

Tax Reform, Mixed-Entity Markets, and Hospitals: How
the 2017 Tax Cuts and Jobs Act Favors the For-Profit
Hospital Model

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When the U.S. Congress passed the Tax Cuts and Jobs Act in 2017 (the “TCJA”), it achieved a significant tax cut for corporations. In doing so, however, Congress simultaneously reshaped the landscape for mixed-entity markets—that is, industries like healthcare and education in which nonprofit, for-profit, and government entities coexist and compete. This is particularly true for the hospital market in which the TCJA’s provisions have subtly but decidedly tilted market conditions towards a for-profit hospital model.

While scholars may debate the benefits of a nonprofit versus a for-profit entity model, the reality is that the majority of U.S. hospitals, and nearly all critical access hospitals, are nonprofits. Increased financial pressure from for-profit competitors will likely compel these hospitals to cut critical but unprofitable services—or otherwise find ways to reduce their provision of uncompensated care. This Article contends that, by failing to adequately account for the complex interactions of a mixed-entity hospital market, the TCJA will increase the disparity of healthcare services in America. As mixed-entity markets increase in prevalence, policymakers should carefully consider the nuances of such markets as they debate and implement policies that may not only trickle down but also inadvertently restructure entire industries.

* J.D., Yale Law School; B.A., Dartmouth College. I am grateful to Professor Michael Graetz for his guidance and feedback on early drafts of this Article. Many thanks as well to the editors of the *Yale Law & Policy Review* for their thoughtful comments and careful editing. A special thanks to Dr. Allen Shih for his inspiration and invaluable insights. All errors and omissions are my own.

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INTRODUCTION

On January 10, 2018, hospital security guards were filmed leaving a 22-year-old woman in near-freezing temperatures outside the University of Maryland Medical Center Midtown (UMMC) in Baltimore.¹ The woman was wearing just a hospital gown and socks.² A video of the incident shared on social media quickly went viral, sparking national outrage and condemnation of the alleged “patient dumping.” The next day, UMMC’s top executive, Dr. Mohan Suntha, publicly apologized to the woman, taking “full responsibility for [the] failure,” and stating that the hospital failed to provide “basic humanity and compassion.” He asserted that the woman’s treatment did not reflect the mission of UMMC’s medical system. At the same time, however, he seemed to hint at a limit to that mission, noting that some “complex social problems” are challenging for hospitals to address.³

This patient dumping incident⁴ reveals some of the unfortunate and harsh realities of healthcare gaps in America. No one likes the idea of patients being left out in the cold without healthcare⁵—and indeed modern society is shocked when it happens—but a general sense of moral

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1. Kimberly Elten, *Video Reportedly Shows Woman in Hospital Gown Left on Street by Baltimore ER Staff*, CBS LOCAL (Jan. 10, 2018), <http://baltimore.cbslocal.com/2018/01/10/woman-left-outside-hospital> [<http://perma.cc/XSR6-EGDH>].
 2. Andrea K. McDaniels & Meredith Cohn, *University of Maryland Hospital Apologizes for its Failure to Discharged Patient Found on Street in Hospital Gown*, BALT. SUN (Jan. 11, 2018), <http://www.baltimoresun.com/health/bs-hs-hospital-video-follow-20180111-story.html> [<http://perma.cc/PL5A-LGDQ>].
 3. *Id.*
 4. Andrea K. McDaniels, *What is Patient Dumping? Incident with Woman at Baltimore Hospital Is Hardly New*, BALT. SUN (Jan. 11, 2018), <http://www.baltimoresun.com/health/bs-hs-what-is-patient-dumping-20180111-story.html> [<http://perma.cc/Z8UX-T4JL>].
 5. See Dan W. Brock & Allen Buchanan, *Ethical Issues in For-Profit Health Care*, in FOR-PROFIT ENTERPRISE IN HEALTH CARE 224, 226 (Gray BH ed., 1986), http://www.ncbi.nlm.nih.gov/books/NBK217906/pdf/Bookshelf_NBK217906.pdf [<http://perma.cc/VJR4-BETX>] (“We assumed that the members of a society as affluent as ours have a collective moral obligation to ensure that everyone has access to some ‘decent minimum’ or ‘adequate level’ of care, even if they are not able to pay for it themselves.”).

obligation has yet to translate into a collective commitment to fund such care.

The federal government has attempted to fill in these gaps with a variety of regulations and mandates.⁶ Paradoxically, however, the government also occasionally widens the gaps. One notable example of this, yet largely overlooked, is the Tax Reform Act of 2017, colloquially called the Tax Cuts and Jobs Act (TCJA). While Congress arguably intended for this tax legislation to have a neutral, if not mildly positive, impact on American healthcare by improving the economy,⁷ in this Article, I contend that this has not been the case. To the contrary, the TCJA significantly and detrimentally reshapes the healthcare marketplace to leave more people out in the cold without healthcare.

Fundamentally, the problem is that there is no such thing as free healthcare: if a patient or their health insurance cannot pay, someone or some entity has to pay for their care. Many federal regulations rely on compelling hospitals to pay. For example, the Emergency Medical Treatment & Labor Act (EMTALA) requires Medicare-participating hospitals to assess and stabilize patients regardless of their ability to pay before transferring or discharging them.⁸ However, despite hospitals' lofty and benevolent missions, they cannot escape the pressures and incentives of financial realities. Today, as costs have risen and revenue has fallen,⁹ many hospitals find themselves in a difficult situation: In the face of dire financial difficulties, should a hospital turn people away, cut services, reduce quality of care, or shut down altogether?

Indeed, while patient dumping may grab national headlines, hospitals across the country have long been struggling to cope with increasing financial pressure in a myriad of discreet ways. Slashing unprofitable

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6. See, e.g., U.S. COMM'N ON CIVIL RIGHTS, PATIENT DUMPING (2014), http://www.usccr.gov/pubs/docs/2014PATDUMPOSD_9282014-1.pdf [<http://perma.cc/Y3JU-BKHY>].
 7. William G. Gale et al., *Effects of The Tax Cuts and Jobs Act: A Preliminary Analysis*, TAX POL'Y CTR. 9-16 (June 13, 2018), http://www.taxpolicycenter.org/sites/default/files/publication/155349/2018.06.08_tcja_summary_paper_final.pdf [<http://perma.cc/4ZW2-QL3Q>].
 8. 42 U.S.C. § 1395dd. See U.S. COMM'N ON CIVIL RIGHTS, *supra* note 6.
 9. *Top Issues Confronting Hospitals in 2017*, AM. C. HEALTHCARE EXECS. (Feb. 1, 2018), <http://www.ache.org/pubs/Releases/2018/top-issues-confronting-hospitals.cfm> [<http://perma.cc/YX4R-95DL>] [hereinafter *Top Issues*].

services,¹⁰ laying off staff,¹¹ reducing prevention outreach, allowing equipment to age or bed shortages to persist, increasing emergency room delays,¹² affiliating or merging with other hospitals, and shutting down¹³ are all common responses to financial pressure. These issues have only been exacerbated in recent years as hospitals face reduced or delayed Medicaid reimbursements, increased costs for staff and supplies, and funding unpredictability.¹⁴ And the new tax reform will soon hurt more than it helps many hospitals.

Historically, federal and state governments have attempted to respond to healthcare gaps¹⁵ by subsidizing the provision of uncompensated or “charity” care. First and foremost of these responses is the tax-exemption for nonprofit hospitals. Tax-exempt status relieves nonprofit hospitals from paying federal and state corporate income tax, grants access to tax-exempt bond financing, allows them to receive tax-deductible charitable deductions, and often precludes state and local property taxes.¹⁶ Second,

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10. See Hsueh-Fen Chen, Gloria J. Bazzoli & Hui-Min Hsieh, *Hospital Financial Conditions and the Provision of Unprofitable Services*, 37 ATL. ECON. J. 259 (2009).
 11. Casey Ross, *Facing a Financial Squeeze, Hospitals Nationwide Are Cutting Jobs*, STAT NEWS (Apr. 30, 2017), <http://www.statnews.com/2017/04/30/hospitals-layoffs-national> [<http://perma.cc/Y6XQ-M8EJ>].
 12. John Commins, *Safety Net Executives Renew Call To Preserve DSH Payments*, HEALTH LEADERS (Dec. 4, 2013), <http://www.healthleadersmedia.com/finance/safety-net-executives-renew-call-preserve-dsh-payments> [<http://perma.cc/MP2T-PUBZ>].
 13. Casey Ross, *In States that Didn't Expand Medicaid, Hospital Closures Have Spiked*, STAT NEWS (Jan. 8, 2018), <http://www.statnews.com/2018/01/08/medicaid-hospital-closures> [<http://perma.cc/36FB-XZ5W>].
 14. *Top Issues*, *supra* note 9.
 15. See generally Howard Waitzkin, *Commentary—The History and Contradictions of the Health Care Safety Net*, 40.3 HEALTH SERVICES RES. 941, 941-52 (June 2005), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361178> [<http://perma.cc/RXZ3-M22M>]; *Establishing the Safety Net Hospital: 1980-2005*, ESSENTIAL HOSPITALS (last visited Mar. 1, 2019), <http://essentialhospitals.org/about-americas-essential-hospitals/history-of-public-hospitals-in-the-united-states/establishing-the-safety-net-hospital-1980-2005> [<http://perma.cc/U9HE-B6QS>].
 16. William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-Profit Hospitals*, in THE CHANGING HOSPITAL INDUSTRY: COMPARING FOR-PROFIT AND NOT-FOR-PROFIT INSTITUTIONS 285, 285-86 (Nat'l Bureau of Econ. Research ed.,

Medicare and Medicaid programs, including Medicaid Upper Payment Limit (UPL), Medicare Uncompensated Care, and Disproportionate Share Hospital (DSH) payments, help offset hospital uncompensated care costs. Finally, the Affordable Care Act (ACA) promised increased health insurance coverage through the individual mandate and insurance subsidies and, correspondingly, a reduction in uncompensated care. Notably, however, this promise was made in exchange for a scheduled slashing of UPL and DSH payments, among other reductions in hospital charity provisions.¹⁷

Unfortunately, this threatened and shrinking patchwork of government support does not stretch nearly far enough to cover the costs of uncompensated care that hospitals incur every year. For instance, the American Hospital Association (AHA) found that between 2013 and 2014, the Medicaid shortfall for all hospitals increased from \$13.2 billion to \$14.1 billion.¹⁸ Moreover, while the DSH payment cuts are currently postponed through 2019, an independent government commission projected that in fiscal year 2018, the scheduled loss of DSH payments would have outstripped the reduction in uncompensated care in twenty states.¹⁹ And given that little has been done to improve the underlying problem of high volumes of uncompensated care, these same federal budget cuts, along with other Medicaid and Medicare cuts that President Trump has proposed,²⁰ continue to threaten hospitals providing

2000), <http://www.nber.org/chapters/c6769.pdf> [<http://perma.cc/Q95K-SFM3>].

17. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-16-568, HOSPITAL UNCOMPENSATED CARE: FEDERAL ACTION NEEDED TO BETTER ALIGN PAYMENTS WITH COSTS (2016), <http://www.gao.gov/assets/680/678127.pdf> [<http://perma.cc/M4VV-LMM3>] [hereinafter GAO UNCOMPENSATED CARE].
18. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO CONGRESS ON MEDICAID AND CHIP 54, 64 (Mar. 2017), <http://www.macpac.gov/wp-content/uploads/2017/03/Analyzing-Disproportionate-Share-Hospital-Allotments-to-States.pdf> [<https://perma.cc/BK6J-QTZ3>].
19. *Id.* at 54; Katie Keith, *New Budget Bill Eliminates IPAB, Cuts Prevention Fund, and Delays DSH Payment Cuts*, HEALTH AFF. (Feb. 2018), <http://www.healthaffairs.org/doi/10.1377/hblog20180209.194373/full> [<https://perma.cc/E9YV-SKR7>].
20. Amy Goldstein & Jeff Stein, *Trump Proposes Big Cuts to Health Programs for Poor, Elderly and Disabled*, WASH. POST. (Mar. 2019), <http://www.washingtonpost.com/national/health-science/trump-proposes-big-cuts-to->

uncompensated care. Thus, while these are estimates and projections, it is evident that government support does not, and is not intended to, fully cover the costs of uncompensated or charity care across the country.²¹

At the same time, not all hospitals bear the burden of charity care equally. While for-profit or investor-owned hospitals provide some charity care, unlike nonprofit hospitals, they are subject only to EMTALA and ethical requirements that physicians treat certain patients regardless of ability to pay.²² On the other hand, in order to retain their tax-exempt status, nonprofit hospitals must comply with these requirements while also conducting a Community Health Needs Assessment (CHNA) every three years and reporting the “community benefits” they provide on Schedule H of their IRS Form 990.²³ Moreover, whereas the managers of for-profit hospitals have a duty to maximize profits, which can mean choosing a higher profit margin over providing critical but less profitable services, the managers of nonprofit hospitals have a responsibility to the hospital’s charitable mission—in addition to needing to stay financially viable.²⁴ Such opposing orientations can result in significantly different approaches to charity care.

Among nonprofit hospitals, this burden is further unequally spread. While certain large, often elite, nonprofit hospitals are able to secure a majority of charitable hospital gifts²⁵ and attract profitable “high acuity” patient cases,²⁶ other hospitals struggle to keep their doors open. For

health-programs-for-poor-elderly-and-disabled/2019/03/11/55e42a56-440c-11e9-aaf8-4512a6fe3439_story.html [https://perma.cc/7MTH-AAUH].

21. See Craig Garthwaite et al., *Hospitals as Insurers of Last Resort*, 10 AMER. ECON. J.: APPLIED ECON. 1 (2018).
22. *Id.* at 1.
23. *New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act*, IRS (Nov. 30, 2018), <http://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act> [http://perma.cc/G5YT-5PRB] [hereinafter *IRS 501(c)(3) Hospital Requirements*].
24. See *infra* note 36.
25. Studies have found that 3.85% of all hospitals receive 71% of national charitable contributions. Many of these hospitals are university-affiliated medical centers or free-standing medical research institutions. Gentry & Penrod, *supra* note 16, at 317.
26. Interview with Michael Angelini, Treasurer, Yale New Haven Hosp., in New Haven, Conn. (Apr. 27, 2018).

example, “safety net” hospitals often face increased financial pressures while providing a disproportionate amount of care to uninsured and underinsured populations.²⁷ Located primarily in rural areas, these hospitals play a critical role as last resort care providers or “insurers” for the most disadvantaged populations in the country.²⁸ Even though some of these hospitals receive additional government support through special designations,²⁹ many operate on negligible, if not negative, margins.³⁰ Some, including 101 rural hospitals from 2010 to 2019,³¹ have even been forced to close despite vigorous community protests against closure.³² Yet, with essentially no regard for the precarious situation of these critical

27. *Establishing the Safety Net Hospital*, *supra* note 15.

28. Garthwaite et al., *supra* note 21, at 2.

29. Such hospitals are designated “Sole Community Hospitals” (SCH), “Medicare Dependent Hospitals” (MDH), or “Critical Access Hospitals” (CAH). Note that in 1999 the Critical Access Hospital designation was expanded to allow for-profit hospitals to participate; however, only forty-one of approximately 1,315 CAHs (about 3%) are for-profits. *See* Jill R. Horwitz & Austin Nichols, *Rural Hospital Ownership: Medical Service Provision, Market Mix, and Spillover Effects* 8 (Nat’l Bureau Econ. Research, Working Paper 16926, 2011), <http://www.nber.org/papers/w16926.pdf> [<http://perma.cc/D7BG-LDS9>].

30. Ten percent of Critical Access Hospitals filed for bankruptcy protection in 2011 and 2012; others were confronted with financial stress, resulting in lender and bondholder risk. Dan McMurray & Juanita Schwartzkopf, *Are Critical Access Hospitals at a Higher Risk*, *FOCUS* (Mar. 2013), <http://www.focusmg.com/wordpress/wp-content/uploads/2013/03/Are-Critical-Access-Hospitals-At-Higher-Risk.pdf> [<http://perma.cc/S49V-VXCA>]; *see* Lisa Kinney Helvin, *Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their Share?*, 8 *YALE J. HEALTH POL’Y, L. & ETHICS* 421, 468 (Mar. 3, 2013).

