse Brown, *supra* note 9, at 133 (“The increasing out-of-pocket burden on patients is exacerbated by a related trend of narrowing networks of providers participating in the patient’s health insurance plan. The ACA prohibits health plans from using traditional insurance underwriting practices to reduce health care spending through risk selection (e.g., avoiding bad risks and cherry-picking good risks). As such, narrow networks have become the primary strategy for health insurers to keep health care premiums from ballooning, by contracting with a limited network of providers who agree to lower fees in exchange for a higher volume of patients.”); Rachel Dolan, *From the Archives: Deductibles and Out-of-Pocket Costs*, HEALTH AFF. BLOG (Sept. 29, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150929.050860/full/> [<https://perma.cc/TYT4-RJAJ>] (“Past surveys and analyses of health spending show that the growth in deductibles and out-of-pocket spending is a trend across the system. Overall out-of-pocket spending has been on the rise for some time, growing nearly 40[%] from 1996–2005. [Although] it has since slowed due to enactment of the Affordable Care Act (ACA) coverage provisions, National Health Expenditure projections call for increased growth over the next decade.”); Elizabeth Johnson, *The Never-Ending Debate over Health Care Narrow Networks*, LAW360 (Mar. 12, 2014, 5:27 PM), <https://www.law360.com/articles/517282/the-never-ending-debate-over-health-care-narrow-networks> [<https://perma.cc/6ENC-QQUS>] (“Narrow networks are networks offered by health insurers that limit an insured’s choice of health care providers, such as physicians and hospitals. Insurers often tout narrow networks as a cost[-]saving measure.”).

11. Valerie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 63, 78 (2015) (providing a rationale behind narrow networks and the different types of narrow networks that insurers use); Fuse Brown, *supra* note 9, at 133.

12. Fuse Brown, *supra* note 9, at 147.

13. See discussion *infra* Part I.

analyzes the role that hospitals play in the insurance market, the current standards for nonprofit hospitals to receive tax exemption under Internal Revenue Code (IRC) § 501, and how these legal standards fall short of accomplishing the goals of the tax exemption.<sup>14</sup> Finally, Part III proposes an alternative solution of using the Tax Code as a means of protecting patients.<sup>15</sup>

### *I. What are Surprise Medical Bills?*

“Surprise medical bills result from providers . . . that patients reasonably assumed would be in-network, but actually are out-of-network.”<sup>16</sup> These bills are unexpected because families believe that the expenses are already covered by their monthly premiums or are limited to their plan’s high deductibles.<sup>17</sup> Many Americans access and pay for healthcare through health insurance because insurance mitigates the cost of healthcare that individuals would otherwise be unable to afford.<sup>18</sup> Even if a patient has insurance, however, there is no guaranteed protection from medical debt or increased costs because most insurance plans do not cover every physician.<sup>19</sup> While the concept of out-of-network physicians is not new, surprise medical

14. See discussion *infra* Part II.

15. See discussion *infra* Part III.

16. MARK A. HALL ET AL., SOLVING SURPRISE MEDICAL BILLS, SCHAEFFER INITIATIVE INNOVATION HEALTH POL’Y 5 (2016) (defining providers as “physicians, hospitals, out-patient facilities, laboratories, etc.”); see also Blake, *supra* note 11, at 87 (“The patient may not even realize he or she is going out-of-network, for example, if the in-network hospital has out-of-network physicians delivering care.”).

17. See Fuse Brown, *supra* note 9, at 131 (“[I]nsurance coverage does not ensure financial protection for patients . . . . The costs of health care are rising, and the patient is picking up a larger portion through out-of-pocket cost-sharing. The financial protection afforded by insurance coverage, even the historically robust coverage provided by employers, is eroding.”).

18. Julian J.Z. Polaris, *Personal Networks: Health Coverage Status and the Invisible Burden on Family and Friends*, 39 HARV. J.L. & GENDER 115, 125–26 (2016).

19. *Id.* at 126–27 (“[H]ealth coverage also provides some measure of protection against the financial costs of medical treatment . . . . When services are needed, most plans do not offer 100% coverage. Indeed, studies show that bankruptcy caused by medical debt often strikes those who had health coverage at the time.”); Bob Herman, *Billing Squeeze: Hospitals in Middle as Insurers and Doctors Battle Over Out-of-Network Charges*, MODERN HEALTHCARE (Aug. 29, 2015), <http://www.modernhealthcare.com/article/20150829/MAGAZINE/308299987> [<https://perma.cc/29U6-MEUA>] (“[A] lot of patients don’t understand that if the hospital takes the insurance, [each] doctor that comes to their bedside might not’ . . .”).

bills arise even when the patient tries assiduously to remain in-network but is unable to avoid out-of-network physicians.<sup>20</sup>

Many hospitals use physician outsourcing firms to staff various departments in the hospital, including the emergency room.<sup>21</sup> Although these physicians work in the hospital, they may not contract with the same insurance providers as the hospital facility.<sup>22</sup> Hospitals outsource various departments, mainly emergency rooms, due to rising costs and staffing shortages.<sup>23</sup> The increased use of staffing agencies is correlated with a significant increase in surprise medical billing.<sup>24</sup> This increased risk arises from the contracting abilities of staffing agencies compared to physicians employed by the hospital who can require their physicians to contract with the same insurance plans or enter into contracts on the physician's behalf.<sup>25</sup>

Although surprise medical bills are most often a product of emergency scenarios, as with Dan and his daughter, these bills can also occur during nonemergency situations.<sup>26</sup> A surprise medical bill stems from a nonemergency situation when a patient goes to the hospital for a scheduled procedure, one that the patient knows is covered by the patient's insurance, and while receiving care is treated by an out-of-network physician or staff or with an instrument or

20. Herman, *supra* note 19.

21. *Id.*; Samantha Liss, *When a Nonprofit Health System Outsources Its ER, Debt Collectors Follow*, ST. LOUIS POST-DISPATCH (Apr. 17, 2016), [http://www.stltoday.com/business/local/when-a-nonprofit-health-system-outsources-its-er-debt-collectors/article\\_826b26bf-0c85-5ae4-9af1-a1f9f9591539.html](http://www.stltoday.com/business/local/when-a-nonprofit-health-system-outsources-its-er-debt-collectors/article_826b26bf-0c85-5ae4-9af1-a1f9f9591539.html) [<https://perma.cc/Y3QH-ZJPU>] (“[Outsourcing emergency services is] a common practice in the industry, but some legal experts say the nonprofit hospitals are exposing their most vulnerable patients, who are poor or uninsured, to potentially aggressive collection practices even when those patients would otherwise be eligible for discounts or charity care.”).

22. Herman, *supra* note 19.

23. See Zack Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States* 7 (Nat'l Bureau Econ. Inst. Research, Working Paper No. 23623, 2017).

24. *Id.* at 36.

25. *Id.*

26. Brief for Tenn. Med. Ass'n, *supra* note 8, at \*17 (“One national survey found that 8% of privately insured individuals used out-of-network care in 2011; 40% of those claims involved surprise (involuntary) out[-]of[-]network claims. This survey found that most surprise medical bills were related to emergency care.”); Hall, *supra* note 16, at 5; Herman, *supra* note 19 (“The second scenario [where surprise billing occurs] is when out-of-network physicians provide surgical or other scheduled care at in-network facilities. Patients may do their homework to see whether their providers are in their plan network. But ‘a lot of patients don’t understand that if the hospital takes the insurance, [each] doctor that comes to their bedside might not . . . .’”).

medical device that is not covered by the patient's insurance.<sup>27</sup> Both emergency and nonemergency surprise medical bills result in the insured patient being charged a substantially higher out-of-network bill because there is no contract between the insurer and the physician for an agreed-upon rate.<sup>28</sup> Non-contracted providers (i.e., out-of-network providers) will typically charge the patient the difference between the provider's full charges and the amount covered by the insurer, a practice called balance-billing, and the insurer will also require a higher level of patient cost sharing. The difficulty, particularly in emergency situations, is that the patient is both unaware that she is receiving out-of-network treatment and that these services include additional costs.<sup>29</sup>

A recent Yale study that analyzed insurance data "to study the drivers of out-of-network billing for emergency care" brought the issue of surprise billing to light.<sup>30</sup> The study found that staffing companies are building business models to capitalize on the policy gap that created the surprise billing issue.<sup>31</sup> One staffing company,

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27. Fuse Brown, *supra* note 9, at 137.

28. Brief for Tenn. Med. Ass'n, *supra* note 8, at \*16 ("When payment disputes occur between providers and insurers, the patient is caught in the middle."); Cooper, *supra* note 23, at 36 ("The fundamental problem in this setting is that there is a missing contract between the physician and the insurer.").

29. Brief for Tenn. Med. Ass'n, *supra* note 8, at \*16 ("Patients may choose to go to facilities in their health insurers' networks, understandably assuming that because the facilities are in their network, all providers who will treat them will also be in their network, and their insurance will pay for most of the allowed charges at an agreed reimbursement rate. However, that is not always the case. Even when patients seek treatment at in-network hospitals, they may be treated by out-of-network physicians who work at the facility. When this happens, patients may receive out-of-network bills from physicians they are often considered 'surprise' bills.").

30. Cooper, *supra* note 23, at 2.

31. *Id.* at 36.