31. *Rural Hospital Closures: January 2010 – Present*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES. (last visited Feb. 21, 2019), <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> [<http://perma.cc/FUY6-UHEE>] [hereinafter *Rural Hospital Closures*]; *see* Brystana G. Kaufman et al., *The Rising Rate of Rural Hospital Closures*, 32 *J. RURAL HEALTH* 35 (2016).

32. *See e.g.*, Adrienne Coles, *Walk To Save Rural Hospitals Concludes at the Capitol*, *AM. FED’N TEACHERS* (June 16, 2015), <http://www.aft.org/news/walk-save-rural-hospitals-concludes-capitol> [<http://perma.cc/GNL7-MF56>].

hospitals, Congress passed the 2017 tax reform act, further tightening the spigot on multiple streams of support for nonprofit hospitals.³³

Through provisions either directly targeting or indirectly impacting hospitals and tax-exempt organizations, the TCJA fundamentally undermines the financial ability of nonprofit hospitals to serve their communities. This is especially the case relative to for-profit hospitals which, in contrast, benefit significantly from the TCJA's reduced corporate tax rate. This is a serious policy-making decision with critical health ramifications, since a majority of U.S. hospitals, and nearly all safety net and special designation hospitals, are nonprofit entities. Moreover, given the complex mixed-entity nature of the hospital market, turning up financial pressures on nonprofit hospitals without counterbalancing measures tilts the market dramatically towards the adoption of for-profit hospital forms. This landscape change significantly affects healthcare provision, access, and quality across the country, and especially in rural communities.

Nevertheless, the TCJA's legislative history shows that in the two months leading up to the passage of the Act, Congress failed to thoroughly evaluate the far-reaching healthcare impact of the proposed bill's provisions. In fact, working groups and hearings leading up to the TCJA's predecessor, Congressman Camp's 2014 Tax Reform draft, focused on fine-tuning tax-exemption requirements and taxing commercial activity rather than assessing the differential impact of tax reform in the mixed-entity hospital market. In particular, while there was a blunt push towards reducing the corporate tax rate to benefit for-profit corporations, scant attention was paid to the disparate impact on nonprofit entities and the need to mitigate negative distributive effects on hospitals.³⁴

In this Article, I contend that it is crucial for policymakers to carefully contemplate the mixed-entity hospital market and unequal distributive consequences when implementing entity-sensitive legislation like tax reform. In Part I, I provide an overview of mixed-entity markets, and the hospital market in particular. I explain the legal and economic differences between hospital entity forms, along with the unique roles they play in the hospital market. In Part II, I turn to the 2017 tax reform law. I examine the legislative history behind the TCJA, and I analyze the ways in which specific provisions will impact the mixed-entity hospital market. In Part III, I discuss the distributive consequences of this impact. In particular, I focus

33. *See infra* Part III.

34. *See infra* Part II.

on how these changes will impact access to healthcare across different geographical regions, the provision of uncompensated care, and community preventative care initiatives. In Part IV, I recommend that policymakers take care to evaluate how policies like tax reform will impact mixed-entity markets like the hospital market. I also suggest that policymakers pay close attention to the critical roles nonprofit hospitals fulfill, while also being careful not to view nonprofit hospitals as one uniform, homogenous group. I conclude in Part V with the hope that future federal policymaking can help shrink, rather than exacerbate, inequality among hospitals and the populations they serve.

I. MIXED-ENTITY MARKETS

A. Background

When people think about hospitals, the concept of “markets” does not always come to mind. However, the reality is that hospitals operate in competition with other providers of healthcare. The market is not perfectly competitive,³⁵ but the conditions of the market nevertheless influence hospital behavior. This is true of all hospitals regardless of entity or ownership form, although government-owned or “public” hospitals are somewhat less sensitive to market changes.³⁶ This Article will focus primarily on interactions in the hospital market between investor-owned or “for-profit” hospitals and tax-exempt or “nonprofit” hospitals.

The hospital market is not unique in its mix of for-profit, nonprofit, and public entities. In fact, many industries are becoming increasingly mixed in terms of entity form.³⁷ Susan Rose-Ackerman has distinguished

35. Paul A. Pautler & Michael G. Vita, *Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?*, 10 J. CONTEMP. HEALTH L. & POL'Y 117, 117-19 (1994).

36. See Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals*, MARKETWATCH 796 (May 2005), <http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.24.3.790> [http://perma.cc/M4DP-LKR7?type=image]; see Jill R. Horwitz & Austin Nichols, *What Do Nonprofits Maximize? Nonprofit Hospital Service Provision and Market Ownership Mix*, NAT'L BUREAU ECON. RESEARCH 1-2 (July 2007), <http://www.nber.org/papers/w16926.pdf> [http://perma.cc/7YUJ-BD3N].

37. Susan Rose-Ackerman, *Competition Between Non-Profits and For-Profits: Entry and Growth*, 1 VOLUNTAS 13, 13 (May 1990).

several types of these mixed markets: ones where for-profits are entering industries with large historical charitable and public sectors, ones where nonprofits are entering industries dominated by for-profits (often to develop supplemental sources of revenue), and others where the mix of nonprofits and for-profits has been fairly stable over time.³⁸ As discussed below, the hospital industry is clearly one where for-profits have entered a traditionally charitable and public sector.³⁹ For such markets, the mix of entities is often unstable, and the entry of for-profits can actually threaten the existence of nonprofits.⁴⁰

Specifically with respect to the hospital industry, the entry of for-profits may have been prompted by the introduction of public subsidies such as Medicaid and Medicare, which made healthcare more profitable. At the same time, more effective public sector monitoring in healthcare reduced the public's need to rely on the altruistic nature of nonprofit entities.⁴¹ For-profits also gain a foothold over nonprofits by avoiding the need to funnel profits into cross-subsidizing charity services; for-profits can instead accrue those profits to their owners. At the same time, for-profits are able to "cream-skim" by specializing in services for the rich or privately insured.

Accordingly, it is worth asking why nonprofits should continue to exist in an industry where for-profits can turn a profit. In other words, what is the value of non-profit entities in markets like the hospital industry? First, the nonprofit form allows an organization to credibly assert an ideological commitment or mission, assuaging consumers' fears of exploitation where there is asymmetry of information.⁴² This clearly applies in the healthcare context, where lay patients must rely, sometimes blindly, on their healthcare providers' expertise. Second, a nonprofit's stated mission may also signal to employees that their selflessness will not enrich someone else, making the entity an attractive employer.⁴³ This may be particularly true of many healthcare professionals, who often choose their profession

38. *Id.* at 14.

39. *Id.*; see *infra* note 41 and accompanying text.

40. Rose-Ackerman, *supra* note 37, at 17.

41. *Id.*

42. *Id.*

43. *Id.*

to help others.⁴⁴ Third, a nonprofit's goals may attract private donations, giving them an additional source of funding; for a hospital, this could mean enabling them to price services below cost. In these ways, nonprofits arise to "fill a market niche when information asymmetry and trust are important."⁴⁵

Furthermore, a nonprofit's managers have no fiduciary obligation to raise prices or lower quality in response to increased demand for its services. This enables nonprofits to pursue altruistic goals in terms of service offerings and pricing and to offer services that are of no interest to paying consumers, such as charity or uncompensated work.⁴⁶ This is particularly critical in healthcare where the cost of vital treatments can be highly disproportionate to market demand and patients' ability to pay. To give just one example, the cost of caring for children with complex chronic diseases such as cerebral palsy consumes a disproportionate share of hospital resources;⁴⁷ however, most people would agree that these children should be cared for even if they are not insured or cannot pay. This is why some scholars have argued that the scrutiny of nonprofits should not always be focused on relative productive efficiency or even total amount of charity provision, since "successful nonprofits should provide *different kinds* of goods and services or appeal to *different types* of customers than for-profits."⁴⁸ In other words, nonprofits play a unique

44. Molly Gamble, *How Much Should We Expect Healthcare to Mimic Other Industries?*, BECKER'S HOSP. REV. (Aug. 13, 2013), <http://www.beckershospitalreview.com/hospital-management-administration/how-much-should-we-expect-healthcare-to-mimic-other-industries.html> [<http://perma.cc/BED6-T6X9>].

45. Susan Rose-Ackerman, *Altruism, Nonprofits, and Economic Theory*, 34 J. ECON. LIT. 701, 717-22 (1996).

46. *Id.*

47. See, e.g., Alan Mozes, *U.S. Children's Hospitals Treating More Complex, Expensive Conditions*, HEALTHDAY (Dec. 27, 2012), <http://consumer.healthday.com/respiratory-and-allergy-information-2/asthma-news-47/u-s-children-s-hospitals-treating-more-complex-expensive-conditions-671962.html> [<http://perma.cc/644F-V2C7>]; Alon Peltz et al., *Hospital Utilization Among Children with the Highest Annual Inpatient Cost*, PEDIATRICS (Feb. 2016), <http://pediatrics.aappublications.org/content/pediatrics/137/2/e20151829.full.pdf> [<http://perma.cc/6LQT-PM5N>].

48. Rose-Ackerman, *supra* note 45, at 722.

role in the market based on “trust, generosity, and ideology”⁴⁹—and in the hospital context, this role can be critical for many patients and communities.

Over the past few decades, joint nonprofit and for-profit commercial ventures have also become a common presence in mixed-entity markets.⁵⁰ These entities must be carefully structured to maintain the nonprofit’s tax-exempt status, often resulting in very complicated entity forms and organizational charts. This has become especially relevant since the implementation of the unrelated business income tax in 1950⁵¹ and continued robust legal and political debates about how much commercial activity, related or unrelated, nonprofits should be allowed to conduct.⁵²

It is worth noting that mixed-entity markets and their unique dynamics have gained renewed relevance in recent years, especially as states have begun creating new legal entity forms such as “benefit corporations” that blur the traditional line between profit-driven and socially-minded enterprises. These hybrid entities are becoming increasingly popular for their commitment to both for-profit and nonprofit purposes.⁵³ One of the most prominent benefit corporations, Laureate Education, has even successfully gone public as a provider of higher education—another industry traditionally dominated by nonprofits.⁵⁴ The

49. *Id.* at 723. Rose-Ackerman notes however, that some studies have shown that stronger competitive pressures within a market area drive down such charity behavior by all entity forms. For instance, nonprofit hospitals have been found to provide more charity care than for-profits but do so less in more competitive markets. *Id.* at 720.

50. Rose-Ackerman, *supra* note 37, at 15.

51. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-08-364, TAX POLICY: COMPETITION BETWEEN TAXABLE BUSINESSES AND TAX-EXEMPT ORGANIZATIONS (1987), <http://www.gao.gov/assets/280/272374.html> [<http://perma.cc/67EF-XS75>].

52. *See generally* Terri Lynn Helge, *Joint Ventures of Nonprofits and For-Profits*, TEX. TAX LAW., Spring 2014, at 1 (2014).

53. *Benefit Corporations/Hybrid Entities*, JUSTIA (last visited Mar. 2, 2019), <http://www.justia.com/business-formation/benefit-corporations-hybrid-entities> [<http://perma.cc/PL4T-X3UA>].

54. Press Release, Laureate Int’l Univs., Laureate Education, Inc., the First Public Benefit Corporation to Go Public, Is Named “B Corp MVP” in 2017 (Oct. 17, 2017), <http://www.laureate.net/newsroom/pressreleases/2017/10/bcorpmpv2017> [<http://perma.cc/3JV7-959Z>].

proliferation of these new entity forms creates new options and considerations for traditional nonprofits looking to carry forward their missions in the face of new market dynamics and competition. As the next Section will discuss, these developments are highly relevant to the hospital marketplace, especially as the recent tax reform heightens financial pressures for nonprofit hospitals.

B. Mixed-Entity Hospital Market

Focusing now on the U.S. hospital market, this Section will look in-depth at the interactions and differences between for-profit investor-owned hospitals (for-profits), non-governmental nonprofit hospitals (nonprofits), and, to a lesser extent,⁵⁵ state or local government-owned hospitals.⁵⁶ Across the nation, 59% of U.S. hospitals are nonprofits, 21% are for-profits, and 20% are government-owned.⁵⁷ However, hospital market mix varies considerably by state, community needs, and other local factors.⁵⁸

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55. This Article addresses government hospitals to a lesser extent because they are relatively insulated from the market by direct government subsidization. *See generally* Lynn Quincy, *What Is Government-Run Healthcare—And What Isn't*, CONSUMERS UNION (Feb. 20, 2010), http://consumersunion.org/research/what_is_government-run_health_care_-_and_what_isnt [<http://perma.cc/G5AY-P6RV>].
56. *See* Horwitz & Nichols, *supra* note 29, at 3; Guy David, *The Convergence Between For-Profit and Nonprofit Hospitals in the United States*, 9 INT'L J. HEALTH CARE FIN. & ECON. 419 (2009), <http://link.springer.com/content/pdf/10.1007%2Fs10754-009-9068-0.pdf> [<http://perma.cc/FSV5-9GXU>].
57. *Pie Charts of Fast Facts on U.S. Hospitals 2018*, AM. HOSP. ASS'N (2018), <http://www.aha.org/statistics/2018-01-09-fast-facts-us-hospitals-2018-pie-charts> [<http://perma.cc/G72Y-V8XC>] [hereinafter *U.S. Hospitals Fast Facts*].
58. Scholars have termed the mixed-entity market in the hospital industry as “market mix” or “ownership mix.” I will use these terms interchangeably with “mixed-entity markets.” *See, e.g.*, Jill R. Horwitz & Austin Nichols, *Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives*, 28 J. HEALTH ECON. 924 (2009), <http://www.sciencedirect.com/science/article/pii/S0167629609000654?via%3Dihub> [<http://perma.cc/F92N-PRJ9>].

These variations in hospital ownership mix are significant because, like other nonprofits in mixed-entity markets, hospitals do not operate in a vacuum but respond to the changing dynamics of a complicated, competitive market with diverse players. Intuitively, it is not too surprising that for-profit hospitals are keenly sensitive to changes in market demand and service profitability, as well as financial incentives created by regulations or tax policies.⁵⁹ However, the same is true of nonprofit hospitals. Despite popular notions that nonprofits should operate tirelessly on employee altruism and donor generosity while remaining revenue-blind, nonprofit hospitals confronted with financial difficulties and pressures are not immune from cutting charitable services and pivoting to more profitable services.⁶⁰ In a competitive market, nonprofits need to effectively navigate both the market and their finances to keep their doors open.⁶¹

In fact, scholars have found that, far from being fixed, nonprofit hospital behavior can be significantly and demonstrably influenced by the presence of for-profit competitors in the market.⁶² For instance, scholars Jill Horwitz and Austin Nichols found that nonprofit hospitals located in markets with more for-profit competitors tended to “offer more profitable services and fewer unprofitable services than those with fewer for-profit competitors.”⁶³ Other studies have found that nonprofits in the same

59. See generally Sujoy Chakravarty et al., *Does the Profit Motive Make Jack Nimble? Ownership Form and the Evolution of the U.S. Hospital Industry*, SSRN (2005), <http://www.ssrn.com/abstract=821464> [<http://perma.cc/TCF6-5TV9>]; Horwitz, *supra* note 36.

60. See Horwitz & Nichols, *supra* note 29, at 14; Tom Chang & Mireille Jacobson, *What Do Nonprofit Hospitals Maximize? Evidence from California's Seismic Retrofit Mandate* 1, 3-4 (Nat'l Bureau of Econ. Research, Working Paper, Dec. 2010), <http://users.nber.org/~jacobson/ChangJacobson12.5.10.pdf> [<http://perma.cc/FC8N-F8S3>].

61. See generally Stuart M. Butler, *Why Capital Markets Are Tough for Scrappy Non-Profits*, BROOKINGS (Aug. 23, 2016), <http://www.brookings.edu/opinions/why-capital-markets-are-tough-for-scrappy-non-profits> [<http://perma.cc/UC7S-6ZTH>]; Frank A. Sloan & Robert A. Vraciu, *Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues*, HEALTH AFF., Spring 1983, at 25.