We find that when both firms enter hospitals, there is a large increase in out-of-network billing. Following the entry of EmCare, we observe that hospitals' out-of-network billing rates increased by between [eighty-one] and [ninety] percentage points. Likewise, after TeamHealth entered hospitals, out-of-network billing rates in our data increased by [thirty-three] percentage points. Consistent with our model, we find evidence of a transfer to hospitals following the entry of these firms. In addition to increasing out-of-network billing, we find that when EmCare enters a hospital, it increases the amount facilities get paid via increases in imaging rates and the rates that patients are admitted from the ED to the hospital. We also find that after EmCare enters a hospital, patients are 43% more likely to have physician services coded using the most high intensity, high paying codes. We find that TeamHealth pursues a different strategy. When TeamHealth enters a hospital, it raises out-of-network rates

TeamHealth, increased out-of-network bills by 33% after staffing the hospital with out-of-network physicians.<sup>32</sup> Another physician staffing company, EmCare, a subsidiary of Envision Healthcare, increased out-of-network billing rates by approximately 81%–90% upon entering the emergency department of hospitals across the United States.<sup>33</sup> Although the patients visiting these emergency departments may have visited a hospital that was in their network, the outsourced emergency room physicians, staffed by EmCare were out-of-network physicians who are costlier due to higher cost-sharing and balance-billing.<sup>34</sup> Further, these physicians bill their patients at the highest level of care, meaning that the physicians charge patients the highest rates possible for the rendered service.<sup>35</sup>

As a result of this study, EmCare’s shareholders filed a class action lawsuit alleging that the company violated securities laws when it included materially false information in its filings with the Securities and Exchange Commission.<sup>36</sup> The allegedly materially false information claimed that EmCare was “well-positioned to continue to generate significant organic growth . . . .”<sup>37</sup> The shareholders challenged that statement, claiming that EmCare’s “revenues were likely to be unsustainable after the [deliberate out-of-network billing

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significantly (although out-of-network billing rates at these hospitals drop over time after entry) and also raises hospital activity rates.

*Id.*; see also Herman, *supra* note 19 (noting that TeamHealth and EmCare are two of the largest physician outsourcing firms in the U.S.).

32. Cooper, *supra* note 23, at 36.

33. *Id.*

34. *Id.*; Julie Creswell, Reed Abelson & Margot Sanger-Katz, *The Company Behind Many Surprise Emergency Room Bills*, N.Y. TIMES (Jul. 24, 2017), <https://www.nytimes.com/2017/07/24/upshot/the-company-behind-many-surprise-emergency-room-bills.html> [<https://perma.cc/FAV6-KMAD>]; Bob Herman, *Envision Faces Lawsuit for Allegedly Hiding Billing Practices*, AXIOS (Aug. 10, 2017), <https://www.axios.com/envision-faces-lawsuit-for-allegedly-hiding-billing-practices-2471470725.html> [<https://perma.cc/BUN4-CPK2>].

35. Cooper, *supra* note 23, at 36; Creswell, Abelson & Sanger-Katz, *supra* note 34; Herman, *supra* note 34; *What is Medical Billing*, AM. ACAD. PROF’L CODERS, <https://www.aapc.com/medical-billing/medical-billing.aspx> [<https://perma.cc/3EUT-FEK6>] (last visited Jan. 14, 2019); see *Fee-Schedule General Information*, CTRS. MEDICAID & MEDICARE SERVS., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html> [<https://perma.cc/DPM2-W4AX>] (last modified Nov. 14, 2018, 3:56 PM) (providing fee basis for “physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies”).

36. Complaint at 5, *Bettis v. Envision Healthcare* (M.D. Tenn. Aug. 4, 2017) (No. 3:17cv112).

37. *Id.* at 9.



practices] came to light” due to the moral considerations involved in the billing practices.<sup>38</sup> The reason that shareholders sued the corporation for presenting materially false information and not for EmCare’s surprise billing practices was that these practices are currently unrestricted in many states.<sup>39</sup> There have been minimal federal efforts to prevent or resolve these bills, and only a few states have taken steps to protect patients from being liable for these bills and to close the gap between insurance coverage and necessary treatment for patients.<sup>40</sup>

#### A. *Cost Increases Lead to Narrower Networks*

Healthcare policy is particularly complicated due to the number of interests involved: patients, hospitals, health plans, physicians, and states are all heavily involved in the system, and each plays an important role.<sup>41</sup> Patients want to receive affordable treatment and minimize their risk of receiving crushing bills.<sup>42</sup> Physicians and hospitals want to be paid for their services.<sup>43</sup> Health plans stand in

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38. *Id.* at 2–3 (“Specifically, [d]efendants made false and/or misleading statements and/or failed to disclose that: (i) EmCare routinely arranged for patients who sought treatment at in-network facilities to be treated by out-of-network physicians; (ii) EmCare accordingly billed these patients at higher rates than if the patients had received treatment from in-network physicians; (iii) the Company’s statements attributing EmCare’s Class Period growth to other factors were therefore false and/or misleading; (iv) Envision’s EmCare revenues were likely to be unsustainable after the foregoing conduct came to light; and (v) as a result of the foregoing, Envision’s public statements were materially false and misleading at all relevant times.”).

39. *Id.*

40. Fuse Brown, *supra* note 9, at 134 (“It is the states . . . that have led the way with an array of legal innovations to address consumer protections in health care—particularly in the area of surprise medical bills but also in limits to medical debt[-]collection practices.”); Alyssa Rege, *7 States Addressing Surprise Medical Billing so Far in 2017*, BECKER’S HOSP. CFO REPORT (Mar. 13, 2017), <http://www.beckershospitalreview.com/finance/7-states-addressing-surprise-medical-billing-so-far-in-2017.html> [<https://perma.cc/BST4-EX65>].

41. Polaris, *supra* note 18, at 125.

The story of American health coverage institutions reveals an attempt to balance the interests of four main groups: (1) individual people, who depend on health coverage to pay for medical care; (2) parties to the individual’s health-related transactions, including healthcare providers, who need to be paid, and private health plans, who often do the paying; (3) employers, who determine the available health plan options for many Americans; and (4) the [s]tate, which mediates among these often-conflicting interests while also accounting for broader public policy goals.

*Id.*

42. *Id.* at 132.

43. See Brian Secemsky, *Health Care 101: How Doctors Are Paid*, HUFFINGTON POST,

between physicians and patients and attempt to mitigate the risk of patients receiving these bills while ensuring that physicians and hospitals are paid.<sup>44</sup> Finally, states have a policy interest in ensuring “population health and financial security.”<sup>45</sup>

Insurance providers pass on their cost increases—from administrative costs and market factors—to the patient through higher deductibles and copays, further straining the protection that health insurance provides.<sup>46</sup> Physicians and hospitals contract with insurance companies for business at the expense of lower rates on products and services with the goal of making up the cost in additional patient volume.<sup>47</sup> A physician or hospital that has a contract with the insurance company is considered to be in-network.<sup>48</sup> However, as insurance companies face increasing costs

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[https://www.huffingtonpost.com/brian-secemsky/health-news\\_b\\_5400348.html](https://www.huffingtonpost.com/brian-secemsky/health-news_b_5400348.html) [https://perma.cc/76FZ-B7UY] (updated Jul. 30, 2014).

44. Polaris, *supra* note 18, at 132.

45. *Id.* at 132–33 (“The [s]tate seeks to preserve a well-functioning healthcare industry that serves the individual interests of health and financial security while maintaining the solvency of critical health[care] institutions. Moreover, the [s]tate itself operates public health[care] plans and hospitals. It thus has an interest in preventing health[care] costs from consuming an increasingly large share of both public and private budgets.”).

46. Fuse Brown, *supra* note 9, at 131 (“There is a great cost shift underway in American health care. The costs of health care are rising, and the patient is picking up a larger portion through out-of-pocket cost[sharing]. The financial protection afforded by insurance coverage, even the historically robust coverage provided by employers, is eroding.”); see John Aloysius Cogan, Jr., *Health Insurance Rate Review*, 88 TEMP. L. REV. 411, 420–21 (2016):

Health insurance rates in the United States have been increasing dramatically . . . . To make matters worse, the cost-sharing component of most health insurance plans—the deductibles, copays, and coinsurance—have increased as well. This means total cost increases borne by American families for their health coverage are even greater than reflected by premium increases alone.

What factors drive these increases? Most discussions of healthcare cost drivers, as if responding to Captain Louis Renault’s famous line in the film *Casablanca*, typically “round up the usual suspects.” The list of cost drivers usually includes some or all of a wide-ranging list of potential culprits, including “[f]ee-for-service reimbursement,” “[f]ragmented delivery of care,” “[a]dministrative burdens on providers,” “population health factors,” “advances in medical technology,” the tax treatment of health insurance, “insurance benefit design,” a “[l]ack of cost and quality transparency,” medical care market consolidation, the high prices of medical goods and services, medical malpractice premiums, fraud and abuse, and the structure and supply of the medical care workforce.