62. See Horwitz & Nichols, *supra* note 29, at 13.

63. *Id.*

locales as for-profits deliver only marginally more uncompensated care—although notably, they still deliver more.⁶⁴

The very existence of for-profit hospitals also creates a choice in ownership form for nonprofit hospitals. Indeed, there is already a robust, if controversial, trend of nonprofits converting to for-profit hospitals: In one study of Medicare data from 2002 to 2010, 237 out of 4,334 (about 5% of) nonprofit hospitals converted to for-profit status.⁶⁵ Scholars such as Guy David have argued that this shows that hospitals essentially choose their ownership type based on local and federal regulatory and tax regimes.⁶⁶ In other words, ownership form is not a fundamental or defining characteristic for hospitals but rather a market-determined choice.⁶⁷

As an alternative to converting, some nonprofit hospitals, like nonprofits in other industries, have chosen to take advantage of for-profit entity benefits by forming joint ventures with for-profit partners or subsidiaries.⁶⁸ For nonprofit hospitals, joint ventures are a popular means of obtaining capital to enhance medical operations and acquire new medical technologies to improve healthcare services.⁶⁹ However, like all ownership entity choices, the advantage of these hybrid entities, and

64. See Edward C. Norton & Doug Staiger, *How Hospital Ownership Affects Access to Care for the Uninsured*, 25 RAND J. ECON 171, 171-75 (1994).

65. Karen E. Joynt, E. John Orav & Ashish K. Jha, *Association Between Hospital Conversions to For-Profit Status and Clinical and Economic Outcomes*, 312 JAMA 1644, 1648 (2014), <http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2014.13336> [<http://perma.cc/DV6U-W2PV>].

66. David, *supra* note 56.

67. Some scholars go further, contending that “focusing on things like for-profit or nonprofit status is a distraction” from improving hospital care. Press Release, Harvard Sch. of Pub. Health, *Hospitals Converting to For-Profit Status Show Better Financial Health, No Loss in Quality of Care* (Oct. 21, 2014), <http://www.hsph.harvard.edu/news/press-releases/hospitals-converting-to-for-profit-status-show-better-financial-health-no-loss-in-quality-of-care> [<http://perma.cc/XZ5M-ZXXZ>].

68. LaVerne Woods & Thomas C. Schroeder, *Joint Ventures Between Tax-Exempt Health Care Organizations and For-Profit Parties*, HEALTH CARE REG. & COMPLIANCE INSIGHTS, Spring 2010, at 21, http://www.willamette.com/insights_journal/10/spring_2010_5.pdf [<http://perma.cc/3TZM-Z28X>].

69. *Id.*

therefore their existence, is highly contingent on favorable tax policies.⁷⁰ Accordingly, policies that readjust hospital finances or shift local market mixes wield even greater power over large-scale hospital behavior than might otherwise be expected.

Ultimately, the fact that hospitals compete in a mixed-entity market is significant because changes in the ratio of nonprofit and for-profit hospitals, as well as changes impacting individual hospitals, can have serious ramifications for patients and communities. As this Article will discuss further below, nonprofit and for-profit entities operate within different frameworks and fulfill different roles in the provision of healthcare. While scholars may debate whether the nonprofit or for-profit entity suits hospitals better,⁷¹ the incontrovertible reality is that most hospitals are nonprofits, and the vast majority of critically needed hospitals are nonprofits. In other words, as of today, whether in terms of service offerings, geographic coverage, or the provision of charity care, nonprofit hospitals are vital to the provision of healthcare in America. Thus, it matters that the same policies can have dramatically different effects on different forms of hospitals, and accordingly, it is essential to examine the impact of policies on hospitals within the context of the mixed-entity market they operate in.

70. Michael I. Sanders, *Health Care Joint Ventures Between Tax-Exempt Organizations and For-Profit Entities*, 15 HEALTH MATRIX 83, 84 (2005).

71. For supporters of the proposition that the nonprofit entity suits hospitals better, see, for example, David, *supra* note 56; Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1346 (2003); and Mark Schlesinger & Bradford H. Gray, *How Nonprofits Matter in American Medicine, and What To Do About It*, 25 HEALTH AFFAIRS 287, 287-88 (2006), <http://content.healthaffairs.org/cgi/doi/10.1377/hlthaff.25.w287> [<http://perma.cc/E9HE-7PYY>]. For supporters of the proposition that the for-profit entity suits hospitals better, see, for example, Chakravarty, *supra* note 59; Pauline Vaillancourt Rosenau & Stephen H. Linder, *Two Decades of Research Comparing For-Profit and Nonprofit Health Provider Performance in the United States*, 84 SOC. SCI. Q. 219 (2003); and INST. OF MED. COMM. ON IMPLICATIONS OF FOR-PROFIT ENTER. IN HEALTH CARE, FOR-PROFIT ENTERPRISE IN HEALTH CARE 2 (Bradford H. Gray ed., 1986), <http://www.ncbi.nlm.nih.gov/books/NBK217919> [<http://perma.cc/KF6R-PY77>].

C. Hospital Entity Forms

To understand the 2017 tax reform bill's differential impact on nonprofit and for-profit hospitals, it is essential to understand the key differences between nonprofit and for-profit regulatory burdens and financial advantages. In this Section, I will first address nonprofit hospitals, then turn to for-profits.

1. Nonprofit Hospitals

From a tax and regulatory standpoint, nonprofits are very different from for-profit hospitals. By definition, non-profits are charitable organizations that qualify for federal tax exemptions.⁷² Non-profits also qualify for state and local income, property, and sales tax exemptions, subject to additional requirements.⁷³ In addition, nonprofit hospitals can issue tax-exempt bonds that do not require lenders to pay income taxes on interest received. This enables nonprofits to obtain financing at lower-than-market costs.⁷⁴ Donors to nonprofit hospitals can also, within certain limits, deduct their charitable contributions from their net income, incentivizing donors to give more.⁷⁵ Taken together, these tax exemptions provide a significant financial benefit to the non-profit entity form. Some sources estimate that the total value of nonprofit hospital tax exemptions was as high as \$24.6 billion in 2011.⁷⁶

72. Daniel B. Rubin, Simone R. Singh & Gary J. Young, *Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice*, 36 ANN. REV. PUB. HEALTH 545, 546 (2015).

73. Julia James, *Nonprofit Hospitals' Community Benefit Requirements*, HEALTH AFF. (Feb. 25, 2016), <http://www.healthaffairs.org/doi/10.1377/hpb20160225.954803/full> [<http://perma.cc/Q2S3-6ZBU>].

74. William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-Profit Hospitals* (Nat'l Bureau of Econ. Research, Working Paper No. 6435, 1998), <http://www.nber.org/papers/w6435> [<http://perma.cc/7T27-3ZHV>].

75. *Id.*

76. *See, e.g.*, Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption Was \$24.6 Billion in 2011*, HEALTH AFF. (July 2015), <http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.1424> [<http://perma.cc/82PU-A9EY>]. However, other sources have estimated the nonprofit tax exemption value to be as low as \$6 billion. *See* Ernst & Young, *Estimates of the Federal Revenue Forgone Due to the Tax Exemption of Non-*

In exchange for this financial subsidization, nonprofit hospitals commit to a plethora of evolving IRS nonprofit requirements and hospital-specific rules, as well as federal, state, and local regulations.⁷⁷ At the broadest level, entities “organized and operated” as nonprofits must “serve[] a public rather than a private interest”—that is, they must benefit the broader public, rather than any particular individual or narrowly defined group. Accordingly, they must observe complete bans on “private inurement,” the distribution of assets to shareholders, and “private benefit.”⁷⁸ A nonprofit’s activities also must not contravene public policy or become overly “commercial.”⁷⁹

In terms of hospital-specific rules, nonprofit hospitals have been subject to a variety of changing IRS schemes all attempting to define “public benefit” within the healthcare context. In 1969, with the introduction of Medicare and Medicaid, the original charitable care requirement⁸⁰ was replaced by the more flexible “community benefit” standard.⁸¹ Under this standard, nonprofit hospitals were no longer explicitly required to care for patients for free or at rates below cost;⁸² instead, they had to provide services “beneficial to their communities.”⁸³ Academics have criticized the vagueness of this standard, noting that it has produced great variation in what is considered a community benefit activity and how its value is measured—providing little assurance that

Profit Hospitals Compared to the Community Benefit They Provide, 2013, AM. HOSP. ASS’N. (Oct. 2017), <http://www.aha.org/system/files/2018-02/tax-exempt-hospitals-benefits.pdf> [<http://perma.cc/RWS5-4279>].

77. See Ernst & Young, *supra* note 76; Susan Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 37 (2015).
78. Tahk, *supra* note 77, at 38.
79. *Id.*
80. Before 1969, to qualify for tax-exempt status a hospital had to provide, “to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it.” James, *supra* note 73.
81. Tahk, *supra* note 77, at 39.
82. Note that later guidance provided in 2002 states that charity care is a “highly significant factor” in determining whether hospitals satisfy the community benefit standard. *Id.* at 40.
83. Factors satisfying this broad standard included: “(1) a community board, (2) an emergency room available to all patients, regardless of ability to pay, (3) a medical staff open to all doctors and (4) a willingness to treat Medicare and Medicaid recipients.” *Id.*

nonprofit hospitals provide public benefit equal to or greater than their tax exemption.⁸⁴ Indeed, one study found that while nonprofits on average spent 7.5% of their operating expenses on community benefits in FY 2009, the level of benefits provided by individual nonprofits varied widely, ranging from approximately 1% in the bottom decile to approximately 20% in the top decile.⁸⁵ Several court cases challenging the tax-exempt status of some hospitals have arisen, alleging that nonprofit hospitals are providing less community benefit than the value of their tax exemption.⁸⁶

After much debate, in 2008 the IRS added a requirement that nonprofit hospitals report their community benefits on a new Schedule H worksheet that was added to hospitals' IRS Form 990s. Schedule H categories of community benefit activities include: net, unreimbursed costs of charity care; participation in means-tested government programs; health professions education; health services research; subsidized health services; community health improvement activities; and contributions to other community groups.⁸⁷ Hospitals can also include what the IRS calls "community building activities" but only if they submit separate evidence demonstrating the relationship between such investments and health improvement—an additional requirement that has been criticized as creating unnecessary uncertainty. Schedule H also "requires the reporting of bad debt (amounts uncollected from patients who did not qualify for

84. See, e.g., *id.* at 40-41.

85. Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 N. ENGL. J. MED. 1519, 1519 (Apr. 18, 2013), <http://www.nejm.org/doi/10.1056/NEJMsa1210239> [<http://perma.cc/4UE8-G6NB>].

86. See, e.g., Tim Darragh, *Morristown Hospital Loses Property Tax Court Case; Judge Says Facility Does Not Meet Non-Profit Status*, NJ.COM (June 26, 2015), http://www.nj.com/morris/index.ssf/2015/06/morristown_medical_center_loses_tax_case_raising_f.html [<http://perma.cc/A2D8-QTRV>]; Molly Gamble, *Pittsburgh v. UPMC: Legal Arguments Behind the Tax-Exempt Challenge*, BECKER'S HOS. REV. (Apr. 26, 2013), <http://www.beckershospitalreview.com/legal-regulatory-issues/pittsburgh-v-upmc-legal-arguments-behind-the-tax-exempt-challenge.html> [<http://perma.cc/E3AY-EV76>]; Lisa Schencker, *Illinois Supreme Court Delivers Partial Win for Hospitals on Property Taxes*, CHI. TRIB. (Mar. 23, 2017), <http://www.chicagotribune.com/business/ct-supreme-court-hospital-taxes-0324-biz-20170323-story.html> [<http://perma.cc/3PBM-G34L>].

87. James, *supra* note 73.

charity care) and shortfalls associated with Medicare payments, but the IRS does not count these amounts as community benefits.”⁸⁸

Finally, in 2010, Affordable Care Act legislation updated the IRS requirements to its current state by adding a few specific obligations. Although it did not impose any quantitative thresholds for charity care or community benefits, the ACA required nonprofit hospitals to conduct a “community health needs assessments” (CHNA) every three years and establish written financial assistance and emergency medical care policies.⁸⁹ In addition, the ACA zeroed in on nonprofit hospitals’ financial policies by limiting their ability to charge uninsured patients at inflated rates or to engage in “extraordinary collection actions” against patients.⁹⁰

As a result of this structured exchange of state subsidization for an expected public benefit, patients often assume nonprofit hospitals will be “more trustworthy, fair, and humane but lower in quality”⁹¹—although the accuracy of that perception is debated.⁹² Regardless, it is clear that while nonprofit hospitals receive financial benefit from their tax-exempt status, this benefit is not free: they are also bound by extensive layers of regulatory oversight to provide community benefits including uncompensated care.

2. For-Profit Hospitals

For-profit hospitals are also held accountable by federal, state, and local regulations. After all, healthcare is a highly-regulated industry.⁹³ Like

88. *Id.*

89. IRS 501(c)(3) Hospital Requirements, *supra* note 23.

90. *Id.*

91. Mark Schlesinger et al., *Public Expectations of Nonprofit and For-Profit Ownership in American Medicine: Clarifications and Implications*, 23 HEALTH AFF. 181, 181 (2004), <http://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.6.181> [<http://perma.cc/R4UG-5BPT>].

92. *See, e.g.*, Rosenau & Linder, *supra* note 71 at 224; Christopher Cheney, *Differences Between NFPs and For-Profits Are Marginal*, HEALTHLEADERS MEDIA (Mar. 14, 2016), <http://www.healthleadersmedia.com/finance/differences-between-nfps-and-profits-are-marginal> [<http://perma.cc/J8EW-E8PZ>].

93. *See, e.g.*, Robert I. Field, *Why Is Health Care Regulation so Complex?*, 33 PHARMACY & THERAPEUTICS 607 (2008) (providing some reasons as to why health care is so heavily regulated).

nonprofits, virtually all for-profit hospitals depend on government subsidization via Medicare and Medicaid payments which come with various requirements like EMTALA.⁹⁴ For-profits are also subject to state and local regulations, and because of wide variation in these regulations, some states, such as Florida, have a 51.4% for-profit hospital market share, whereas other states, like New York, Vermont, Minnesota, and Hawaii, have no for-profit presence at all.⁹⁵

But, to start with the fundamentals, what are for-profit or investor-owned hospitals? As the names suggest, for-profit hospitals are businesses operated to produce profit for their owners, or shareholders. Most for-profit hospitals are legally organized as corporations and therefore are governed by their shareholders through a board of directors. Corporate entities are regulated by the business laws of their state of incorporation.⁹⁶ In addition to shareholder accountability and state corporate laws, hospitals are also subject to accreditation requirements established by the Joint Commission on Accreditation of Hospitals and the American Osteopathic Association.⁹⁷ Hospital corporations that make their shares available for purchase by the public are subject to additional federal regulation under the federal securities laws, as well as the oversight of the Securities and Exchange Commission (SEC) and the Federal Trade Commission (FTC).⁹⁸ Thus, although for-profits are not beholden to nonprofit requirements, they are still subject to government regulation.

Perhaps the most significant difference between nonprofit and for-profit hospitals is that for-profit corporations are required to pursue profit

94. In fact, some scholars would argue that these guaranteed payments actually helped spark the creation and explosive growth of for-profit hospital conglomerates. See, e.g., ROBERT I. FIELD, *MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED "FREE-MARKET" HEALTH CARE* 107, 109 (2014).

95. *Hospitals by Ownership Type*, KAISER FAM. FOUND. (2015), <http://www.kff.org/other/state-indicator/hospitals-by-ownership/?activeTab> [<http://perma.cc/KA5H-TXGM>].

96. A few for-profit hospitals are set up as general or limited partnerships (mostly those owned by a group of physicians) but most use the corporate form. John F. Harty & Daniel M. Mulholland III, *Legal Differences Between Investor-Owned and Nonprofit Health Care Institutions*, in *THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 17, 17 (Bradford H. Gray ed., 1983).

97. *Id.* at 19.

98. FIELD, *supra* note 94 at 108.

maximization for their shareholders over the interests of other stakeholders or society at large.⁹⁹ At the same time, they have no obligation to report community benefit. They do not have an equivalent Schedule H form to fill out and are subject only to Medicaid and Medicare requirements.¹⁰⁰

For-profit hospitals also have more options for raising capital. While nonprofits can issue tax-exempt bonds, for-profits have the option of using debt or equity financing. A for-profit entity's cost of equity can vary significantly based on the volatility of its stock (beta), the market risk free rate of return, and the market rate of return; however, simply having the choice of either issuing debt or equity is valuable.¹⁰¹ That said, for-profit hospitals tend to have a very high debt-to-equity ratio,¹⁰² which can cause concern among investors. Nevertheless, Moody's investors service has maintained a "stable outlook" for the U.S. for-profit hospital sector based on "moderate outpatient volume growth and positive pricing."¹⁰³

Today, the for-profit hospital arena is dominated by several giant conglomerates located primarily in the Sunbelt, that is, the southern U.S.

99. See, e.g., Stephen Bainbridge, *A Duty to Shareholder Value*, N.Y. TIMES (Apr. 16, 2015), <http://www.nytimes.com/roomfordebate/2015/04/16/what-are-corporations-obligations-to-shareholders/a-duty-to-shareholder-value> [<http://perma.cc/255T-AYH3>].

100. Les Masterson, *Report: For-profit Hospitals Hurt by Regulations, Cost-cutting Pressures*, HEALTHCARE DIVE (Oct. 2, 2017), <http://www.healthcaredive.com/news/report-for-profit-hospitals-hurt-by-regulations-cost-cutting-pressures> [<http://perma.cc/A8MJ-22WN>].

101. See Claire Boyte-White, *How Does a Company Choose Between Debt and Equity in Its Capital Structure?*, INVESTOPEDIA, <http://www.investopedia.com/ask/answers/032515/how-does-company-choose-between-debt-and-equity-its-capital-structure.asp> [<http://perma.cc/WZT9-DRS3>]; Jill R. Horwitz, *Does Nonprofit Ownership Matter?*, 24 YALE J. REG. 140, 145-56 (2007). But see Uwe E. Reinhardt, *The Economics of For-Profit and Not-for-Profit Hospitals*, 19 HEALTH AFF. 178 (2000) (arguing that for-profits have a higher cost of capital).

102. James A. Ligon, *The Capital Structure of Hospitals and Reimbursement Policy*, 37 Q. REV. ECON. & FIN. 59, 59 (1997).

103. Ayla Ellison, *Moody's Maintains Stable Outlook on For-Profit Hospital Sector*, BECKER'S HOSP. CFO REP. (Sept. 22, 2017), <http://www.beckershospitalreview.com/finance/moody-s-maintains-stable-outlook-on-for-profit-hospital-sector-092217.html> [<http://perma.cc/YT9W-AN7P>].

stretching from Florida to some parts of California.¹⁰⁴ Aside from economies of scale and the tendency for business enterprises to prioritize growth,¹⁰⁵ the dramatic expansion of for-profit chains can be at least partially attributed to for-profits' restructuring advantage. Because for-profit hospitals are corporations owned by shareholders, it is relatively easy to merge them into multi-corporate systems under the umbrella of a holding company that owns all of their stock. This advantage is particularly salient in comparison to nonprofit hospitals for whom entity ownership is a foreign concept and organizational structures are frequently very convoluted.¹⁰⁶ Furthermore, some scholars suggest that once a for-profit has acquired several subsidiaries, it gains the additional advantage of a chain holding company model. This is because removing central management from local hospital sites can help insulate major fiscal and operating decisions from local pressure, either from the community or from physicians. Thus, local hospitals in a chain are more likely to be governed with more removed, but perhaps more rational, efficiency.¹⁰⁷

There is much disagreement among academics, policymakers, and the public regarding the social value of for-profit hospitals.¹⁰⁸ Nonetheless, whether or not "[a] hospital is a hospital," as one for-profit's hospital CEO has asserted, it is apparent that nonprofit and for-profit regulations, financial incentives, and charity requirements are quite distinct. Thus, a hospital that chooses to incorporate as a for-profit entity can strategically subject itself to different frameworks of regulations, tax schemes, and financing options based on entity options.¹⁰⁹

As evidenced by the multi-dimensional, interwoven regulatory regimes creating and defining nonprofit and for-profit hospitals,

104. The five largest for-profit chains include Hospital Corporation of America (HCA), Tenet, Community Health Systems, LifePoint and Universal. Harris Meyer, *For-Profit Hospitals Blaze Separate Path to Efficiency, Quality*, MOD. HEALTHCARE (May 28, 2016), <http://www.modernhealthcare.com/article/20160528/MAGAZINE/305289981> [<http://perma.cc/7A3X-VF3B>].

105. Mike Myatt, *Does Size Really Matter?*, FORBES (Oct. 29, 2012), <http://www.forbes.com/sites/mikemyatt/2012/10/29/does-size-really-matter> [<http://perma.cc/FDD4-22TT>].

106. Horty & Mulholland III, *supra* note 96.

107. *Id.* Conversely, this may also be the source of accusations that for-profit hospitals cold-heartedly close local hospitals.

108. *Supra* notes 72-91 and accompanying text.

109. David, *supra* note 66.

government regulation fundamentally shapes the hospital market landscape. Accordingly, policymakers, especially at the federal level, have tremendous power to reshape the market with even the slightest changes to healthcare, nonprofit, corporate, or tax law. In the next Section, I examine how the newest tax reform law does not tread carefully enough amidst this complex web of hospital regulations and a dynamic mixed-entity hospital market.

II. THE 2017 TAX REFORM LAW

The tax reform law of 2017 is a tax law and not a healthcare law, but it nonetheless carries serious ramifications for our nation's healthcare system—and hospitals in particular. Signed into law by President Trump on December 22, 2017,¹¹⁰ the bill, H.R.1, was originally named the Tax Cuts and Jobs Act (TCJA). However, it was subsequently re-named the much lengthier and wonkier title, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 to satisfy the Senate “Byrd rule.”¹¹¹ Voted through without any Democratic votes in either the House or the Senate,¹¹² the Republican TCJA was proposed and enacted in under two months, triggering Democratic complaints about a rushed, nontransparent process.¹¹³ It is seen as an

110. Louise Radnofsky, *Trump Signs Sweeping Tax Overhaul into Law*, WALL ST. J. (Dec. 22, 2017, 11:45 AM), <http://www.wsj.com/articles/trump-signs-sweeping-tax-overhaul-into-law-1513959753> [http://perma.cc/ML3V-8N2].

111. The “Byrd rule” applies to bills moving through the “budget reconciliation” process that allows legislation to pass by a simple majority (and avoid a Democratic filibuster in the Senate). Under the rule, reconciliation bills cannot include provisions that do not have an impact on the budget. Eli Watkins, *Senate Rules Force Republicans to Go with Lengthy Name for Tax Plan*, CNN (Dec. 19, 2017, 10:14 PM) <http://www.cnn.com/2017/12/19/politics/tax-bill-name-delay/index.html> [http://perma.cc/UBE7-G4JC].

112. *Congress Approves Republican Tax Plan Setting Up Delivery to Trump's Desk*, N.Y. TIMES (Dec. 19, 2017), <http://www.nytimes.com/2017/12/19/us/politics/tax-bill-vote-republicans.html> [http://perma.cc/G7E9-U2RB] [hereinafter *Republican Tax Plan*].

113. Jim Tankersley & Alan Rappeport, *G.O.P. Rushed to Pass Tax Overhaul. Now It May Need to Be Altered*, N.Y. TIMES (Mar. 11, 2018), <http://www.nytimes.com/2018/03/11/us/politics/tax-cut-law-problems.html> [http://perma.cc/QYM4-5BNA].

essential accomplishment for Republican Congressmen and the Trump administration, especially against the backdrop of their earlier failure to repeal the ACA, often referred to as “Obamacare,” in July.¹¹⁴ In this Section, I discuss the two-part legislative history that laid the foundation for the TCJA: the work behind the 2014 tax reform draft, and legislative efforts leading up to the 2017 tax reform bill. In particular, I lay out Congress’s longtime fears of unfair nonprofit competition and abuse of the charitable tax exemption. I then address each healthcare-impacting provision of the TCJA in detail and examine the impact it will have on the mixed-entity hospital market. I conclude that the TCJA will help for-profit hospitals while making life harder for nonprofits.

A. Legislative History

Before the new tax reform bill was unveiled, President Trump stated on October 31, 2017 that he would sign the bill by Christmas.¹¹⁵ And indeed, he ended up signing it on December 22nd.¹¹⁶ During this brief two-month time period, Democrats complained that there had been “no hearings on the bill,”¹¹⁷ while Republicans simultaneously claimed they had held “dozens of hearings on tax policy.”¹¹⁸ How can that be? In a sense, both Republicans and Democrats were right: while there were very few hearings held leading up to the TCJA’s unveiling, and none after the TCJA

114. *Health Care Reform Comparison: The Long Road to Nowhere – ACA Repeal Effort Over?*, BLOOMBERG BNA, <http://www.bna.com/american-health-care-m73014451393/> [<http://perma.cc/Y3C2-KVQB>].

115. Rebecca Ballhaus, *President Donald Trump Says He’ll Sign Tax Bill By Christmas*, WALL ST. J. (Oct. 31, 2017, 12:22 PM), <http://www.wsj.com/livecoverage/tax-bill-2017/card/1510607902> [<http://perma.cc/2G8N-Y4NL>].

116. Radnofsky, *supra* note 110.

117. *Tax Reform Watch: The Future of the U.S. Tax Code*, BLOOMBERG L., <http://www.bna.com/taxreform> [<http://perma.cc/6GKK-XSTY>]; Ryan Clancy, *Regrets on Tax Reform? Both Parties May Have a Few*, HILL (Dec. 26, 2017, 5:30 PM), <http://thehill.com/blogs/congress-blog/economy-budget/366493-regrets-on-tax-reform-both-parties-may-have-a-few> [<http://perma.cc/JQ9L-PLZD>].

118. Richard Rubin, *A Bill Without a Hearing?*, WALL ST. J. (Nov. 13, 2017), <http://www.wsj.com/livecoverage/tax-bill-2017/card/1510607902> [<http://perma.cc/85S2-A325>].

draft was introduced,¹¹⁹ the Senate Finance Committee and the House Ways and Means Committee had been working on tax reform for years in anticipation of other tax bills.

In this Section, I analyze the two-part legislative history leading to the 2017 TCJA for Congressional intent and motivations. I do so by tracing the implementation of key tax reform provisions that will impact hospitals. These provisions include: changes to the Unrelated Business Income Tax (UBIT), new excise taxes on executive compensation, repeal of advance refunding bonds, an increased standard deduction, reduced corporate tax rate, and the repeal of the individual mandate penalty. The specific details and impact of these provisions will be discussed in Part II.B.

1. Tax Reform Act of 2014 (Draft)

Congressman Dave Camp's drafting of the Tax Reform Act of 2014 is widely recognized as laying the foundational groundwork for the TCJA. Although the 2014 Act never passed into law and arguably was doomed from the beginning,¹²⁰ analysts at the time noted that the 979-page draft was "monumentally important" and "changed the tax policy landscape like no other single document in the last three decades."¹²¹ They predicted that any future Congressional efforts to reform the tax code would start with this draft document.¹²² And indeed, it did: the TCJA borrowed heavily from

119. The Senate Finance Committee held one hearing on October 3rd on International Tax Reform, however, this was largely lacking in substance and occurred before the tax reform draft was introduced. There were also just a few weeks of discussion on the 448-page TCJA itself. *International Tax Reform: Hearing Before the S. Comm. on Fin. 115th Cong.* (2017); see Albert R. Hunt, *Republican Haste Warps Tax Bills*, BLOOMBERG (Nov. 29, 2017), <http://www.bloomberg.com/view/articles/2017-11-29/republican-haste-warps-tax-bills> [<http://perma.cc/7Q5J-DTL3>].

120. Brett LoGiurato, *Here's One Republican's Sweeping Plan to Overhaul America's Tax System*, BUS. INSIDER (Feb. 26, 2014), <http://www.businessinsider.com/dave-camp-tax-reform-plan-full-text-2014-2> [<http://perma.cc/5QB2-GUGV>].

121. Martin Sullivan, *If Camp's Tax Reform Bill Won't Pass, Why Is it so Important?*, FORBES (Mar. 10, 2014, 2:07 PM), <http://www.forbes.com/sites/taxanalysts/2014/03/10/if-camps-tax-reform-bill-wont-pass-why-is-it-so-important> [<http://perma.cc/9XY2-2Z7Y>].

122. *Id.*; see Legal Research Ctr., *Legislative History of Tax Cuts and Jobs Act: Bills*, DREXEL U. THOMAS R. KLINE SCH. L. (Dec. 21, 2017),

the 2014 draft and many of the healthcare-related provisions in the 2017 TCJA appear to have been lifted from the draft with minimal edits.¹²³

Accordingly, a deep-dive into the legislative history behind this draft is both generally important and particularly relevant here. The first draft of the 2014 tax reform bill was made available on February 26, 2014 and was subsequently introduced in the House on December 10, 2014.¹²⁴ During this extended discussion period, Representative Camp (R-MI), the Chairman of the House Ways and Means Committee, and Senator Max Baucus (D-MT), the Chairman of the Senate Finance Committee, made a concerted effort to solicit public comments and complaints about the tax code.¹²⁵ Following in the footsteps of former House Ways and Means Chairman Dan Rostenkowski's (D-Ill) to reform the tax code with popular input,¹²⁶ Chairmen Camp and Baucus launched a website (taxreform.gov) and a Twitter account (@simplertaxes).¹²⁷ "Max and Dave" then went on a road show, "The Simpler Taxes for America Tour,"¹²⁸ over the summer of 2013 to hear from individuals and businesses across the country. Meanwhile, back in Washington D.C., a bipartisan group of about a dozen senators and representatives were gathering every couple of weeks to talk about tax reform over a "two-pitcher" lunch.¹²⁹

<http://drexellaw.libguides.com/c.php?g=732113&p=5237677>
[<http://perma.cc/9TR5-AYMK>] [hereinafter TCJA Bills].

123. See *infra* notes 145 to 149 and accompanying text.

124. TCJA Bills, *supra* note 122.

125. Susan Davis, *Lawmakers Seek Public Support for Tax Overhaul*, USA TODAY (May 8, 2013, 10:00 PM), <http://www.usatoday.com/story/news/politics/2013/05/08/baucus-camp-rosty-campaign-tax-overhaul/2144589> [<http://perma.cc/7XUH-BFR6>].

126. In 1985, former House Ways and Means Chairman Dan Rostenkowski encouraged viewers on national television to write him letters about reforming the tax code. Viewers reportedly sent upwards of 75,000 letters to the congressman and the next year, Congress approved a broad overhaul of the federal tax code. *Id.*

127. *Id.*

128. John D. McKinnon, *Lessons from 'Simpler Taxes for America' Tour*, WALL ST. J. (Sept. 9, 2013), <http://blogs.wsj.com/washwire/2013/09/09/lessons-from-simpler-taxes-for-america-tour/> [<https://perma.cc/2KUV-AMQ2>].

129. The name of these gatherings paid homage to when, over two pitchers of beer, members of Congress hatched a plan to overhaul the tax system back in 1986. Tamara Keith, *On the Road with Max and Dave: A Tax Overhaul Tour*,

However, Camp and Baucus' efforts to reform the tax code actually began over three years before this final valiant, but futile, push. From the moment Camp ascended to the chairmanship of the House tax-writing committee in 2011, he began working on tax reform.¹³⁰ Under his direction, the House Ways and Means Committee created eleven working groups focused on different issue areas including one on "Charitable/Exempt Organizations" led by David Reichert (R-WA) and John Lewis (D-GA).¹³¹ Meanwhile, the Senate held a series of closed-door meetings on various issue areas including a few hearings addressing the charitable and exempt sector.¹³² The work of both committees and the public comments they received were then summarized in a nearly 600-page Joint Committee on Taxation (JCT) report laying out the current law, as well as proposals and options for reform.¹³³ This report, along with the hearings and paper trail leading up to it, focused extensively on preventing abuse of the tax exemption system and nonprofit engagement in unrelated commercial activity.¹³⁴

NPR (Aug. 6, 2013, 3:29 AM), <http://www.npr.org/sections/itsallpolitics/2013/08/06/209238865/on-the-road-with-max-and-dave-a-tax-overhaul-tour> [<http://perma.cc/ZVP5-J4CS>].