*Id.*

47. Fuse Brown, *supra* note 9, at 131.

48. Deborah Farringer, *Everything Old is New Again: Will Narrow Networks Succeed Where HMOs Failed?*, 34 QUINNIPIAC L. REV. 299, 317 (2016).

and restraints, “including prohibitions on denying individuals with pre-existing conditions and limitations on the rating of patients,” they have resorted to limiting networks to provide more cost-effective solutions.<sup>49</sup> Although narrower networks may reduce insurance premiums up front, these plans are much riskier and open the door for increases in surprise billing by increasing the pool of out-of-network physicians and services.<sup>50</sup> These gaps in coverage, which patients are unaware of, are precisely what the staffing companies have used to their advantage.<sup>51</sup>

### B. Current Legislative Solutions

The federal government has taken steps to address narrow networks and denials of coverage, such as setting network adequacy standards and preventing health plans from treating emergency care as out-of-network, but has not done much to address surprise billing from the physician providing the emergency care.<sup>52</sup> Most of the policy changes have come from the states.<sup>53</sup> Although states are

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49. *Id.* at 302–03 (“As health insurers try to navigate the new limitations set forth under the ACA, including prohibitions on denying individuals with pre-existing conditions and limitations on the rating of patients, insurers are looking toward[] models that will enable them to control costs without access to their usual tools. What they have developed is not so much a new insurance model[] but actually a concept that first arose during the rise of managed care; that is, limited provider networks utilized within health maintenance organizations (‘HMOs’). These ‘new’ insurance products, often referred to as narrow networks or high-performance networks, offer beneficiaries a more limited network of physicians typically in exchange for lower premiums. These insurance plans are becoming increasingly common both on the federal and state health insurance exchanges as well as in insurance product offerings outside the exchanges.”); Johnson, *supra* note 10 (“The theory is that if insurers can guarantee some providers a higher volume of patients based on a limited network of providers, those providers will be willing to accept a lower reimbursement for services, thus controlling costs.”).

50. HALL, *supra* note 16, at 12 (“[U]nder existing market forces, provider networks are becoming narrower, creating more situations where patients encounter a mix of network and non-network providers.”).

51. See Cooper, *supra* note 23, at 35.

52. Farringer, *supra* note 48, at 317–22; HALL, *supra* note 16, at 17. Network adequacy standards require insurers to provide patients with an adequate selection of physicians and hospitals over a range of specialties. Farringer, *supra* note 48, at 314.

53. Brief for Tenn. Med. Ass’n, *supra* note 8, at \*10 (“Federal law does not provide a clear-cut standard for payment of out-of-network emergency services.”); Berke, *supra* note 9, at 173 (“Interestingly, the Patient Protection and Affordable Care Act (ACA) provides only minimal protection for patients in these situations.”); Fuse Brown, *supra* note 9, at 154–55 (“The Federal government, by contrast, appears to be taking a more incremental approach. In 2016, the Centers for Medicare and Medicaid Services (CMS) issued a very limited measure to address surprise medical bills . . . [T]his provides very limited protection against surprise medical bills . . .”).

leading the way in patient protection from these bills, states are limited in the regulations that they can pass due to the preemptive effects of the Employee Retirement Income Security Act (ERISA).<sup>54</sup> New York, Connecticut, California, Florida, and Texas are some of the states that have passed medical-billing legislation in an attempt to protect patients from being stuck with a surprise bill, and there are several other states proposing and debating new legislation.<sup>55</sup>

The debate over surprise-billing legislation focuses on which party carries the burden of negotiating the treatment fee. Some states, such as New York, hold the patient harmless and prohibit the patient from being charged more than he would be charged if the physician was in-network.<sup>56</sup> This approach requires that the dispute be resolved between the insurer and the out-of-network provider, many times with the hospital acting as the mediator between the parties.<sup>57</sup>

### C. *The Hospital's Role*

Hospitals contract with both physicians and insurance companies.<sup>58</sup> The hospital provides physicians a facility and staff to work with and provides insurance companies discounted hospital services to the insureds by contracting for these discounts.<sup>59</sup> Patients run the risk of incurring additional costs when the hospital contracts with a physician who has not separately contracted with the insurance company.<sup>60</sup> Thus, even when the patient shows up to an in-network hospital for treatment, not every service provided by physicians in the hospital may be in-network.

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54. Fuse Brown, *supra* note 9, at 134–35.

55. *Id.* at 147–49 (“A number of states have begun to pass legislation targeting surprise bills and balance[billing] directly . . . . More recently, states have begun passing legislation to more specifically address the phenomenon of surprise medical bills . . . . Thus far, New York, Connecticut, California, Florida, and Texas have passed laws curtailing surprise medical billing.”); Rege, *supra* note 40 (“Legislators from seven states have proposed legislation in the first few months of 2017 to mitigate the practice of surprise medical billing.”). These states include Rhode Island, Georgia, Ohio, Arizona, Oregon, Utah, and Texas. Rege, *supra* note 40.

56. Fuse Brown, *supra* note 9, at 149.

57. *Id.*; Herman, *supra* note 19.

58. Berke, *supra* note 9, at 174.

59. *Id.*

60. Brief for Tenn. Med. Ass’n, *supra* note 8, at \*7.

Due to the societal benefits that hospitals provide, the United States Tax Code allows tax exemptions for hospitals that qualify as charitable organizations under 26 U.S.C. § 501(c)(3).<sup>61</sup> Under this provision, hospitals may qualify as charitable, nonprofit organizations and are exempt from federal tax.<sup>62</sup> Further, many states, including Georgia, allow a property-tax exemption for charitable, nonprofit organizations.<sup>63</sup> The estimated savings to hospitals from federal tax exemptions are approximately \$12 billion annually, and the estimated savings from state property tax are almost \$2 million annually.<sup>64</sup> The public benefit to the community from hospitals' services drives the policy behind allowing hospitals to receive this tax exemption.<sup>65</sup> The following section analyzes the requirements that hospitals must satisfy to remain tax exempt and how the tax-exemption requirements can be used to protect patients from receiving a surprise medical bill.

## II. *The Hospital as an Intermediary*

The hospital is the place where the participants in the market meet: physicians have a facility to provide healthcare to those in need, and patients have a location to receive those services.<sup>66</sup> The hospital

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61. I.R.C. § 501(c)(3) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019).

62. *Id.* § 501(c).

63. Bobby Courtney, *Hospital Tax-Exemption and the Community Benefit Standard: Considerations for Future Policymaking*, 8 IND. HEALTH L. REV. 365, 371 (2010) (“[Although] most states have historically recognized nonprofit community hospitals as being exempt from property taxes, 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.”); *Basics of Property Tax Exemption for Nonprofits in Georgia*, PRO BONO P’SHIP ATLANTA 1 (Sept. 25, 2013), <https://www.pbpatl.org/wp-content/uploads/2013/09/Basics-of-Property-Tax-Exemption-for-Nonprofits-in-Georgia2.pdf> [<https://perma.cc/YDU8-K3SS>].

64. Susannah Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 35 (2014); Gary J. Young, *Federal Tax-Exemption Requirements for Joint Ventures Between Nonprofit Hospital Providers and For-Profit Entities: Form over Substance?*, 13 ANNALS HEALTH L. 327, 329 (2004).

65. *St. Luke’s Hosp. v. United States*, 494 F. Supp. 85, 89 (W.D. Mo. 1980) (“Statutory provisions which grant tax exemptions to organizations designed to benefit the public good through charitable, religious, scientific, or educational purposes are construed liberally against taxation. This rule of construction is based upon the policy that the benefit derived from the revenue is outweighed by the benefit derived by the public from the services of these organizations.”).

66. *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456, 465–66 (N.J. Tax Ct. 2015) (quoting

serves an invaluable function by providing a centralized location for health care access rather than dispersing treatment across multiple facilities.<sup>67</sup> However, hospitals often find themselves in the middle of billing disputes between patients, staff physicians, and the patients' insurers.<sup>68</sup> Hospitals are placed in the position of mediating between the insurer or insured and the physician to settle billing disputes.<sup>69</sup> Any portion of the bill that the insurer does not cover will be paid by either the patient or the hospital.<sup>70</sup> Further, hospitals often struggle to get the physicians to the table to meet and negotiate a resolution to these disputes.<sup>71</sup> The irony is that hospitals were the ones who brought the physicians to the hospitals in the first place.<sup>72</sup>

Many physicians do not actually work for the hospital but are independent contractors who have separate contracts with the hospital; therefore, they are not bound to be in-network with the insurance companies that the hospital contracts with and, significantly, have separate contracts with health plans.<sup>73</sup> This trend of hospitals outsourcing various departments, including emergency rooms, and using staffing companies is not likely to diminish because

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*Belmar v. Cipolla*, 475 A.2d 533, 537–38 (N.J. 1984) (“[A] hospital is a complex business vitally affected with a public interest’ . . . . [A] hospital is a work place for hundreds of people who care for patients, maintain and operate the plant and equipment, and conduct the business of a complicated health care facility.”).

67. *Id.*

68. Herman, *supra* note 19 (“[H]ospitals increasingly find themselves caught in the middle as patients, insurers[,] and physicians fight over who should pick up bills for services that patients unknowingly receive from out-of-network doctors.”).

69. *Id.* (“The most stressful part for hospital officials, who often serve as mediators between insurers and out-of-network physicians, is getting physicians to come to the table.”). See generally Drew Calvert, *Who Bears the Cost of the Uninsured? Nonprofit Hospitals.*, KELLOGGINSIGHT (June 22, 2015), <https://insight.kellogg.northwestern.edu/article/who-bears-the-cost-of-the-uninsured-nonprofit-hospitals> [<https://perma.cc/J97F-7XHD>].