130. Lori Montgomery, *Dave Camp Drops a Tax Reform Bill on His Way Out the Door*, WASH. POST (Dec. 24, 2014), http://www.washingtonpost.com/business/economy/dave-camp-drops-a-tax-reform-bill-on-his-way-out-the-door/2014/12/23/ec9cb998-863a-11e4-b9b7-b8632ae73d25_story.html [<http://perma.cc/VYG4-RK2W>].
131. Press Release, Camp and Levin Announce Ways and Means Tax Reform Working Groups: 11 Working Groups Will Report Findings Back to Full Committee, House Ways & Means Comm. (Feb. 13, 2013), <http://waysandmeans.house.gov/camp-and-levin-announce-ways-and-means-tax-reform-working-groups> [<http://perma.cc/FW82-HFFT>] [hereinafter 11 Working Groups].
132. *Tax Reform*, INDEP. SECTOR (Mar. 25, 2014), http://web.archive.org/web/20140327171646/https://independentsector.org/tax_reform#sthash.zWNF2WEj.QfMiB68u.dpbs [<http://perma.cc/FL5E-TN97>].
133. STAFF OF JOINT COMM. ON TAXATION, 113TH CONG. REPORT TO THE HOUSE COMMITTEE ON WAYS AND MEANS ON PRESENT LAW AND SUGGESTIONS FOR REFORM SUBMITTED TO THE TAX REFORM WORKING GROUPS (2013).
134. *Public Charity Organizational Issues: Hearing Before the S. Comm. on Oversight of the Comm. on Ways & Means*, 112th Cong. (2012) (statement of John D. Colombo, Professor of Law, University of Illinois College of Law). This is evident from the titles and content of the report and hearings. For

This emphasis appeared to be rooted in Congress's long-held anxieties about nonprofits competing unfairly with for-profit businesses, abusing the charitable tax-exemption, and specifically, nonprofit hospitals providing insufficient charitable services. Concerns about "unfair competition" date back to scholarly debates in the early 1900s which led to the implementation of the Unrelated Business Income Tax (UBIT) in the Revenue Act of 1950 and its subsequent expansion in 1969.¹³⁵ Similarly, Congress has long worried about abuses of tax-exemption such as the use of nonprofits as tax shelters, scandals in the credit counseling and hospital industries, and indirect private inurement or excess compensation.¹³⁶ Accordingly, Congress has continually increased restrictions on section 501(c)(3) nonprofit designation since its creation in 1913.¹³⁷ Finally, congressional focus on the nonprofit hospital sector's provision of charitable services also has a long history that is reflected in the convoluted evolution of the nonprofit IRS filing requirements. Notably, just

instance, the House Committee held a hearing on tax-exempt organizations entitled *Hearing on Public Charity Organizational Issues, Unrelated Business Income Tax, and the Revised Form 990. Hearing Before the S. Comm. on Oversight of the Comm. on Ways & Means*, 112th Cong. (2012), [hereinafter House Hearing on Charity Organizational Issues]. The Senate's primary hearing relating to tax-exempt organizations was *Tax Reform Options: Incentives for Charitable Giving*, which focused on anti-abuse provisions. *Hearing Before the S. Comm. on Fin.*, 112th Cong. (2011), [hereinafter Senate Hearing on Charitable Giving]. Similarly, out of the three main sections in the Senate's tax-exempt organizations tax reform option paper, the first was on reforming the charitable deduction and the second was on taxation of business activities of nonprofits (the third, less relevant for this Article, was on political activity and lobbying). BUSINESS INVESTMENT AND INNOVATION: SENATE FINANCE COMMITTEE STAFF TAX REFORM OPTIONS FOR DISCUSSION, S. FIN. COMM. (2013), <http://www.finance.senate.gov/imo/media/doc/2013%20option%20papers.pdf> [<http://perma.cc/P4MU-QSUJ>].

135. Paul Arnsberger et al., *A History of the Tax-Exempt Sector: An SOI Perspective*, STAT. INCOME BULL. 105, 107-08 (2008), <http://causeinspiredmedia.com/wp-content/uploads/2017/02/tehistory.pdf> [<http://perma.cc/GU5V-T7KU>]; see, e.g., Henry B. Hansmann, *Unfair Competition and the Unrelated Business Income Tax*, 75 VA. L. REV. 605 (1989).

136. *Tax Exempt Organizations: Hearing Before the S. Comm. on Oversight of the Comm. on Ways & Means*, 112th Cong. 4 (2012) (testimony of Professor Roger Colinvaux) [hereinafter Colinvaux Testimony].

137. *Id.*

a few years before drafting the 2014 tax reform bill, the House Ways and Means and Senate Finance Committees held hearings on this very topic.¹³⁸ These hearings on the tax-exempt hospital sector led to an IRS compliance check of hospitals and health systems in 2006¹³⁹ and the addition of Schedule H to hospitals' Form 990s in 2008.¹⁴⁰ Then, in 2010, Congress adopted new exemption standards for nonprofit hospitals as part of the ACA.¹⁴¹ Nevertheless, despite implementing a plethora of changes in response to these concerns, Congress has continued to be compelled by fears of unfair competition, tax-exemption abuse, and insufficient hospital charity. This is evident in the Committees' extensive questioning about nonprofit commercial activity,¹⁴² abuses of the charitable deduction,¹⁴³ and hospital community-benefit requirements in the hearings for the 2014 tax reform draft.¹⁴⁴

Most significantly, these ongoing concerns produced tax reform changes first drafted in the 2014 tax reform bill and subsequently implemented in the 2017 TCJA. First, the 2014 tax reform draft included another adjustment of the UBIT: separating out a nonprofit's unrelated trades or businesses such that net operating loss deductions cannot be shared.¹⁴⁵ The 2017 TCJA adopted this change to the UBIT without substantive edits to the net operating loss and carryover language.¹⁴⁶ The

138. *The Tax-exempt Hospital Sector: Hearing Before the Comm. on Ways & Means*, 109th Cong. (2005); *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before the S. Comm. on Fin.*, 109th Cong. (2006).

139. Colinvaux Testimony, *supra* note 136, at 3.

140. *See infra* text accompanying note 87.

141. *See infra* text accompanying note 88.

142. House Hearing on Charity Organizational Issues, *supra* note 134.

143. Senate Hearing on Charitable Giving, *supra* note 134.

144. *Tax Exempt Organizations: Hearing Before the S. Comm. on Oversight of the Comm. on Ways & Means*, 112th Cong. (2012), [hereinafter House Hearing on Tax Exempt Organizations].

145. STAFF OF THE COMM. ON WAYS & MEANS, 113TH CONG., TAX REFORM ACT OF 2014 DISCUSSION Draft § 5003 (Comm. Print 2014) [hereinafter TAX REFORM DRAFT OF 2014].

146. An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018, Pub. L. No. 115-

TCJA also further increased the UBIT burden on nonprofits by taxing certain fringe benefit expenses.¹⁴⁷ Second, the 2014 draft imposed a twenty-five percent excise tax on executive compensation in excess of \$1 million paid to the top five highest compensated covered employees of all tax-exempt organizations.¹⁴⁸ The TCJA modified this provision by lowering the excise tax to twenty-one percent (in accordance with the lower overall corporate tax rate) and added an exception for remuneration paid for the performance of medical services. Otherwise, the TCJA implemented this provision in whole.¹⁴⁹ Third, the 2014 draft proposed to eliminate tax-favored private activity bonds (PABs) for nonprofits.¹⁵⁰ This change also made it into the 2017 tax reform bill drafts, but ultimately was not adopted in the face of heavy pushback from the nonprofit sector.¹⁵¹ Both the 2014 draft and the final TCJA did, however, repeal tax-exemption for advance refunding bonds using almost identical language.¹⁵²

Notably, the House's discussion draft voices a concern that tax-exempt organizations are enjoying a "tax subsidy" from the federal government multiple times as key "considerations" behind the adoption of these provisions.¹⁵³ The draft further questions whether high executive compensation wrongfully diverts nonprofit resources away from

97, § 13702 (2017) (codified as amended at 26 I.R.C. § 512(a)) [hereinafter TCJA].

147. *Id.* § 13703.

148. TAX REFORM DRAFT OF 2014 § 4960, *supra* note 145.

149. TCJA §§ 13602, 13602(c)(1)(3)(B), I.R.C. 4960 (2018) (exception for remuneration for medical services).

150. TAX REFORM DRAFT OF 2014 § 3431, *supra* note 145.

151. *See* Press Release, CDFA, Legislative Victory!: Private Activity Bonds Fully Preserved in Final Tax Bill (Dec. 19, 2017), [http://www.cdfa.net/cdfa/cdfaweb.nsf/0/3E64D87C610FE1FE882581FB0064C621/\\$file/2017%20Preserve%20PABs%20presser.pdf](http://www.cdfa.net/cdfa/cdfaweb.nsf/0/3E64D87C610FE1FE882581FB0064C621/$file/2017%20Preserve%20PABs%20presser.pdf) [<http://perma.cc/HL2M-SBSU>].

152. *Compare* TAX REFORM DRAFT OF 2014 § 3433, *supra* note 145, *with* TCJA § 13532.

153. STAFF OF H.R. COMM. ON WAYS AND MEANS, 113TH CONG., DISCUSSION DRAFT, TAX REFORM ACT OF 2014, at 137, https://web.archive.org/web/20140307092948/http://waysandmeans.house.gov/uploadedfiles/ways_and_means_section_by_section_summary_final_022614.pdf [<https://perma.cc/99KE-BNC8>] [hereinafter 2014 Discussion Draft Summary].

nonprofits' purposes.¹⁵⁴ Thus, it is evident from the reports, history, and hearings underlying the 2014 tax reform effort that the goals of preventing abuse, unfair competition, and ensuring the provision of charity healthcare remained at the forefront of congressional intent in their policymaking regarding tax-exempt organizations.

It is also worth noting that throughout the process leading up to the 2014 tax reform draft, the JCT consistently assessed and framed tax reform in reference to large tax-exempt organizations such as universities and nonprofit hospital systems.¹⁵⁵ Unsurprisingly, this led to 2014 tax reform hearings that subtly but clearly contemplated the needs and effects of tax-exemption reform in relation to large, well-known non-profits: large multi-hospital systems' complex organizational structures and multiple streams of "unrelated" business income were discussed at length, while small organizations were only discussed as an exception relevant for IRS form filings.¹⁵⁶ Small hospitals in particular, that is, Critical Access Hospitals and other specially-designated rural hospitals, do not appear to have been mentioned at all.¹⁵⁷ This oversight is striking in light of the considerably

154. *Id.* at 138.

155. For instance, Professor John D. Colombo, a witness for the House hearing on charity organizational issues, began his statement with references to the Metropolitan Museum of Art, Yale School of Management, and megachurches. He then proceeded to discuss common structures for large institutional public charities. Similarly, other House witnesses included Thomas Hyatt, a Partner at SNR Denton who works predominantly with "large institutional non-profits... with regional and national reach," and Donald Tobin, an associate dean and professor at The Ohio State University Moritz College of Law who likewise spoke primarily about large affiliated entities, as well as their political advocacy. House Hearing on Charity Organizational Issues, *supra* note 134. The other House hearing on tax-exempt organizations invited witnesses from the National Association of College and University Business Officers (large institutions) and the Senior Vice President of the Voluntary Hospital Association, who primarily raised concerns about multi-hospital systems. *Hearing on Tax Exempt Organizations: Hearing before the S. Comm. on Oversight of the Comm. on Ways and Means*, 112th Cong. (2012), <http://republicans-waysandmeansforms.house.gov/news/documentsingle.aspx?DocumentID=326340> [<http://perma.cc/7YKR-G9VG>] [hereinafter House Hearing on Tax Exempt Organizations].

156. House Hearing on Charity Organizational Issues, *supra* note 134.

157. House Hearing on Tax Exempt Organizations, *supra* note 155.

greater negative impact the TCJA has on small and rural nonprofit hospitals.¹⁵⁸

2. Tax Cuts and Jobs Act 2017

In stark contrast to the extensive research, outreach, and tax-exempt-specific analysis leading up to Congressman Camp's 2014 tax reform draft, the TCJA was passed with few hearings and limited assessment of the bill's potential impact on tax-exempt entities. According to the Senate Finance Committee, chaired by Senator Orrin Hatch (R-UT), "years of analysis, papers, hearings and legislating lay the groundwork for a once-in-a-generation tax overhaul"; however, most of the work referenced was done indirectly in preparation for the 2014 tax reform draft.¹⁵⁹ After that bill failed to pass, Chairman Hatch and Ranking Member Ron Wyden (D-OR) created five new bipartisan tax reform working groups in January 2015—less than half of the eleven groups in 2014.¹⁶⁰ These working groups were focused on the individual income tax, business income tax, savings and investment, international tax, and community development and infrastructure. None was specifically devoted to tax-exempt or charitable entities.¹⁶¹ Subsequently, the Senate Finance Committee asked for public input on March 11, 2015,¹⁶² and then released those submissions on April 29, 2015, less than two months later.¹⁶³ These comments were then

158. *Infra* Part III.

159. Press Release, S. Comm. on Fin., Senate Finance Committee Takes on Tax Reform, 1 (Sept. 27, 2017) <http://www.finance.senate.gov/imo/media/doc/11.9.17%20Committee%20History.pdf> [<http://perma.cc/35AH-QDAR>].

160. Press Release, S. Comm. on Fin., Hatch, Wyden Launch Bipartisan Finance Committee Tax Reform Working Groups (Jan. 15, 2015), <http://www.finance.senate.gov/chairmans-news/hatch-wyden-launch-bipartisan-finance-committee-tax-reform-working-groups> [<http://perma.cc/JV2E-S39X>]; 11 Working Groups, *supra* note 131.

161. Hatch, Wyden Launch Bipartisan Finance Committee Tax Reform Working Groups, *supra* note 160.

162. Press Release, S. Comm. on Fin., Hatch, Wyden Launch New Effort to Seek Input on Bipartisan Tax Reform (Mar. 11, 2015), <http://www.finance.senate.gov/chairmans-news/hatch-wyden-launch-new-effort-to-seek-input-on-bipartisan-tax-reform> [<http://perma.cc/3CGN-9L7M>].

163. Press Release, S. Comm. on Fin., Hatch, Wyden Release Public Input on Bipartisan Tax Reform (Apr. 29, 2015), <http://www.finance.senate.gov/>

incorporated into the working groups' reports, which were released on July 8, 2015.¹⁶⁴

Nonprofit-related tax issues were only superficially assessed and involved little coordination among the different working groups. Only three of the reports addressed tax-exempt issues. The business-income group covered electronic filing of Form 990s and private foundation excise taxes.¹⁶⁵ The individual-tax group addressed tax incentives for charitable gifts with a primary focus on property contributions.¹⁶⁶ The community development and infrastructure group discussed tax-exempt bonds.¹⁶⁷ Oddly enough, aside from the corporate tax rate and charitable gift incentives, none of these reports touched on the key healthcare-impacting provisions that were ultimately adopted. Even the section on tax-exempt bonds did not explicitly mention advanced refunding bonds.¹⁶⁸ Indeed, hospitals and healthcare issues more broadly are conspicuously missing from these working groups' reports.

While it is possible that the 2017 tax reform working groups assumed it was unnecessary to address tax-exempt entities given existing 2014 groundwork, the lack of any in-depth or updated analysis before adopting

chairmans-news/hatch-wyden-release-public-input-on-bipartisan-tax-reform [http://perma.cc/F3V7-647W].

164. Press Release, S. Comm. on Fin., Finance Committee Bipartisan Tax Working Group Reports (July 8, 2015), <http://www.finance.senate.gov/chairmans-news/finance-committee-bipartisan-tax-working-group-reports> [http://perma.cc/8596-PMQN].

165. THE BUSINESS INCOME BIPARTISAN WORKING GROUP REPORT, S. COMM. FIN., 55-56 (2015), <http://www.finance.senate.gov/imo/media/doc/The%20Business%20Income%20Bipartisan%20Tax%20Working%20Group%20Report.pdf> [http://perma.cc/PA9L-ZGZP] [hereinafter Business Income Report].

166. THE INDIVIDUAL TAX BIPARTISAN TAX WORKING GROUP REPORT, S. COMM. FIN., 13-20, (2015), <http://www.finance.senate.gov/imo/media/doc/The%20Individual%20Tax%20Bipartisan%20Tax%20Working%20Group%20Report.pdf> [http://perma.cc/C3JJ-MP9T].

167. THE COMMUNITY DEVELOPMENT & INFRASTRUCTURE BIPARTISAN TAX WORKING GROUP REPORT, S. COMM. FIN., iv-v, (2015), <http://www.finance.senate.gov/imo/media/doc/The%20Community%20Development%20&%20Infrastructure%20Bipartisan%20Tax%20Working%20Group%20Report.pdf> [http://perma.cc/XW3A-4H54] [hereinafter Community Development Report].

168. *Id.*

the 2014 provisions still appears to be a significant oversight. At a minimum, it shows that the drafters of the TCJA were not attuned to how it would impact tax-exempt entities, or nonprofit hospitals in particular—if it even crossed their minds. Rather, there seems to have been minimal discussion underlying the House’s decision to repeal advanced refunding bonds and the excise tax on executive compensation. Similarly, the Senate tacked on the UBIT siloing provision as an amendment.¹⁶⁹

On the other hand, the 2017 working groups did discuss charitable gifts. However, whereas the 2014 draft provisions were calculated based on Joint Committee estimates to “increase charitable giving by up to \$2.2 billion per year,”¹⁷⁰ the 2017 provisions were not calculated to increase charitable giving as a whole. Rather, as discussed in the next Section, the TCJA as passed is estimated to reduce overall charitable giving by \$12-20 billion each year. Changes to the estate tax are projected to further reduce charitable giving by as much as \$7 billion.¹⁷¹ Thus, Congress appears to have clearly chosen to increase government tax revenues at the expense of nonprofit revenues.¹⁷²

Notably, there was substantial congressional discussion and debate on lowering the corporate tax rate to twenty-one percent¹⁷³—four percentage points lower than the 2014 draft, and without a five-year phase-in.¹⁷⁴ However, unlike the 2014 reform efforts, which included cautions to “[c]arefully consider how any changes to the tax law will affect the

169. JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE, COMM. OF CONFERENCE, 410 (Dec. 18, 2017), <http://docs.house.gov/billsthisweek/20171218/joint%20Explanatory%20Statement.pdf> [<http://perma.cc/HP8B-XWRU>] [hereinafter Joint Explanatory Statement].

170. 2014 Discussion Draft Summary, *supra* note 153, at 22.

171. 2017 FINAL TAX BILL SUMMARY, INDEP. SECTOR, 1-2 (2018), <http://independentsector.org/wp-content/uploads/2018/01/2017-final-tax-bill-summary.pdf> [<http://perma.cc/UH83-E8JZ>].

172. Congress did not, however, repeal the deduction for medical expenses, likely in response to lobbying by the American Hospital Association and other groups. Press Release, Am. Hosp. Ass’n, AHA Shares Tax Reform Concerns with House, Senate Conferees (Dec. 8, 2017), <http://www.aha.org/news/headline/2017-12-08-aha-shares-tax-reform-concerns-house-senate-conferees> [<http://perma.cc/T4KM-ZXBQ>].

173. TCJA § 13001, I.R.C. § 11 (2018).

174. *See* TAX REFORM DRAFT OF 2014 § 3001, *supra* note 145.

nonprofit sector,¹⁷⁵ there was very little, if any, consideration of how such a large reduction in the corporate tax rate might negatively impact tax-exempt entities and mixed-entity markets, or the public entitlements that they depend on.¹⁷⁶ Indeed, there was hardly any mention of nonprofit interests throughout the House Republicans' tax-reform blueprint¹⁷⁷ or President Trump's (one-page) plan.¹⁷⁸ Rather, the political emphasis throughout was on tax relief, job creation, and simplicity. These priorities are accordingly reflected in the TCJA.

The extreme outlier among healthcare-related TCJA provisions is the repeal of the individual mandate penalty. Not mentioned at all during the 2014 tax reform drafting, this last-minute provision was tacked on by the Senate barely a month before the bill was passed into law.¹⁷⁹ Although initially introduced by Senator Tom Cotton (R-AR), the repeal was partially spurred on by a pair of tweets from President Trump.¹⁸⁰ Strangely, despite Congress' initial discussion of the penalty repeal as part

175. *Report to The House Committee On Ways And Means On Present Law And Suggestions For Reform Submitted To The Tax Reform Working Groups*, JOINT COMM. TAXATION, 493 (May 6, 2013), http://web.archive.org/web/20150908033437/http://independentsector.org/uploads/Policy_PDFs/JCTReportonWaysandMeansWorkingGroups.pdf [<http://perma.cc/4JQR-75ZD>].

176. *See generally* Business Income Report, *supra* note 165.

177. Press Release, U.S. Dep't Treasury, Unified Framework for Fixing our Broken Tax Code (Sept. 27, 2017), <http://www.treasury.gov/press-center/press-releases/documents/tax-framework.pdf> [<http://perma.cc/RRZ4-SQRS>].

178. *The 1-Page White House Handout on Trump's Tax Proposal*, CNN (Apr. 26, 2017), <http://www.cnn.com/2017/04/26/politics/white-house-donald-trump-tax-proposal> [<http://perma.cc/8UNU-DK9Q>].

179. DESCRIPTION OF THE CHAIRMAN'S MODIFICATION TO THE CHAIRMAN'S MARK OF THE "TAX CUTS AND JOBS ACT", JOINT COMM. ON TAXATION, 10, (Nov. 15, 2017), <http://www.finance.senate.gov/imo/media/doc/11.14.17%20Chairman's%20Modified%20Mark.pdf> [<http://perma.cc/4BP8-ML6S>].

180. On November 1, 2017, President Trump tweeted, "Wouldn't it be great to Repeal the very unfair and unpopular Individual Mandate in ObamaCare and use those savings for further Tax Cuts . . . for the Middle Class. The House and Senate should consider ASAP as the process of final approval moves along. Push Biggest Tax Cuts EVER." Nathaniel Weixel, *Trump Suggests Repealing ObamaCare Mandate in Tax Bill*, HILL (Nov. 1, 2017), <http://thehill.com/policy/healthcare/358201-trump-suggests-repealing-obamacare-mandate-in-tax-bill> [<http://perma.cc/4ZFT-CFRS>].

of a “skinny” Affordable Care Act repeal effort,¹⁸¹ the actual adoption of the penalty repeal occurred without any mention of the original ACA tradeoffs. That is, Congress ignored the fact that the individual mandate was implemented to offset the costs of health insurance coverage in order to reduce uninsured patients; and in exchange for this, the ACA significantly reduced Medicaid DSH payments and other federal funding for hospitals.¹⁸² Consequently, the repeal of the individual mandate penalty was essentially a lopsided policy: it reduced insurance coverage, shifting the burden of uncompensated care back to hospitals, while simultaneously retaining major cuts to uncompensated care payments. While ACA Medicare and Medicaid cuts are currently postponed, Congress has yet to permanently fix this imbalance.¹⁸³

Congress has stated that it will continue conducting hearings to assess the TCJA’s impact.¹⁸⁴ While it will take some time before the full effects of the Act are evident, its general impact and implications are clear. It has benefited small businesses and profitable corporations,¹⁸⁵ but has had negative ramifications for entities unable to take advantage of the Act’s significant tax cuts—like nonprofits.¹⁸⁶ Perhaps in response to unintended consequences, as well as serious concerns about sustainability, Republicans have begun proposing a “second phase” of tax reform.¹⁸⁷ Although it is unclear what these efforts will produce, it is apparent that

181. Sahil Kapur, *Trump Calls for Using Tax Bill to Repeal Obamacare’s Individual Mandate*, BLOOMBERG (Nov. 1, 2017), <http://www.bloomberg.com/news/articles/2017-11-01/trump-backs-repealing-obamacare-individual-mandate-in-tax-bill> [<http://perma.cc/8HKX-BM5D>].

182. GAO UNCOMPENSATED CARE, *supra* note 17, at 1-2.

183. John Commins, *Safety Nets Cheer DSH Cuts Delay*, HEALTHLEADERS (Feb. 12, 2018), <http://www.healthleadersmedia.com/health-plans/safety-nets-cheer-dsh-cuts-delay> [<http://perma.cc/8B4W-DKRX>].

184. *Early Impressions of the New Tax Law: Hearing Before the S. Comm. on Fin.*, 115th Cong. (2018), <http://www.finance.senate.gov/hearings/earlyyearly-impressions-of-the-new-tax-law> [<http://perma.cc/5SUT-JFP8>].

185. *Id.* (Statement of David K. Cranston, Jr.); *id.* (Statement of Douglas Holtz-Eakin).

186. *Id.* (Statement of David Kamin).

187. CCHTaxGroup, *SFC Examines New Tax Law, Brady Floats Second Phase*, WOLTERS KLUWER (Apr. 25, 2018), <http://news.cchgroup.com/2018/04/25/sfc-examines-new-tax-law-brady-floats-second-phase> [<http://perma.cc/H5P3-HUV7>].

the expedited, tumultuous legislative path of the TCJA differs greatly from those of previous tax reform drafts and bills. While Congress could be commended for successfully passing a significant and complicated tax overhaul, albeit along pure party lines, the prioritizing of political expediency over detailed, comprehensive analysis is disappointing. And unfortunately, the costs of this rushed process will be borne in part by tax-exempt organizations, like nonprofit hospitals, that overall gained little from the TCJA but lost multiple benefits and key lines of support.

B. Key Healthcare Provisions

In this Section, I explain each provision in detail and then assess the magnitude and nature of each provision's impact on different hospital entity forms and the mixed-entity hospital market as a whole. I begin with the repeal of the ACA's individual mandate penalty. Then, I examine the elimination of advance refunding for tax-exempt bonds, the imposition of excise taxes on nonprofit executive compensation, and changes to the unrelated business income tax. Following that, I address the reduced corporate tax rate and changes to charitable-gift incentives. Lastly, I examine the long-term effect of the law's \$1.5 trillion addition to the debt, with a focus on how it will likely compel reductions in Medicare and Medicaid entitlement funding.

I find that the elimination of advance refunding bonds, new excise taxes, UBIT changes, and charitable deduction will have a small but decidedly negative financial impact on nonprofit hospitals. At the same time, these reforms will cumulatively impact small, financially vulnerable hospitals far more than large, reputable hospital systems. And for all nonprofit hospitals, these tax-exemption reductions constitute "one less arrow in the quiver"¹⁸⁸ and costly regulatory uncertainty in the face of increasing financial challenges.

On the other hand, the TCJA's dramatic reduction in the corporate tax rate, its unbalanced repeal of the individual mandate, and its enormous cost (which will likely result in reductions of Medicare and Medicaid entitlements) will all have significant ramifications for nonprofit budgets, competition, and financial stability. These effects will be the most salient for hospitals in several different contexts: nonprofit hospitals in direct competition with for-profits; hospitals that provide disproportionately

188. As described by one executive of a large nonprofit hospital. Interview with Michael Angelini, *supra* note 26.

more uncompensated care; and hospitals that rely heavily on Medicare and Medicaid reimbursement. Thus, the cumulative effect of the TCJA's provisions will be to increase financial pressure on nonprofit hospitals to convert to or merge with a for-profit entity form. At the same time, the TCJA increases financial pressure on all hospitals that serve uninsured and publicly insured communities. As I will discuss in Part III, this increased financial pressure on both nonprofit and for-profit hospitals will likely have deleterious effects on healthcare equality, access, and quality across the country.

1. Individual Mandate Penalty Repeal

When most people think about the 2017 tax reform law and healthcare, the most salient issue is likely the repeal of the ACA's individual mandate penalty. Starting in 2019, those who do not sign up for an insurance plan will no longer have to pay a tax penalty.¹⁸⁹ Unsurprisingly, eliminating a core component of Obamacare—the most extensive health care reform act since the enactment of Medicare and Medicaid in 1965¹⁹⁰—is expected to have a significant impact on healthcare.¹⁹¹ The Congressional Budget Office projects that this change will result in thirteen million more Americans becoming uninsured by 2027 and premiums on the individual market increasing by ten percent per year.¹⁹² However, healthcare needs do not just disappear when people

189. Morgan Lewis, *Update: Several Ways Final Tax Reform Legislation Will Change Healthcare*, JD SUPRA (Dec. 27, 2017), <http://www.jdsupra.com/legalnews/update-several-ways-final-tax-reform-51027> [<http://perma.cc/VDH7-ZD7A>].

190. Jonathan Oberlander, *Long Time Coming: Why Health Reform Finally Passed*, HEALTH AFF. (June 2010), <http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.0447> [<http://perma.cc/UGM9-9JZR>].

191. *See e.g., Repealing the Individual Health Insurance Mandate: An Updated Estimate 1*, CONG. BUDGET OFF. (Nov. 2017), <http://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf> [<http://perma.cc/ay36-x4ra>].

192. *Id.*; Benjy Sarlin, *Republican-Led Congress Passes Sweeping Tax Bill*, NBC NEWS (Dec. 20, 2017), <http://www.nbcnews.com/politics/congress/republican-tax-bill-house-senate-trump-n831161> [<http://perma.cc/VQ9C-UG7N>]. Conversely, some suggest that President's Trump's October 2017 Executive Order, which directed the Department of Labor to study how to make it easier for small businesses, and possibly individuals, to join

become uninsured. In fact, studies have shown that reduced health insurance coverage correlates with worse health outcomes, resulting in costly additional care that could have been avoided by preventative care.¹⁹³

Moreover, given EMTALA's emergency-room mandate and societal expectations¹⁹⁴ that people will not be turned away from healthcare, someone will have to pay these costs of care for uninsured individuals who show up in the emergency room or underinsured individuals who cannot pay their medical debt. Although federal payments to disproportionate-share hospitals (DSH payments) increase with the proportion of uninsured populations, these payments cover only approximately thirty-five percent of uncompensated care costs, leaving hospitals with a hefty sixty-five percent of these rising costs.¹⁹⁵ The TCJA does nothing to address or alleviate this increased burden.

Further, the TCJA ignores the ACA's original tradeoff: an individual mandate combined with a penalty to increase insured populations, in exchange for reduced DSH and other federal payments to hospitals. In other words, the TCJA increased hospital burdens while leaving in place plans to cut federal support meant to relieve those burdens. As mentioned earlier, the ACA reductions have been delayed, but Congress has yet to put in place a permanent solution.¹⁹⁶ Accordingly, without offsetting policies, the repeal of the individual mandate penalty increases financial pressure on all hospitals, but especially safety-net hospitals, disproportionate-share

together and buy health insurance through nationwide association health plans could counterbalance reductions in insured individuals. Saul Ewing Arnstein & Lehr LLP, *2017 Tax Reform Legislation: Impact on Tax-Exempt Organizations, Including Educational and Health Care Institutions*, JDSUPRA (Jan. 8, 2018), <http://www.jdsupra.com/legalnews/2017-tax-reform-legislation-impact-on-98315/> [<http://perma.cc/DQ7T-VW5D>].

193. Benjamin D. Sommers et al., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 *NEW ENG. J. MED.* 586, 586 (2017), <http://www.nejm.org/doi/full/10.1056/NEJMs1706645> [<http://perma.cc/DCA3-L9NW>].

194. *See supra* notes 5-10 and accompanying text.

195. Jack O'Brien, *After Individual Mandate Repeal, Who'll Pay for Rise in Uncompensated Care?*, HEALTHLEADERS (Dec. 20, 2017), <http://www.healthleadersmedia.com/finance/after-individual-mandate-repeal-who%E2%80%99ll-pay-rise-uncompensated-care> [<http://perma.cc/YE6E-QDXB>].

196. Commins, *supra* note 183.

hospitals, and other specially designated hospitals¹⁹⁷—almost all of which are nonprofits¹⁹⁸—serving greater proportions of uninsured and underinsured populations.