70. Herman, *supra* note 19; Calvert, *supra* note 69 (“That means hospitals are effectively serving as ‘insurers of last resort’ within the American health[care] sector by providing care to uninsured patients who cannot afford to pay their medical bills. ‘People are still going to the emergency room . . . and they are still receiving treatment—so the cost is still there. When governments do not provide health insurance, hospitals must effectively provide it instead.’”).

71. Herman, *supra* note 19 (“The most stressful part for hospital officials, who often serve as mediators between insurers and out-of-network physicians, is getting physicians to come to the table . . . . A growing number of hospitals and insurers are setting up processes to resolve out-of-network bills before the problem escalates into a public relations disaster that could undermine support for narrow-network plans.”).

72. *Id.*

73. Liss, *supra* note 21.

hospitals are dealing with increasing costs and challenges in staffing emergency rooms.<sup>74</sup> Although using staffing agencies may alleviate costs, outsourcing puts patients at a greater risk of receiving a surprise medical bill.<sup>75</sup>

While patients are becoming more susceptible to receiving crushing bills, hospitals are still enjoying their tax-exempt status.<sup>76</sup> Hospitals are not exempt from taxation solely due to their status as hospitals; the hospital must qualify for this tax exemption under IRC § 501(c)(3).<sup>77</sup> Previously, to qualify as tax exempt, a hospital simply had to meet the community-benefit standard to demonstrate that it was serving charitable purposes under 501(c)(3).<sup>78</sup> The definition of what constituted community benefit for this requirement is not formalized in the Tax Code but was articulated in a series of IRS Revenue Rulings.<sup>79</sup> However, after the passage of the ACA, hospitals must also satisfy additional operational requirements under § 501(r).<sup>80</sup> These requirements were added to protect uninsured

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74. Herman, *supra* note 19; Liss, *supra* note 21 (“Concerned about the rising cost and complexities needed to staff emergency rooms, SSM made the decision in 2008 to contract out most of its ERs . . .”).

75. Herman, *supra* note 19.

76. See Mary Crossley, *Health and Taxes: Hospitals, Community Health and the IRS*, 16 YALE J. HEALTH POL’Y L. & ETHICS 51, 54 (2016) (“The annual value of federal tax exemption for hospitals was estimated at over six billion dollars more than a decade ago, and a recent estimate placed the value of the federal exemption at thirteen billion dollars.”).

77. I.R.C. § 501(c) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Courtney, *supra* note 63, at 368 (“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).”).

78. I.R.C. § 501(c), (r) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. 509, 522 (2016) (“The ACA created a series of new requirements for nonprofit hospitals to maintain their tax-exempt status for all tax years after March 23, 2010.”). These new requirements were added after “years of litigation, congressional hearings, and media attention on the dichotomy between the ostensibly charitable purposes of tax-exempt hospitals” to protect patients from excessive bills and collection practices by nonprofit hospitals. Fuse Brown, *supra*, at 511.

79. Rev. Rul. 83-157, 1983-2 C.B. 94; Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 56-185, 1956-1 C.B. 202; see James McGrath, *Overcharging the Uninsured in Hospitals: Shifting a Greater Share of Uncompensated Medical Care Costs to the Federal Government*, 26 QUINNIPIAC L. REV. 173, 203 (2007).

80. I.R.C. § 501(c)(3) (2018) (exempting “[c]orporations, and any . . . foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes . . . no part of the net earnings of which inures to the benefit of any private shareholder . . .”), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan.

individuals who generally receive the highest bills and then face the repercussions of that debt.<sup>81</sup> If the hospital fails to meet the requirements set out in § 501(c)(3) and § 501(r), the hospital will forfeit its tax-exempt status; however, there is no private right of action for a patient to sue to enforce compliance.<sup>82</sup>

### A. Requirements for Tax Exemption

Hospitals must satisfy requirements under § 501(c) as well as IRC § 501(r)(1) to qualify for federal tax exemption.<sup>83</sup> Under § 501(c), the hospital must satisfy charitable requirements discussed below. Additionally, § 501(r) requires hospitals to perform a community-health-needs assessment every three years, establish a financial-needs assistance policy, limit charges to those who qualify for financial assistance to charges that are generally billed for the treatment, and adhere to certain billing and collection requirements.<sup>84</sup>

#### 1. Charitable Requirements

Charitability is the first criterion that a hospital must satisfy to qualify as tax exempt; however, the term “charitable” is not defined

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7, 2019); Courtney, *supra* note 63, at 368 (“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.”); Fuse Brown, *supra* note 78, at 514; Rachel Weisblatt, *Uncharitable Hospitals: Why the IRS Needs Intermediate Sanctions to Regulate Tax-Exempt Hospitals*, 55 B.C. L. REV. 687, 694 (2014).

81. Fuse Brown, *supra* note 78, at 510–11 (noting the § 501(r) requirements “were designed in part to address the problem of the uninsured being charged the highest amounts for hospital care and then being hounded by aggressive debt[ ]collection efforts, often to the point of financial ruin”).

82. See generally *Feliciano v. Thomas Jefferson Univ. Hosp.*, No. 04-CV-04177, 2005 U.S. Dist. LEXIS 21565 (E.D. Pa. Sept. 28, 2005) (lawsuit by uninsured and indigent patient against nonprofit hospital and hospital system was dismissed because: (1) hospitals’ tax-exempt status under I.R.C. § 501(c)(3) did not create contract with patient as third-party beneficiary requiring hospitals to provide affordable medical care to all patients; (2) even if it did, only relief obtainable was right to assess and collect federal taxes if hospitals failed to comply with terms of tax exemption; and (3) there was no private right of action under § 501(c)(3)); Lisa Kinney Helvin, *Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL’Y L. & ETHICS 421, 427 (2008) (“As the recent lawsuits demonstrate, § 501(c)(3) of the Internal Revenue Code simply does not supply federal courts with the tools to hold not-for-profit hospitals accountable for caring for uninsured patients when the complaining parties are third-party patients.”).

83. I.R.C. § 501(r).

84. *Id.*



in IRC § 501(c).<sup>85</sup> The regulations surrounding § 501(c) state that not-for-profit hospitals gain their tax-exempt status by serving a public interest rather than a private interest.<sup>86</sup> The Internal Revenue Service (IRS) issued a series of Revenue Rulings to further explain what is meant by charitable and “serves a public rather than a private interest” by establishing a set of standards to satisfy these requirements.<sup>87</sup> The IRS determines the charitable status on a case-by-case basis.<sup>88</sup> Revenue Ruling 56-185 spells out general requirements that would establish a hospital as tax exempt.<sup>89</sup> These requirements look to whether the hospital is (1) organized as a nonprofit, (2) open to those who are both able and unable to afford treatment, (3) not operated exclusively with one group of physicians, and (4) not directing profits to a private individual or shareholder.<sup>90</sup> Revenue Ruling 69-545 broadened the requirements of Revenue Ruling 56-185 and held that the IRS would “weigh all of the relevant facts and circumstances” when determining whether a hospital has satisfied the charitable requirement and added factors—including operating an emergency room that is open to all as well as reinvesting profits to improve patient care.<sup>91</sup> However, the ruling also clarified that the presence or absence of one factor does not mean that the hospital is no longer tax exempt *per se*.<sup>92</sup> This sets a very broad, ad hoc standard for hospitals to be considered charitable. Even a hospital that does not operate an emergency room or admits only those who can pay for their treatment would still qualify for tax exemption.<sup>93</sup> This is because the presence of an emergency

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85. *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976).

86. 26 C.F.R. § 1.501(c)(3)-1(d)(1)(ii) (2018).

87. *Id.*; Rev. Rul. 83-157, 1983-2 C.B. 94; Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 56-185, 1956-1 C.B. 202.

88. McGrath, *supra* note 79, at 203.

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

90. *Id.*; Helvin, *supra* note 82, at 440–41 (“[T]he IRS set forth four ‘general requirements’ that a health care organization was obligated to meet in order to be deemed ‘charitable’ for federal tax[-]exemption purposes . . . [T]he most notable of these requirements was that a hospital must serve those who are unable to pay for health services[] and not exclusively care for patients who can afford the costs.”).

91. Rev. Rul. 69-545, 1969-2 C.B. 117; Weisblatt, *supra* note 80, at 692–93.

92. Rev. Rul. 69-545, 1969-2 C.B. 117; Weisblatt, *supra* note 80, at 692–93.

93. Rev. Rul. 83-157, 1983-2 C.B. 94; Helvin, *supra* note 82, at 442.

department is merely one of several weighted factors used to determine whether a community benefit is being provided rather than being required to qualify for tax exemption.<sup>94</sup> Accordingly, the outsourcing of an emergency room using a staffing company, whose strategy is to bill patients at out-of-network rates and use harsh collection practices, would not prohibit tax exemption of the hospital facility.