2. Advance Refunding Bonds

In addition to the repeal of the individual mandate, there are several provisions in the tax reform law that will explicitly impact nonprofits, including nonprofit hospitals. To begin, the law eliminates advance refunding of tax-exempt bonds issued after December 31, 2017.¹⁹⁹ Previously, 501(c)(3) bonds were permitted a single advance refunding. This allowed issuers to take advantage of reductions in interest rates to realize billions of dollars in savings. In fact, the Government Finance Officers Association (GFOA) states that, on a present value basis, an advance refunding should generally produce a minimum savings of three to five percent.²⁰⁰ After the TCJA, hospitals can still do a “current refunding,” but they no longer have the flexibility of refinancing after ninety days, when refinancing would likely be the most beneficial.²⁰¹

197. *See supra* note 26 and accompanying text.

198. *See supra* note 29.

199. *Under Pressure: How Tax Reform May Squeeze Hospitals*, KING & SPALDING (Dec. 14, 2017), <http://www.kslaw.com/news-and-insights/under-pressure-how-tax-reform-may-squeeze-hospitals> [<http://perma.cc/KA4K-F69E>] [hereinafter *Under Pressure*].

200. Letter from the American Hospital Association et al. to Congress (Dec. 6, 2017) (on file with the American Hospital Association), <http://www.aha.org/system/files/advocacy-issues/letter/2017/171206-letter-groups-pabs.pdf> [<http://perma.cc/AQ99-3FSL>].

201. *See* James Sweeney, *New Tax Law Disallows Advance Refunding of All Tax-Exempt Bonds*, RSM (Jan. 2018), <http://rsmus.com/what-we-do/services/tax/lead-tax/new-tax-law-disallows-advance-refunding-of-all-tax-exempt-bonds.html> [<https://perma.cc/4CLY-8D9W>]; McDermott Will & Emery, *Tax Reform Bill Becomes Law: Lessons for Tax-Exempt Organizations* (Dec. 23 2017), <http://www.jdsupra.com/legalnews/tax-reform-bill-becomes-law-lessons-for-69386> [<http://perma.cc/ZK4U-PJF5>]. Interestingly, this change could cause the bond market to shorten the callable periods for tax-exempt bonds (from typically ten and a half years after the date of issuance), thereby making refunding easier in the future. The ultimate effect remains to be seen. *Id.*

While the TCJA did not eliminate all tax-exempt bond financing, or “private activity bonds”, as the House bill originally threatened to do, this provision will nonetheless hurt nonprofit finances. This is true despite the current low interest rates and onerous tax-exempt bond requirements.²⁰² Congress previously estimated that private nonprofit hospital facilities would receive \$12.5 billion of benefit from the use of PABs from 2014-2018.²⁰³ Given that approximately 25% of PAB activity consisted of advance refundings, hospitals now face losing one-fourth of this \$12.5 billion benefit.

This loss will affect small hospitals the most. Large, reputable hospitals, and especially those like Yale-New Haven Hospital that are associated with large universities, can often rely on high credit ratings to obtain favorable bond pricing.²⁰⁴ These hospitals also have greater access to the taxable bond market since they can issue bonds with a total value of \$250 million or more.²⁰⁵ Smaller hospitals, on the other hand, especially those in debt or difficult financial situations, rely more on the advantage of tax-exempt financing to obtain favorable terms and substantial savings.²⁰⁶ For example, Memorial Hospital, a 25-bed critical access hospital in Kansas, was forced to rush through a bond refinancing before the TCJA provision took effect in order to save \$1.3 million on a bond issue to build a new inpatient wing and emergency room.²⁰⁷ Now, small hospitals like Memorial will no longer have that option. The importance of flexible financing has only become more pertinent since Moody’s Investors Service assigned nonprofit hospitals (but not for-profit hospitals) a negative

202. Angelini, *supra* note 26.

203. Community Development Report, *supra* note 167, at v.

204. Angelini, *supra* note 26.

205. Tana Bannow, *Hospitals Rushing to Get Bonds Issued Before Tax Reform Takes Effect*, MODERN HEALTHCARE (Dec. 7, 2017), <http://www.modernhealthcare.com/article/20171207/NEWS/171209888> [<http://perma.cc/3YEF-5JRY>].

206. They also face additional challenges such as an inherent market bias against low- and non-investment grade health care credits. For instance, community hospitals not rated above the BBB category will face additional pricing and covenant pressures. See Steve Kennedy & Kyle Hemminger, *Tax Reform and Its Impact on Health Care and Senior Living Finance*, LANCASTER POLLARD & Co., <http://www.lancasterpollard.com/wp-content/uploads/tci-fe-jan18-tax-reform.pdf> [<http://perma.cc/P2JN-8QNF>].

207. Bannow, *supra* note 205.

outlook and then reaffirmed the designation after the TCJA was passed—in part because of unfavorable TCJA provisions.²⁰⁸

For the most vulnerable nonprofits, this increased cost of financing is particularly detrimental because these hospitals rely on bond issues to update and obtain new equipment. If a facility is old enough and cannot update enough to stay compliant and in business, lack of financing could cause it to shut down.²⁰⁹ The serious consequences of this problem are evident in the fact that the AHA has taken action to address the issue, having already helped champion a bipartisan bill proposal to restore advanced refunding bonds for nonprofit hospitals.²¹⁰ Indeed, through this provision, the TCJA appears to have increased the federal budget by an estimated \$17.3 billion from 2018 to 2027 at the expense of nonprofits, including many nonprofit hospitals.²¹¹

3. Excise Taxes on Executive Compensation

The TCJA “imposes an excise tax equivalent to the new twenty-one percent corporate tax rate on excess compensation,” defined as remuneration in excess of one million dollars paid to “covered employees” at 501(c)(3) tax-exempt organizations.²¹² “Covered employees” include

208. *Moody's: US Not-for-Profit and Public Healthcare Outlook Changed to Negative with Rising Operating Pressure*, MOODY'S INV. SERV. (Dec. 4, 2017), http://www.moody.com/research/Moodys-US-not-for-profit-and-public-healthcare-outlook-changed--PR_376421; *Moody's: US NFP, Public Healthcare Outlook to Remain Negative on Flat to Slightly Down Operating Cash Flow*, MOODY'S INV'RS SERV. (Dec. 3, 2018), http://www.moody.com/research/Moodys-US-NFP-public-healthcare-outlook-to-remain-negative-on--PBM_1152323.

209. Bannow, *supra* note 205.

210. *Bipartisan Bill Would Restore Tax-Exempt Advance Refunding Bonds*, AM. HOSP. ASS'N. (Feb. 14, 2018), <http://www.aha.org/news/headline/2018-02-14-bipartisan-bill-would-restore-tax-exempt-advance-refunding-bonds> [<http://perma.cc/58PQ-8B6A>].

211. ESTIMATED REVENUE EFFECTS OF THE CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 1, THE “TAX CUTS AND JOBS ACT,” SCHEDULED FOR MARKUP BY THE COMMITTEE ON WAYS AND MEANS ON NOVEMBER 6, 2017, JOINT COMM. TAX, 4 (Nov. 3, 2017), <http://www.taxreformandtransition.com/wp-content/uploads/sites/29/2017/11/x-47-17.pdf> [<http://perma.cc/9ZL7-CAFG>].

212. Patterson Belknap Webb & Tyler, *Sweeping Tax Reform Impacts Tax-Exempt Organizations*, JDSUPRA (Jan. 18, 2018), <http://www.jdsupra.com/>

“any current or former employee who is one of the organization’s five highest compensated employees in a given taxable year,” including previous years, starting in 2017.²¹³ Covered employees are determined by each nonprofit entity and remain covered employees permanently once designated, so many nonprofits may actually have more than five covered employees due to their complex organizational structures.²¹⁴ As noted earlier, there is an exclusion for remuneration paid for medical services by professionals, including doctors and nurses,²¹⁵ but this does not exclude salary for administrative functions.

In terms of magnitude, this provision is relatively less significant and will not impact all nonprofit hospitals.²¹⁶ However, for some nonprofits, this change could still cost over six million dollars per year.²¹⁷ In addition, since the provision took effect immediately after December 31, 2017, many nonprofits have found themselves forced to pay unexpected excise taxes on salaries they are bound by employment contracts to maintain. Thus, “[i]n the longer term, these nonprofits will either need to pay less and risk losing executives to for-profit competitors” that have more budgetary leeway to pay more and can give stock options, or “maintain current income levels and be forced to incorporate the excise tax into their budgets.”²¹⁸ Accordingly, this provision will likely have far-reaching ripple

legalnews/sweeping-tax-reform-impacts-tax-exempt-62419
[<http://perma.cc/R95E-9VAV>].

213. *Id.*

214. Steven Porter, *About 16% of Nonprofit Hospital Orgs Face New Excise Tax on Exec Pay*, HEALTHLEADERS (Feb. 7, 2018), <http://www.healthleadersmedia.com/finance/about-16-nonprofit-hospital-orgs-face-new-excise-tax-exec-pay> [<http://perma.cc/L79X-Q23T>].

215. TCJA § 13602, I.R.C. 4960 (2018); *id.* § 13602(c)(3)(B) (delimiting an exception for remuneration for medical services).

216. Some studies estimate that 16% of nonprofit hospitals will need to pay this excise tax. Porter, *supra* note 214.

217. For example, Ascension Health Alliance would likely need to pay \$6,124,068 of executive compensation excise tax. See Scott C. Withrow, *New Excise Tax Cuts into Tax-Exempt Executive Compensation*, 14 ABA 7, http://www.americanbar.org/groups/health_law/publications/aba_health_esource/2017-2018/march2018/newexcise.html [<http://perma.cc/4J4H-ZR8N>].

218. Linda M. Lampkin, *Tax Reform Hits Compensation of Nonprofit Executives in 2018*, ECON. RES. INST. (Jan. 24, 2018), <http://www.eri.com/blog/post/2018/01/24/Tax-Reform-Hits-Compensation-of-Nonprofit-Executives->

effects in terms of talent recruitment, especially for complex, difficult hospital operations. This problem is particularly salient for hospitals located in less popular locations such as rural communities.²¹⁹

4. Unrelated Business Income Tax

The TCJA also makes several notable changes to the unrelated business income tax (UBIT). These provisions essentially require that tax-exempt entities with more than one unrelated trade or business compute their UBIT in separate silos. That is, a net operating loss deduction is allowed only with respect to the specific trade or business from which the loss arose. In addition, with some exceptions, the Act treats as UBIT income the value of certain fringe benefits, including transportation, parking facilities, and on-premises athletic facilities.²²⁰ Although it remains to be seen how the IRS will precisely implement these UBIT changes, they will likely increase tax liability for any nonprofits with multiple UBIT operations such as periodicals, accommodations, retail services, or joint ventures with for-profit entities.²²¹

Like the executive compensation excise taxes, the changes to the UBIT will only affect a segment of nonprofit hospitals: those with multiple unrelated trades or businesses such as pharmacies with outside sales.²²²

in-2018 [<http://perma.cc/39EX-8MM3>]; Kelly Gooch, *Physician Recruitment and Retention: How 2 Rural Hospitals Are Overcoming the Challenge*, BECKER'S HOSP. REV. (Feb. 28, 2018), <http://www.beckershospitalreview.com/hospital-management-administration/physician-recruitment-and-retention-how-2-rural-hospitals-are-overcoming-the-challenge.html> [<http://perma.cc/32VH-KBXU>].

219. Gooch, *supra* note 218.

220. Lewis, *supra* note 189; *Under Pressure*, *supra* note 199.

221. See *Tax on Unrelated Business Income of Exempt Organizations*, IRS (Feb. 2019), <http://www.irs.gov/pub/irs-pdf/p598.pdf> [<http://perma.cc/YD4N-E48R>]; *SOI Tax Stats - Exempt Organizations' Unrelated Business Income (UBI) Tax Statistics, Section 501(c)(3) Organizations Only: Classified by Primary Unrelated Business Activity or Industrial Grouping, 2013*, IRS (Jan. 30, 2019), <http://www.irs.gov/statistics/soi-tax-stats-exempt-organizations-unrelated-business-income-ubi-tax-statistics> [<http://perma.cc/V6MW-K7PV>] [hereinafter SOI UBIT Statistics].

222. *Tax Cuts and Jobs Act Provisions and Other Recent Developments Affecting Tax-Exempt Organizations*, BAKERTILLY, (Sep. 13, 2018), <http://bakertilly.com>.

The impact of these changes may be relatively limited given that these changes are only meant to fine-tune existing law. IRS Statistics of Income (SOI) data indicates that in 2013, 501(c)(3) exempt organizations filed 46,3680 UBIT tax returns (Form 990-T). Of these, about half, 22,520 returns, had taxable income. This translated to about \$1.99 billion of income and a \$1.08 billion deficit, resulting in the payment of \$581 million in UBIT paid. Of course, not all of these returns were filed by hospitals, but the data nevertheless gives an idea of the overall magnitude of the UBIT.²²³

More critically, the UBIT “increases taxes on legitimate, market-based solutions that charities rely upon for revenue,” particularly when faced with decreases in charitable giving or government funding.²²⁴ In other words, it further contributes to the TCJA’s tilting of the hospital market towards for-profit entity forms. Even without large monetary impact, these provisions increase the burden of unpredictable nonprofit regulations and compel nonprofits subject to these taxes to divert resources to restructure their unrelated businesses solely for tax purposes.²²⁵

5. Increased Standard Deduction (Charitable Donation Incentives)

Nonprofit hospitals across the nation will likely experience a drop in charity donations as a result of TCJA measures that reduce the incentive to make charitable gifts. In addition to lowering individual tax rates,

com/insights/unrelated-business-taxable-income-offset-activities-rule [http://perma.cc/9686-T4W9].

223. SOI UBIT Statistics, *supra* note 221. Statistics aggregated by type of 501(c)(3) charitable organization is unavailable.

224. Letter from Independent Sector to Senate Finance Committee on Tax Reform, (Nov. 17, 2017), <http://independentsector.org/resource/letter-senate-finance-committee-tax-reform/> [http://perma.cc/6FVX-JVEY].

225. Some nonprofit hospitals “may . . . consider spinning off entities as separate for-profit entities,” but that can sometimes draw “increased scrutiny from state and local officials who might question whether the hospital is still functioning as [a] not-for-profit organization [that] deserves tax-exempt status.” Harris Meyer, *Seven Key Changes the New Tax Law Will Force Hospitals to Consider*, MODERN HEALTHCARE (Jan. 2, 2018), <http://www.modernhealthcare.com/article/20180102/NEWS/180109995> [http://perma.cc/78QR-TPYP].

including a reduction for individuals in the top bracket from 39.6% to 37%, the TCJA also exempts larger inheritances from the estate tax, doubling thresholds to \$11 million for individuals and \$22 million for married couples.²²⁶ Accordingly, individuals with high incomes or estates worth less than the new exemption amount no longer have the same income tax incentive to make charitable bequests.

The TCJA also nearly doubles the standard deduction to \$12,000 for singles and \$24,000 for couples.²²⁷ This, along with other deduction eliminations and limitations, greatly reduces the average taxpayer's incentive to itemize and benefit from charitable deductions. The Act does, however, increase the limitation for cash contributions to 501(c)(3) public charities to 60% of an individual donor's adjusted gross income (AGI), up from 50%. These two provisions are both temporary, applying only to taxable years beginning after December 31, 2017 and ending before January 1, 2026.²²⁸ Nevertheless, many researchers predict that the cumulative effect of these provisions over the nearly ten years they will be in force will be to greatly reduce charitable giving.²²⁹ For instance, one study found that under the TCJA, fewer than 10% of taxpayers may choose to itemize and claim the charitable deduction, a seemingly minor change that nevertheless is anticipated to cause a \$12 to \$20 billion decline in charitable giving per year.²³⁰

226. *US Tax Bill: Winners and Losers*, BBC NEWS (Dec. 19, 2017), <http://www.bbc.com/news/business-42420221> [<http://perma.cc/P3ZY-M7XT>].