The charitable requirement looks in part at the amount of free or charity care that the hospital provides as reported on its annual informational return to the IRS.<sup>95</sup> In addition to not charging patients for products and services, nonprofit hospitals may take unpaid and uncollectible bills and mark them as charity care.<sup>96</sup> The higher the bills are from the outset, the more likely it is that patients default on payments.<sup>97</sup> When patients default on payments, the hospital can denote the cost of the unpaid services as charity care and use that cost toward its charitable requirement.<sup>98</sup> As a result, bad debt expenses or the costs of uncollectible services becomes more than just a deduction—they allow the nonprofit entity to avoid paying any federal tax or state property taxes.<sup>99</sup> Because the hospital is able to categorize the bad debt as charity, the federal government is, in effect, the insurer of those who are unable to pay their medical

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94. Weisblatt, *supra* note 80, at 693–94 (“[T]he IRS defines the community benefits standard as broadly as possible in recognition of the diverse needs of each tax-exempt hospital’s surrounding community. For example, a hospital that does not operate an emergency room can still qualify for a tax exemption if a state agency determines that an additional emergency room would duplicate services already being provided elsewhere in the community. This is particularly important for many specialty hospitals that lack emergency rooms (e.g., surgical facilities) or other hospitals that typically treat very few Medicare patients (e.g., children’s hospitals). Thus, given the broad interpretation of the community benefits standard, a hospital can obtain tax-exempt status as a charitable organization even if it does not provide any charitable care.”).

95. McGrath, *supra* note 79, at 175–76.

96. *Id.* (“Rather than write off unpaid, uncollectible bills, not-for-profit entities report them as ‘charity care.’ The ability to maintain their charitable status by overstating their provision of free care is part of the calculus that allows these hospitals to be classified as not-for-profit; it may also net these hospitals great savings from property tax burdens.”).

97. *Id.* at 176.

98. Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL’Y 11, 37 (2014). Historically, hospitals reported the billed amount as bad debt rather than the cost of the unpaid services provided. *Id.* Now, hospitals must report the cost of the unpaid services as the bad debt expense to prevent hospitals from driving up the billed cost to increase their bad debt expense. *Id.*

99. I.R.C. § 166 (2018) (allowing a deduction for whole or partially worthless debts).

bills.<sup>100</sup> These bills are only written off once the hospital has tried to collect on the bill or predetermined that the patient would be unable to pay.<sup>101</sup>

In an effort to both focus on preventative medicine and put hospitals in a stronger position to serve the community's needs, the IRS now requires a Community Health Needs Assessment (CHNA) to be performed every three years.<sup>102</sup> Through this assessment and the consideration of the needs of the community, the IRS looks not only at charity care but also at community health involvement.<sup>103</sup> This assessment includes gathering health data on the community and adopting strategies to address the issues facing the particular area where the hospital is located.<sup>104</sup> The CHNA includes data on financial access to care as well as nutrition and “social, behavioral, and environmental factors,” all of which play a role in public health.<sup>105</sup>

When conducting the CHNA, hospitals have the discretion—after considering all facts and circumstances—to prioritize the “health needs of their communities” over profits to earn tax-exempt status.<sup>106</sup> Because the guidelines do not set criteria for what is a significant health need, the hospital may prioritize a need that is minor as opposed to a major community need.<sup>107</sup> In addition to considering “factors like the availability or absence of healthful foods, transportation options, living wages, and safe neighborhoods,”

100. McGrath, *supra* note 79, at 176 (“The federal government, in other words, has become the unwitting insurer for many who do not actually have either private or government health insurance[] and are unable to pay for health care out-of-pocket.”).

101. *Id.*

102. I.R.C. § 501(r) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Crossley, *supra* note 76, at 56; Weisblatt, *supra* note 80, at 692.

103. Jessica Mantel, *Tackling the Social Determinants of Health: A Central Role for Providers*, 33 GA. ST. U. L. REV. 217, 244 (2017); Weisblatt, *supra* note 80, at 694–95.

104. Crossley, *supra* note 76, at 56; Weisblatt, *supra* note 80, at 695.

105. Mantel, *supra* note 103, at 245; Weisblatt, *supra* note 80, at 694–95.

106. Crossley, *supra* note 76, at 56; Jillian A. Swogier, *Finding a Fit for Nonprofit Hospitals: A National Perspective of State Property Tax Exemption Laws*, 41 SETON HALL LEGIS. J. 461, 465 (2017).

107. Crossley, *supra* note 76, at 69; Mary Crossley, *Health Reform and the Mission of Nonprofit Hospitals*, HEALTH CARE BLOG (Apr. 28, 2014), <http://thehealthcareblog.com/blog/2014/04/28/health-reform-and-the-mission-of-nonprofit-hospitals/> [<https://perma.cc/4E3T-K2A3>] [hereinafter *Health Reform*].

financial access to healthcare is also relevant.<sup>108</sup> From this standpoint, as surprise medical bills become a bigger issue, an emergency room that serves the needs of the community without burdening it with medical bills should be included in the CHNA, along with a plan as to how the hospital intends to address this need.<sup>109</sup> When conducting the CHNA, the value of the medical debt in the community that arose from treatment at the hospital should be considered in the data on the financial access to care. For example, in St. Louis, Missouri, over one thousand lawsuits have been filed to collect on medical debt, and 99% of these lawsuits involve debt that arose from treatment at a nonprofit hospital's emergency room.<sup>110</sup> When the hospital is performing its CHNA, these debt-collection cases should be considered, and the hospital should implement a plan to address the community need and financial access to healthcare. These strategies could include reviewing the hospital's hiring and contracting practices. Through completing this assessment and addressing the need of the community, the hospital would be fulfilling the purpose of the CHNA.

## 2. *Financial Assistance Policy and Requirements on Charges*

IRC § 501(r)(4) requires every tax-exempt hospital to write and publish two financial assistance policies (FAPs)—one general policy and one emergency-services policy.<sup>111</sup> Included in the FAP are the eligibility criteria, information on how charges are calculated, the

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108. Crossley, *supra* note 76, at 69; Mantel, *supra* note 103, at 245.

109. See Fox & Derenowski, *supra* note 8.

110. Liss, *supra* note 21. Additionally, in St. Joseph, Missouri, the only hospital in the small town is responsible for a majority of the 11,000 debt-collection suits that were filed from 2009 to 2013. Paul Kiel, *From the E.R. to the Courtroom: How Nonprofit Hospitals Are Seizing Patients' Wages*, PROPUBLICA (Dec. 19, 2014, 6:00 AM), <https://www.propublica.org/article/how-nonprofit-hospitals-are-seizing-patients-wages> [https://perma.cc/KB67-NLBA].

111. I.R.C. § 501(r)(4) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,954, 78,972 (Dec. 31, 2014) (“FAP must apply to all emergency and other medically necessary care provided in a hospital facility by a partnership owned in part by, or a disregarded entity wholly owned by, the hospital organization operating the hospital facility, to the extent such care is not an unrelated trade or business with respect to the hospital organization.”); Fuse Brown, *supra* note 78, at 523; Weisblatt, *supra* note 80, at 695.

hospital's method for applying for financial assistance, and the actions that the hospital takes in the event of nonpayment.<sup>112</sup> IRC § 501(r) and the Revenue Regulations do not contain guidelines as to how hospitals are to determine eligibility for financial assistance.<sup>113</sup> This leaves the determinations of the eligibility requirements to the hospitals' complete discretion.<sup>114</sup> The hospitals generally set the FAP requirements to cover those individuals who are uninsured or underinsured and fall at or near the poverty line.<sup>115</sup> Although the FAP may help those who are uninsured, those with insurance generally do not qualify for this type of assistance and therefore will be subject to out-of-network bills and the collection practices of private companies.<sup>116</sup>

Similar to insurance with out-of-network providers, the hospital FAP covers bills coming directly from the hospital but does not cover treatment a patient may receive from a provider who bills separately from the hospital.<sup>117</sup> For those who qualify for the FAP, these

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112. I.R.C. § 501(r)(4); Weisblatt, *supra* note 80, at 695.

113. Fuse Brown, *supra* note 78, at 522–23.

114. *Id.*

115. *Financial Assistance (Charity Care)*, NEWPORT HOSP. & HEALTH SERVS., <http://newporthospitalandhealth.org/patients-families/patient-financial-services/charity-care/uncompensated-services/> [<https://perma.cc/9KFF-L884>] (last visited Oct. 15, 2017); *Financial Assistance Program Policy*, NORTHSIDE HOSP. <https://www.northside.com/financial-assistance-policy> [<https://perma.cc/C58V-6HVL>] (last visited Oct. 15, 2017).

116. Fuse Brown, *supra* note 78, at 519.

Patients may find themselves unprotected by the fair pricing and collection rules because they fall into a coverage gap. The patient may receive care at a for-profit hospital not subject to § 501(r)'s rules, which make up over one-fifth of all hospitals in the United States and almost half of the hospitals in some states. Or the patient may be ineligible for financial assistance, either because the hospital adopts a stingy policy or the patient is part of a group excluded from financial assistance, such as middle class uninsured or insured patients paying out-of-pocket for care because they are out-of-network, have a high deductible, or are otherwise underinsured.

*Id.* at 511.

117. Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,954, 78,971 (Dec. 31, 2014) (codified at 26 C.F.R. §§ 1.501(r)–.507(a) (2018)) (“A number of commenters noted that patients, including emergency room patients, are commonly seen (and separately billed) by private physician groups or other third-party providers while in the hospital setting . . . . [C]ommenters noted that patients are often unaware of the financial arrangements between various providers in the hospital facility and may unknowingly be transferred to a provider that separately bills the patients for care.”).

surprise bills are often especially detrimental.<sup>118</sup> Similar to the measures that states are taking to prevent patients from receiving an out-of-network bill, the regulations have tried to improve transparency by requiring that a list of physicians who bill separately for emergency services be listed as not covered by the hospital's FAP.<sup>119</sup>

Under the FAP, IRC § 501(r)(5) requires that the hospital limits the amount that an individual can be charged for emergency or any other medically necessary care to the amount generally billed to those covered by insurance.<sup>120</sup> The limitation on billing charges only applies to those who qualify under the FAP and not to every patient who walks through the hospital doors.<sup>121</sup> Further, the underlying incentive to increase pricing for those who do not meet the FAP requirements is still present because these bills can be considered charity care if they go unpaid and are determined to be uncollectible.<sup>122</sup>

### 3. *Billing and Collections*

Harsh debt-collection practices plague the health industry and impact both the insured and the uninsured.<sup>123</sup> Patients are not only

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118. *Id.*

119. *Id.* (“[L]ist the providers, other than the hospital facility itself, delivering emergency or other medically necessary care in the hospital facility and to specify which providers are covered by the hospital facility’s FAP (and which are not).”).

120. I.R.C. § 501(r)(5) (2018) (“[A]mounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the amounts generally billed to individuals who have insurance covering such care, and (B) prohibits the use of gross charges.”), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Fuse Brown, *supra* note 78, at 523.

121. I.R.C. § 501(r).

122. Fuse Brown, *supra* note 78, at 535–36; McGraph, *supra* note 79, at 175–76 (“The ability to maintain their charitable status by overstating their provision of free care is part of the calculus that allows these hospitals to be classified as not-for-profit; it may also net these hospitals great savings from property tax burdens.”).

123. Fuse Brown, *supra* note 78, at 522 (“Price discrimination and aggressive debt collection have been routine practices of nonprofit, tax-exempt hospitals and for-profit, taxable hospitals alike.”); McGraph, *supra* note 79, at 176 (“The practice of claiming uncollectible debt as charity care has come under heavy scrutiny lately, as for-profit hospitals provide similar benefits to the community using this standard, leading many to question the value of not-for-profit hospitals’ tax-exempt status.”); Kiel, *supra* note 110 (“When it secured a judgment, as it typically did, Northwest was entitled to seize a hefty

left with large bills but are also subsequently hounded by debt collectors for payment.<sup>124</sup> The unpaid debts generally do not stay at the hospital but are sold to debt-collection agencies at a discounted rate.<sup>125</sup> Section 501(r)(6) prohibits a tax-exempt hospital from engaging in extraordinary collection actions or sending the bill to a debt-collection agency before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the FAP.<sup>126</sup> Again, similar to the limits on billing charges, the collections restriction only applies to those who may qualify for the hospital's FAP.<sup>127</sup>

Because the ACA has helped close the gap in the number of individuals who do not have insurance, fewer individuals now qualify

portion of a debtor's paycheck. During those years, the company garnished the pay of about 6,000 people and seized at least \$12 million—an average of about \$2,000 each . . . .”).

124. Fuse Brown, *supra* note 78, at 518–19 (“The problem of unfair hospital prices is exacerbated by harsh debt[-]collection practices. Hospitals have used aggressive debt[-]collection practices to recover unpaid bills, inflicting significant financial, emotional, and health-related hardship on patients. In 2003, Lucette Lagnado wrote about Quinton White, a seventy-eight[-]year[-]old widower who was still paying his late wife's \$18,740 medical bill to Yale-New Haven Hospital twenty years later, which, with interest charges, had grown to more than \$55,000. The Whites were an uninsured, working[-]class couple ineligible for Medicaid. The hospital put a lien on White's home, seizing his bank account, and putting him on an installment plan to pay nearly \$33,000 interest. Around this time, news outlets all over the country started reporting about hospitals' use of harsh measures to collect unpaid medical bills, including assigning the debt to collection agencies, suing patients, putting liens or seeking foreclosure on patients' homes, garnishing wages, charging high interest rates, and even seeking arrest or body attachment for failing to appear in court for a debt[-]collection hearing.”); Kiel, *supra* note 110.

125. McGraph, *supra* note 79, at 193 (“When medical bills are not paid, hospitals and doctors often turn the debt over to a collection agency, which may harm a person's credit history. This damage to their credit will further interfere with their ability to pay, as he or she will then likely pay higher interest rates in the unlikely event they are able to secure financing to pay these debts. About 23% of uninsured people in 2003 reported they were contacted by a collection agency.”); Kiel, *supra* note 110. A 2017 Supreme Court opinion changed the landscape of debt-collection laws by holding that a company that owns a debt and attempts to collect it, instead of attempting to collect on behalf of another entity like a hospital, falls outside the scope of federal laws that regulate the practices of debt collectors. Matthew D. Haan, *Gorsuch's Purgatory: Attempting to Define Debt Collector Under the Fair Debt Collection Practices Act*, 35 GA. ST. U. L. REV. 433, 434 (2019).

126. I.R.C. § 501(r)(6) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Weisblatt, *supra* note 80, at 696–97.

Extraordinary collection actions occur when a hospital engages a legal or judicial process to procure payment of a hospital bill for care that is covered under the hospital's financial assistance policy. It is also considered an extraordinary collection action to sell an individual's debt to a third party or to report adverse information about an individual to consumer credit reporting agencies.

Weisblatt, *supra* note 80, at 696–97.

127. I.R.C. § 501(r)(5) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019).

for financial assistance, and thus, more individuals are not protected by capped billing and harsh collection practices.<sup>128</sup>

*B. How the Standards Apply to Outsourced Entities*

The tax-exemption requirements set out in IRC §§ 501(c) and 501(r) only apply to hospitals and not to those with whom the hospital contracts because it is solely the hospital, and not the contractor, who is exempt from taxation.<sup>129</sup> As hospitals continue to outsource entire departments—especially emergency rooms—patients are at a greater risk of receiving surprise medical bills from hospitals whose main purpose is supposed to be charitable work.<sup>130</sup> So long as hospitals comply with IRC §§ 501(c) and 501(r), they can continue to enjoy federal and state tax exemption while private companies can bill and use collection agencies to collect on those bills.<sup>131</sup>

Though the hospital facility itself may satisfy the requirements to be considered a charitable organization, the staffing agency is a wolf in sheep's clothing, using the nonprofit facility to exploit those who are unknowingly unable to afford treatment.<sup>132</sup> The staffing agency, EmCare, is a prime example.<sup>133</sup> A not-for-profit hospital in Washington state outsourced its emergency room staffing through EmCare due to increasing costs.<sup>134</sup> EmCare, a for-profit staffing agency, used the strategy of staying out-of-network as a way to increase revenues. Thus, EmCare did not routinely contract with the same health plans that the hospitals did and relied on balance billing and harsh debt-collection practices to collect from patients. EmCare

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128. See Weisblatt, *supra* note 80, at 696–97.

129. Liss, *supra* note 21 (“The physician practice doesn’t have to comply with the tax-exempt standards . . .”).

130. *Id.*

131. *Id.*

132. See Creswell, Abelson & Sanger-Katz, *supra* note 34.

133. See Cooper, *supra* note 23, at 36; Creswell, Abelson & Sanger-Katz, *supra* note 34; Fuse Brown, *supra* note 78, at 511. Although the additional standards imposed by I.R.C. § 501(r) were intended to protect “many financially vulnerable patients from inflated hospital bills and aggressive debt[-]collection tactics,” the nonprofit is, in effect, allowed to skirt these requirements through using staffing agencies who are not bound by these requirements. Fuse Brown, *supra* note 78, at 511.

134. See Creswell, Abelson & Sanger-Katz, *supra* note 34.



was not subject to the same requirements as the hospital, and thus, for every patient that came through the emergency room doors, there were no charitable care requirements, financial assistance policies, caps on billing, or protections against harsh debt-collection practices.<sup>135</sup>

Because relatively few states have taken steps to protect their citizens from receiving a surprise medical bill, patients are still exposed to out-of-network billing.<sup>136</sup> Although some of the legislation focuses on different mechanisms to resolve medical bills and release patients from the burden of huge bills, most of the legislation does not address preventing patients from receiving these bills. The following section proposes how the tax-exempt requirements of not-for-profit hospitals can be used to protect patients in states that are currently lacking protection from surprise medical billing.

### *III. Tax Exemption as an Incentive for Patient Protection*

Approximately 60% of hospitals in the United States qualify as tax-exempt organizations under IRC § 501.<sup>137</sup> Hence, 60% of

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135. See Cooper, *supra* note 23, at 36; Creswell, Abelson & Sanger-Katz, *supra* note 34. Although the hospital's tax-exempt status is not at risk due to EmCare's business practices, the hospital may not be considered to be operating an emergency room open to all under these circumstances, which is one of the factors for satisfying the community benefit standard. See Rev. Ruling 69-545. However, as discussed above, the presence of an emergency room is merely one of several weighted factors, and it is still uncertain whether the hospital would be considered to not be operating an emergency room under these circumstances. See discussion *supra* Section II.A.1.; discussion *infra* Section III.B.

136. See Berke, *supra* note 9, at 173 ("Very few states have extended balance billing protections to enrollees who obtain care from out-of-network providers . . . [I]nvoluntary encounters with out-of-network care, such as those that result from emergency medicine and drive-by-doctoring, are different because consumer choice has been removed."); see Herman, *supra* note 19.

A number of states such as California, New York[,] and Texas have approved or are considering rules that address unexpected out-of-network bills. New York has adopted the toughest measure. Since April, the state has required insurers and providers that disagree on out-of-network payment to go through an independent dispute-resolution process.

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... [Although] the ACA requires health plans to pay out-of-network emergency providers at network rates, patients in many states still are exposed to balance billing.

Herman, *supra* note 19.

137. I.R.C. § 501(c) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Stacy Madden, *Did You Know: For-Profit Versus Nonprofit Hospitals*, HEALTH NET (Oct. 11, 2013), <http://healthnetpulse.com/broker/2013/10/11/did-you-know->

hospitals in the United States are organized with the purpose of providing charitable work to the communities that they serve.<sup>138</sup> As expressly stated in numerous hospital mission statements, the hospitals' goals are to provide accessible acute and emergency care to the communities that they serve.<sup>139</sup>

Nationally, the tax-exempt status of nonprofit hospitals has saved them approximately \$12 billion per year in federal income tax.<sup>140</sup> Nonprofit hospitals that outsource their emergency departments using companies such as EmCare or TeamHealth receive this tax-exemption benefit from being qualified as charitable organizations while placing increased burdens on the patients who come to the hospitals seeking care.<sup>141</sup>

To justify the federal tax exemption, nonprofit hospitals should be obligated to better serve patients in their communities. The Tax Code is a unique mechanism that Congress can use to incentivize certain behaviors.<sup>142</sup> To effectuate these policy goals, the tax-exemption requirements for hospitals should be expanded in two ways. First, Congress and the IRS need to place additional emphasis on the value of operating an accessible emergency room. Second, the IRS should revoke the tax exemption of hospitals where the subcontractors engage in surprise billing and extraordinary collections against their

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for-profit-versus-nonprofit-hospitals/ [https://perma.cc/BF9G-4ZCL].

138. Madden, *supra* note 137.

139. *Health Reform*, *supra* note 107.

140. Tahk, *supra* note 64, at 35. In addition to the annual \$12 billion in tax savings, the tax exemption also “allows hospitals to raise \$5.3 billion in tax-deductible contributions annually. As a result, the exemption plays a key role in providing health care in the U.S.” *Id.* (footnote omitted).

141. See Cooper, *supra* note 23, at 36; McGrath, *supra* note 79, at 175–76 (“Most hospitals, however, do not pay income tax because they qualify as charitable, not-for-profit entities. While these not-for-profit hospitals may not benefit from tax deductions, they still benefit by charging the uninsured inflated list prices.”).

142. Susannah Camie Tahk, *Everything is Tax: Evaluating the Structural Transformation of U.S. Policymaking*, 50 HARV. J. ON LEGIS 67, 67–68 (2013).

Congress has been relying increasingly on the [T]ax [C]ode to accomplish goals beyond raising revenue. Taxpayers have quietly become accustomed to finding social and regulatory programs buried in the [T]ax [C]ode. Perhaps as a result, no one has seemed to notice as Congress and presidential administrations have, more and more frequently, employed the [T]ax [C]ode to accomplish goals that have nothing to do with raising revenue.

*Id.* at 67.

patients to ensure that the societal benefits behind the tax exemption are realized.

### A. Tax as a Policy Incentive

The Tax Code is used for much more than simply raising revenue.<sup>143</sup> Congress uses its taxing power to accomplish policy goals and regulatory and social-benefit programs.<sup>144</sup> Under the Patient Protection and Affordability Care Act, Congress used its taxing power in the healthcare sector.<sup>145</sup> One of the provisions in which Congress previously used its taxing power to effectuate the goals of the ACA was the individual mandate that imposed a tax penalty on those who are not covered by health insurance.<sup>146</sup>

Similarly, IRC § 501(r) imposes additional restrictions on nonprofit hospitals as discussed above.<sup>147</sup> These requirements incentivize charitable hospitals to have a community focus by providing them a tax benefit for complying with the set standards.<sup>148</sup>

143. *Id.* (“[T]he [T]ax [C]ode has recently come to incorporate ‘policies aimed at the environment, conservation, green energy, manufacturing, innovation, education, saving, retirement, health care, child care, welfare, corporate governance, export promotion, charitable giving, governance of tax exempt organizations, and economic development . . . .’”) (quoting Pamela F. Olson, Laurence Neal Woodworth Memorial Lecture: And Then Cnut Told Reagan . . . Lessons from the Tax Reform Act of 1986 (May, 6, 2010)).

144. *Id.*

145. *Id.* at 68 (“Most observers know the Affordable Care Act as a major piece of social and regulatory legislation. However, they have failed to focus on the fact that the bill was in large part a tax bill. Many of the bill’s major elements took the form of [T]ax [C]ode provisions.”).

146. *See generally* Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); Tahk, *supra* note 142, at 67–68, 71. Although the individual mandate has since been repealed, it serves as an example as to how the Tax Code can be used to advance policy in the healthcare sector. *See* Christina Lima, *Trump Boasts of Individual Mandate Repeal in GOP Tax Bill*, POLITICO (Dec. 20, 2017), <https://www.politico.com/story/2017/12/20/trump-individual-mandate-repeal-tax-bill-308286> [<https://perma.cc/48C3-9RBV>].

147. *See* discussion *supra* Part II.

148. Eric J. Santos, *Property Tax Exemptions for Hospitals: A Blunt Instrument Where a Scalpel Is Needed*, 8 COLUM. J. TAX. L. 113, 129 (2017).

Hospitals are huge, complicated businesses, and addressing the issues they face is made more difficult by the fact that they provide services that are essential. Quality healthcare is important for both the individuals who receive it and all others who benefit from living in a generally healthy place. However, the current system grew out of a world where hospitals were simpler and less integral to our society.

The fundamental problem is that tax exemption is all or nothing; a hospital either keeps exemption or loses it. Losing exemption from state property taxes would be massively costly for any hospital. Modern hospitals necessarily own and occupy a

However, nonprofit hospitals have no incentive to go beyond these set requirements because they are still in some capacity a profit-driven enterprise.<sup>149</sup> Recently, nonprofit hospitals have been financially strained.<sup>150</sup> Nonprofit hospitals cannot sustain themselves merely on charitable donations alone.<sup>151</sup> They must be profitable to generate sufficient funds to maintain the hospital while ensuring that they are not incurring losses.<sup>152</sup> The function of the hospital as a profit-seeking enterprise incentivizes them to comply with tax exemption requirements. Otherwise, the federal tax expense that the hospital would be subject to would impose a greater financial burden than the cost of operating an emergency room without a staffing agency. Thus, the Tax Code can be used as a mechanism to protect patients from surprise medical bills while still effectuating the goals and missions of nonprofit hospitals and the policy reasons behind providing tax exemptions.<sup>153</sup>

The tax-exempt provisions for charitable hospitals in the Tax Code have the power to alleviate the impact of surprise medical bills in United States hospitals.<sup>154</sup> This unique position rests on the \$12 million incentive that the tax provision provides hospitals that have to balance costs in the healthcare market.<sup>155</sup> The Tax Code could be used to decrease the number of surprise medical bills that Americans receive in a number of ways: first, by redefining the charitable deduction standards that a hospital must meet by further clarifying “community benefit” to emphasize the importance of the emergency room factor; second, by incorporating calculations of the burdens of patients’ medical debts from hospital services in the CHNA or Schedule H, which hospitals must complete in the annual Form 990

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huge amount of property . . . . Being forced to bear such a cost with little warning could predictably force a hospital to cancel unprofitable services and become for-profit, or close its doors entirely.

*Id.*

149. *Id.* at 129–31.

150. Swogier, *supra* note 106, at 483.

151. *Id.*

152. *Id.*

153. *See* Santos, *supra* note 148, at 133.

154. *Id.*

155. *See id.* at 129; Tahk, *supra* note 64, at 35; Young, *supra* note 64, at 329.

informational return to the IRS; lastly, by revoking the tax exemption of any hospital whose contracted emergency room physicians engage in routine surprise billing, this would incentivize hospitals to contract with staffing agencies that do not engage in these practices.

### *B. The Importance of Emergency Rooms*

The emergency room is the community medical center where those with health care needs most commonly enter the hospital.<sup>156</sup> From the emergency room, patients are transferred or referred to other departments of the hospital to receive further treatment.<sup>157</sup> Due to its function, the emergency room is one of the most important departments of the hospital and must be available to patients at all hours of the day.

The current revenue rulings are not clear as to whether operating an accessible and affordable emergency room is necessary to retain tax-exempt status. Revenue Ruling 69-545 sets forth a balancing test using the community-benefit approach that considers the overall benefit that the hospital provides to the community.<sup>158</sup> The presence of an emergency room that is open to all is one of several factors considered in this analysis.<sup>159</sup> Subsequently, Revenue Ruling 83-157 states that an emergency room is not necessary in all circumstances to retain tax exemption.<sup>160</sup> Revenue Ruling 83-157 provides examples of situations where an emergency room is not needed, including specialized hospitals or communities where an alternative, functional emergency room is already present.<sup>161</sup> This Revenue Ruling emphasizes a totality-of-the-circumstances approach when determining whether an emergency room is necessary for tax exemption.<sup>162</sup>

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156. *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456, 483–84 (N.J. Tax Ct. 2015); Cooper, *supra* note 23, at 3.

157. *AHS Hosp. Corp.*, 28 N.J. Tax at 484.

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

159. 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, 45–46 (1995).

160. Rev. Rul. 83-157, 1983-2 C.B. 94.

161. *Id.*

162. 1 TAXATION OF HOSPITALS & HEALTH CARE ORGANIZATIONS § 4.03 (2017).

The regulations specifically look to whether the emergency room is open to all patients regardless of their ability to pay.<sup>163</sup> As the number of patients who are covered by insurance has increased as a result of the ACA, the amount of charity care has decreased because hospitals' focus has shifted from the level of charity care to the overall benefit that the hospital provides the public.<sup>164</sup> However, the mere presence of an emergency room does not benefit the community if the patients using the emergency room are leaving with inflated medical bills or are subjected to harsh collection practices.

When determining whether an emergency room is functional and open to the public, the standard should focus on the output of the hospital, meaning the percentage of the patients who visit the emergency room receiving affordable care. Currently, the focus is on the patients' financial and insured status when they enter the hospital—whether they are covered by insurance, are indigent, or qualify for the FAP.<sup>165</sup>

Further, the value of medical debts that patients are left with after receiving treatment from the nonprofit hospital's emergency room must be considered in the calculation of the overall community benefit provided by the nonprofit hospital. For example, in St. Louis, Missouri, there has been a dramatic increase in the number of lawsuits involving medical debt resulting from treatment at nonprofit hospitals' emergency rooms.<sup>166</sup> The value of medical debt pursued against patients through extraordinary collection actions indicates that the hospital is not operated primarily for charitable purposes by promoting health for the benefit of the community. Thus, this

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163. Helvin, *supra* note 82, at 440–41 (“[T]he IRS set forth four ‘general requirements’ that a health care organization was obligated to meet in order to be deemed ‘charitable’ for federal tax exemption purposes . . . . [T]he most notable of these requirements was that a hospital must serve those who are unable to pay for health services[] and not exclusively care for patients who can afford the costs.”).

164. See Santos, *supra* note 148, at 132–33.

165. Fuse Brown, *supra* note 78, at 519.

166. Liss, *supra* note 21 (“CP Medical has filed at least 1,078 lawsuits in St. Louis . . . between Dec. 2, 2014, and March 10, 2016. After reviewing all the lawsuits, the newspaper found that 99[%] of the cases involved debt that originated from ER treatment at an SSM hospital.”). The Morristown hospital case involved the revocation of state-tax-exempt status, not federal. See *generally* AHS Hosp. Corp. v. Town of Morristown, 28 N.J. Tax 456 (N.J. Tax Ct. 2015).

information must be included in the mandated CHNA along with a proposal of the hospital's solution to fix it.

The unavailability of an affordable emergency room to those who are covered by insurance should be sufficient for the IRS and states to challenge the tax-exempt status of hospitals for failure to adhere to the community benefit standard.<sup>167</sup> However, further issues occur as more hospitals are not running their own emergency rooms but are outsourcing the department to other companies.<sup>168</sup>

### C. Contracting Agencies

Although the emergency room is arguably one of the most important departments in the hospital facility, it is also one of the most unprofitable departments.<sup>169</sup> Additional costs are required to keep the emergency room staffed and operating at all hours of the day.<sup>170</sup> Further, compared to other departments, many of those seeking treatment in the emergency room are poor or uninsured.<sup>171</sup> Currently, there are incentives for emergency room physicians to remain out-of-network. The ACA requires that insurers pay for out-of-network emergency room care, so physicians will be paid and will be paid more if they remain out-of-network than if they contract with payers. A Texas study showed that out of several insurance companies' in-network hospitals, up to 56% of the emergency rooms in those hospitals had zero in-network physicians.<sup>172</sup> As a result, the physicians' bills received from treatment in those emergency rooms are not covered by the insurance company.

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167. *AHS Hosp. Corp.*, 28 N.J. Tax at 465, 483 (holding a nonprofit hospital did not meet the statutory standards for tax exemption because it bore "little, if any, resemblance" to their "early origins as charitable alms houses providing free basic medical treatment to the infirm poor[.]" because "they are [now] sophisticated centers of medical care . . . providing a litany of medical services regardless of a patient's ability to pay"); Beth Jones Sanborn, *IRS Revokes Tax-Exempt Status for County-Run Hospital, Raising Specter of More Actions Against Nonprofits*, HEALTHCARE FIN. (Aug. 16, 2017), <http://www.healthcarefinancenews.com/news/irs-revokes-tax-exempt-status-county-run-hospital-raising-specter-more-actions-against> [<https://perma.cc/HY2D-9ME5>] (revoking tax-exempt status of a nonprofit hospital for failure to perform a community health needs assessment).

168. Cooper, *supra* note 23, at 36.

169. Swogier, *supra* note 106, at 466.

170. Cooper, *supra* note 23, at 3.

171. Swogier, *supra* note 106, at 466.

172. Berke, *supra* note 9, at 174.

Currently, physicians are not required to participate in the same networks as the hospital to receive privileges to work in the hospital.<sup>173</sup> Even though they operate “under the same roof,” the hospital must comply with the tax-exempt-status requirements while the third-party contractors do not.<sup>174</sup> Thus, the level of out-of-network care and consequential surprise medical billing is due to contracting failure between the hospital and the third-party contractors.

If, as a condition of retaining tax exemption, tax-exemption requirements had to be considered during these contract negotiations, the hospital would be incentivized not only to choose the cheapest contractor but also to consider the effect that each contract would have on the community it serves.<sup>175</sup> This incentive would hopefully result in fewer out-of-network bills because, by considering the effect on the community, the hospital would negotiate with physicians and third parties who contract with the same insurer as the facility.<sup>176</sup> Without this requirement, hospitals will continue to act in the profit-maximizing manner of using the cheapest option to staff and maintain their emergency rooms, regardless of the financial effect that it has on patients.

Further, third-party staffing companies such as EmCare and TeamHealth will be incentivized to adhere to the Tax Code as a way to market their services toward nonprofit hospitals. By adhering to the same tax exemption requirements as the hospital, these staffing companies become more attractive to nonprofit hospitals when staffing difficult-to-maintain departments because they could contract with the staffing company to save both on department costs as well as retain their tax-exempt status. Because over half of the hospitals in

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173. *Id.*

174. Liss, *supra* note 21 (“[T]he two entities are held to different standards when it comes to helping patients financially. The hospital itself is under a charitable obligation, but not the contractor . . . . [T]hat’s the problem in this case, there is a middleman that is allowing them to skirt that requirement . . . .”).

175. Herman, *supra* note 19 (“[H]ospitals could require physicians, as a condition of practicing at their facilities, to join the same health plan networks in which they participate . . . .”).

176. *Id.* (“At Boca Raton Regional . . . contracting anesthesiologists, emergency physicians, pathologists[,] and radiologists ‘know they have to contract with the plans that [the hospital] contract[s] with.’ The hospital has handled fewer complaints as a result.”).



the United States are classified as nonprofit, the staffing companies would be strongly incentivized to negotiate with insurance companies and comply with the tax-exemption standards.

### CONCLUSION

Surprise medical billing is an ever-growing issue in the United States as networks continue to shrink and more Americans leave the hospital with out-of-network bills.<sup>177</sup> The complexities of the healthcare system and varying standards set across states make this an even more difficult issue to resolve.<sup>178</sup> Currently, only a handful of states have taken steps to protect their citizens from receiving a crushing medical bill.<sup>179</sup>

The federal government, whose goal is to increase public health and the financial security of the population, has allowed for a tax exemption for hospitals that comply with specified standards.<sup>180</sup> These standards focus on the community benefit that the hospital provides and look to a certain level of charity care and financial assistance provided by the hospital.<sup>181</sup>

Currently, nonprofit hospitals are facing cost constraints, incentivizing hospitals to staff emergency rooms with out-of-network providers. This cost-saving action burdens patients with the cost of emergency services and has effectively made healthcare less accessible.

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177. *Id.* (“[A] published [] survey in June 2013 . . . showed roughly 40% of people who went to out-of-network physicians did so involuntarily. A March 2015 study from Consumers Union found that surprise medical bills hit 30% of privately insured Americans, and a quarter of those patients said the bill came from a doctor they did not expect.”).

178. *See* discussion *infra* Part I.

179. Fuse Brown, *supra* note 9, at 147–49 (“A number of states have begun to pass legislation targeting surprise bills and balance[]billing directly . . . . More recently, states have begun passing legislation to more specifically address the phenomenon of surprise medical bills . . . . Thus far, New York, Connecticut, California, Florida, and Texas have passed law[s] curtailing surprise medical billing.”).

180. I.R.C. § 501(c), (r) (2018), *invalidated by* Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (appeal filed 5th Cir. Jan. 7, 2019); Rev. Rul. 83-157, 1983-2 C.B. 94; Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 56-185, 1956-1 C.B. 202; Polaris, *supra* note 18, at 132; Santos, *supra* note 148, at 118–19.

181. I.R.C. § 501(c), (r); Rev. Rul. 83-157, 1983-2 C.B. 94; Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 56-185, 1956-1 C.B. 202; McGrath, *supra* note 79, at 175–76; Weisblatt, *supra* note 80, at 694.

As the healthcare market continues to evolve, tax law must also evolve to ensure that the policy goals of the community, government, and hospital are being effectuated.<sup>182</sup> By using the Tax Code as a mechanism to induce nonprofit hospitals to maintain an accessible and affordable emergency room and simultaneously incentivizing those who contract with the hospital to comply with tax-exempt standards, Congress can require hospitals to continue providing public benefits while protecting patients from medical debt.

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182. See Santos, *supra* note 148, at 133.