227. Lewis, *supra* note 189.

228. *Id.*

229. The National Council of Nonprofits predicted that the changes will “damage charitable giving by \$13 billion or more annually; destroy more than 220,000 nonprofit jobs; and impair the ability of nonprofits to address community needs by taxing tax-exempt organizations to fund tax cuts for wealthy corporations and individuals.” Seyfarth Shaw LLP, *Nonprofit Guide to the “Tax Cuts and Jobs Act,”* JDSUPRA (Dec. 26, 2017), <http://www.jdsupra.com/legalnews/nonprofit-guide-to-the-tax-cuts-and-69042/> [<http://perma.cc/7FKF-3H3R>].

230. *2017 Final Bill Summary*, INDEP. SECTOR, <http://independentsector.org/wp-content/uploads/2018/01/2017-final-tax-bill-summary.pdf> [<http://perma.cc/287K-P45Z>].

As noted earlier, charitable gifts are more important sources of revenue for large, reputable nonprofits.²³¹ Nevertheless, reducing the tax incentives for charitable giving further reduces the benefits of the nonprofit entity form and shrinks revenue options for nonprofit hospitals.

6. Reduced Corporate Tax

The TCJA will impact nonprofit hospitals indirectly but significantly through the reduced corporate tax rate. By slashing the corporate tax rate from 35% to 21%, Republicans are hoping to encourage economic growth through corporations—that is, the for-profit sector.²³² However, the corporate rate reduction will also simultaneously reduce the value of nonprofit-sector tax exemptions by an equivalent amount. In other words, this provision reduces the comparative federal benefit and support nonprofits gain in exchange for complying with extensive and frequently onerous nonprofit regulations. Perhaps it should be expected that the TCJA is “prompting some hospital boards to consider converting to for-profit status or diversifying their assets into for-profit subsidiaries.”²³³

At the same time, the corporate tax reduction hands companies on the for-profit side of the health industry millions of free dollars. PricewaterhouseCoopers estimates that the TCJA will produce tax reductions of \$10 million to \$500 million for large for-profit providers in 2018.²³⁴ For-profit providers have already announced plans to spend this money on investment in workforce development and capital spending, such as adding capacity, improving and adding new facilities, and enhancing technology.²³⁵ For-profit hospitals may also use these resources to pursue new mergers and acquisitions, joint ventures, partnerships and

231. *See supra* note 25 and accompanying text.

232. *See Tax Cuts and Jobs Act*, WHITE HOUSE (Feb. 2018), http://www.whitehouse.gov/wp-content/uploads/2018/02/WH_CuttingTaxesForAmericanWorkers_Feb2018.pdf [<http://perma.cc/YZ6S-249U>].

233. Bannow, *supra* note 205.

234. *Tax Reform Imposes Costs on Tax-Exempt Healthcare Organizations as For-Profit Peers Weigh Benefits*, PWC (Feb. 2018), <http://www.pwc.com/us/en/health-industries/health-research-institute/publications/pdf/pwc-hri-impact-of-TCJA-on-tax-exempt-healthcare-org-2018.pdf> [<http://perma.cc/HEZ4-K5AH>] [hereinafter *PwC Report*].

235. *Id.*

collaborations.²³⁶ Consequently, not only will for-profit hospitals gain a significant leg up over nonprofit hospitals through a massive tax boon, but the very presence of for-profits in the market will exert increased pressure on nonprofits to change entity forms.²³⁷

Thus, beyond the purely budgetary impact of an increased tax of \$3.2 billion on tax-exempt organizations from 2018 to 2027,²³⁸ the TCJA critically reshapes relationships between nonprofit and for-profit entities, particularly in mixed-entity markets such as the hospital market. The resulting new “U.S. health ecosystem,” as some have called it,²³⁹ clearly tilts the hospital market towards the for-profit entity form.

7. Increased Deficit (Impact on Medicare, Medicaid, & DSH Payments)

The tax bill’s most long-lasting consequence will likely be its estimated \$1.5 trillion cost. The Tax Policy Center projects that, including macroeconomic effects, the TCJA will increase the national debt by about \$1.5 trillion (or 5% of GDP) in 2027, and about \$1.6 trillion (or 3.9% of GDP) in 2037.²⁴⁰ This is significant because both Medicare and Medicaid will likely be on the chopping block as the TCJA shrinks government revenues going forward.²⁴¹

Medicaid and Medicare respectively comprise about 14% and 21% of federal spending.²⁴² Medicaid also accounts for a large share of state

236. *Id.*

237. *Id.*

238. *Estimated Revenue Effects of the Chairman’s Amendment in the Nature of a Substitute to H.R. 1, the “Tax Cuts and Jobs Act”*, JCX-47-17 JOINT COMM. TAXATION 7 (Nov. 3, 2017), http://www.jct.gov/publications.html?func=download&id=5027&chk=5027&no_html=1 [<http://perma.cc/DFT6-7L3L>].

239. *PwC Report, supra* note 234.

240. Without macroeconomic effects, the Tax Policy Center projects that the bill would increase US debt by about \$1.8 trillion (or 6.3% of GDP) in 2027 and by about \$1.9 trillion (or 4.6% of GDP) in 2037. Benjamin R. Page et al., *Macroeconomic Analysis of the Tax Cuts and Jobs Act*, TAX POL’Y CTR. 4 (Dec. 20, 2017), <http://www.taxpolicycenter.org/publications/macroeconomic-analysis-tax-cuts-and-jobs-act/full> [<http://perma.cc/CHZ3-NWN3>].

241. *See Id.*

242. *Historical Tables: Budget of the U.S. Government*, OFF. MGMT. & BUDGET (2017), at tbl. 8.5, <http://www.gpo.gov/fdsys/search/pagedetails.action?>

budgets (about 15.3% of the state-financed portion of states' budget), and nearly half of state spending from federal funds (about 25.6% of states' combined state- and federally-financed budgets).²⁴³ Since Medicare and Medicaid together comprise about 37% of health spending in the U.S.,²⁴⁴ any reductions to these reimbursements—a likely outcome as government revenues shrink—would have an immediate, detrimental, and potentially destabilizing impact on hospitals across the country. This will be especially true for nonprofits relying disproportionately on these payments.

At the same time, pressure on the federal budget will also likely endanger DSH payments and other fundamental support lines for safety net and critical access hospitals serving vulnerable populations. Consequently, even if the TCJA provides tax relief for for-profit entities and spurs national economic growth as promised, it will also inevitably impose new and increasing financial burdens on critical hospitals.

III. DISTRIBUTIVE IMPACT ON HEALTHCARE

So, Congress favored for-profit entities over nonprofit entities in the TCJA—why does that matter? First, as mentioned earlier, the vast majority of hospitals in the United States are nonprofit organizations and the TCJA darkens all of their financial outlooks. This does not bode well for the ability of a large segment of U.S. hospitals to thrive in their mission of improving healthcare. Moreover, this increased pressure will have the greatest and most detrimental impact on small, rural hospitals that provide critical services for their communities, but have negligible financial room to maneuver and adjust for unexpected expenses.

Second, many nonprofits serve a critical role in the hospital market as the providers of charity care and unprofitable services in exchange for the benefits of tax-exemption. While for-profit hospitals with emergency departments are barred by EMTALA from turning people away,²⁴⁵ they are

granuleId=&packageId=BUDGET-2017-TAB [http://perma.cc/XE67-KE4X].

243. *Spending*, MACPAC (last visited Feb. 21, 2019), <http://www.macpac.gov/medicaid-101/spending> [http://perma.cc/7MUQ-XCZW].

244. *National Health Expenditures 2017 Highlights*, CMS 2 (2017), <http://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf> [http://perma.cc/NZR2-YBAR].

245. *Supra* note 8 and accompanying text.

not beholden to the same public benefit requirements as nonprofits. Rather, they are free and, in fact, compelled by their corporate charters, to pursue profit over charity by choosing profitable locations, providing more lucrative services, and serving “cream-skimming” segments of the market.

Third, any profits generated in nonprofit hospitals must be reinvested in the hospital and its community. Profits generated by for-profits, in contrast, accrue to the owners or shareholders of the hospital. This means that through tax-exempt regulation, nonprofits can be compelled to spearhead critical community engagement and preventative healthcare outreach. While for-profit hospitals could also theoretically serve these purposes, they are unlikely to do so unless coerced by new government regulation.

Thus, given current market and regulatory conditions, it is essential that federal policies, including tax reform, support rather than undermine the ability of nonprofit hospitals to provide critical healthcare services for the country. In other words, disrupting the mixed-entity hospital market is not fundamentally bad, but doing so without addressing the unequal impact on different entity forms will produce negative distributive consequences. In this Section I examine how the TCJA’s disproportionate negative impact on nonprofit hospitals will likely reduce healthcare access to hospitals and services in geographically vulnerable regions, exacerbate the problem of uncompensated care, and reduce preventative community health engagement.

A. Increased Disparity of Healthcare Access Across Geographic Regions

First, the TCJA threatens the viability of both vulnerable rural hospitals that may be the only accessible source of care for rural communities, as well as crowded urban area hospitals that serve large underinsured or uninsured populations. Hospitals and access to healthcare is deeply unequal across the country. While some communities have multiple hospitals all within a reasonable distance, others, especially those in rural areas, may depend on a single provider of critical healthcare services like emergency care and obstetrics.²⁴⁶ However, in spite of these fundamental

246. Dartmouth Inst. for Health Pol’y & Clinical Prac., *Data by Region*, DARTMOUTH ATLAS HEALTH CARE (2019), <http://archive.dartmouthatlas.org/data/region> [<http://perma.cc/63GL-ER4C>] [hereinafter “Dartmouth Atlas”]; see Gloria J. Bazzoli et al., *The Effects of Safety Net Hospital Closures and Conversions on Patient Travel Distance to Hospital Services*, 47 HEALTH

community needs, recent studies have documented an increasing rate of rural hospital closures since 2010.²⁴⁷

These hospital closures are alarming given that rural Americans already tend to be older, sicker, and poorer than those living in urban and suburban counties.²⁴⁸ Simply in terms of health-related demographics, a 2017 University of North Carolina report found that, “[c]ompared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, . . . more uninsured residents under the age of sixty-five, and higher rates of mortality . . .”²⁴⁹ Studies have also shown that rural Americans are significantly less likely than urban Americans to be screened for various risk factors and diseases, including high cholesterol and cervical cancer.²⁵⁰ Screening rates could likely be improved by reducing distance to hospitals and trauma centers, as well as increasing access to specialized care;²⁵¹ however, as noted earlier, rural hospital access has actually continued to decrease, rather than increase.²⁵² To add insult to injury, hospital closures frequently compound reduced healthcare access with detrimental income and

SERVS. RES. 129 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3272769/pdf/hesr0047-0129.pdf> [<http://perma.cc/559E-XB9U>].

247. Brystana G. Kaufman et al., *The Rising Rate of Rural Hospital Closures*, 32 J. RURAL HEALTH 35, 37 (2016), <http://www.ncbi.nlm.nih.gov/pubmed/26171848> [<http://perma.cc/9HQT-G2W9>]; Rural Hospital Closures, *supra* note 31.
248. Jessica Seigel, *Sequestration: More Threats to Rural in Tax Reform*, NAT’L RURAL HEALTH ASSOC. (Nov. 16, 2017), <http://www.ruralhealthweb.org/blogs/ruralhealthvoices/november-2017/sequestration-more-threats-to-rural-in-tax-reform> [<http://perma.cc/H9VB-3ZGB>].
249. Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, AAMC NEWS (Oct. 31, 2017), <http://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun> [<http://perma.cc/BA9P-F94F>].
250. Julia T. Caldwell et al., *Intersection of Living in a Rural Versus Urban Area and Race/Ethnicity in Explaining Access to Health Care in the United States*, 106 AM. J. PUB. HEALTH 1463, 1463 (2016), <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303212> [<http://perma.cc/XX42-HX3B>].
251. *Rural Americans at Higher Risk of Death from Five Leading Causes*, CDC (Jan. 12, 2017), <http://www.cdc.gov/media/releases/2017/p0112-rural-death-risk.html> [<http://perma.cc/4EB4-4E4G>].
252. *See supra* note 247 and accompanying text.

employment effects on members of these already-struggling communities.²⁵³

The problem of reduced access is particularly acute in states that chose not to expand Medicaid after the Supreme Court decision in *National Federation of Independent Business v. Sebelius*.²⁵⁴ This has resulted in a widening disparity between states that expanded Medicaid versus those that did not. For states that chose not to expand Medicaid, the hospital closure rate has doubled, from 0.45 per 100 hospitals in 2012 to 0.90 in 2013, and this trend has continued since. In sharp contrast, states that chose to expand Medicaid have seen their closure rate decrease by 0.33 per 100 hospitals during the same period.²⁵⁵

It is also worth noting that access to healthcare insurance is also unequally spread across different states and counties.²⁵⁶ This is particularly true for unemployed or self-employed individuals looking to buy health insurance in the ACA marketplace. Indeed, after a series of insurer failures and exits in the past few years, Americans in 1,388 counties now have only one insurer to choose from, and Americans in 45 counties have no insurer.²⁵⁷ As a result, many of these individuals face

253. George M Holmes et al., *The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH SERV. RES. 467, 467 (2006), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512> [<http://perma.cc/XXY4-L5XJ>].

254. 567 U.S. 519 (2012).

255. Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFF. 111, 114-15 (2018), <http://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976> [<http://perma.cc/2KEU-8HLK>]; see Steven Ross Johnson, *Changes to Medicaid Could Accelerate Hospital Closures*, MODERN HEALTHCARE (Jan. 8, 2018), <http://www.modernhealthcare.com/article/20180108/NEWS/180109931> [<http://perma.cc/XQC9-KJZF>].

256. Reed Abelson & Margot Sanger-Katz, *Obamacare Options? In Many Parts of Country, Only One Insurer Will Remain*, N.Y. TIMES (Aug. 19, 2016), <http://www.nytimes.com/2016/08/20/upshot/obamacare-options-in-many-parts-of-country-only-one-insurer-will-remain.html> [<http://perma.cc/CM28-PFA3>].

257. Haeyoun Park & Audrey Carlsen, *For the First Time, 45 Counties Could Have No Insurer in the Obamacare Marketplaces*, N.Y. TIMES (June 9, 2017), <http://www.nytimes.com/interactive/2017/06/09/us/counties-with-one-or-no-obamacare-insurer.html> [<http://perma.cc/FF4W-5NBD>].

much higher insurance costs than the rest of the country.²⁵⁸ Eliminating the individual mandate penalty is unlikely to entice insurers to return.²⁵⁹ To the contrary, taking away a key incentive for young and healthy individuals to buy insurance is projected to further drive up premiums and increase uninsured or underinsured populations.²⁶⁰ Given this context, the TCJA provisions that disadvantage rural hospitals put these essential hospitals at even greater risk of closure and may push even more to the brink of closing their doors.²⁶¹

B. Reduced Provision of Unprofitable Services and Uncompensated Care

The TCJA will likely reduce the provision of both unprofitable services and uncompensated care across the country. Beginning with the former, the TCJA's negative financial impact on nonprofit hospitals will likely result in reduced provision of services that may be less profitable or more expensive to provide.²⁶² For instance, rural hospitals already suffering from unstable finances may be forced to close down expensive services like burn facilities and emergency departments, or shut their doors altogether as mentioned above.²⁶³ Even in urban markets, increased

258. Lauren Carroll, *Donald Trump: One-Third of Counties Have Only One Insurer on Affordable Care Act Exchanges*, POLITIFACT (Mar. 13, 2017), <http://www.politifact.com/truth-o-meter/statements/2017/mar/13/donald-trump/donald-trump-one-third-counties-have-only-one-insu/> [http://perma.cc/44LT-R3T6].

259. *Id.*

260. *Republican Tax Plan*, *supra* note 112.

261. Seigel, *supra* note 248; see *Rural Health Bills*, AM. HOSP. ASSOC. (last visited Feb. 21, 2019), <http://www.aha.org/2011-09-02-rural-health-bills> [http://perma.cc/QHY5-CR66].

262. Hsueh-Fen Chen et al., *Hospital Financial Conditions and the Provision of Unprofitable Services*, 37 ATLANTIC ECON. J. 259, 260 (2009), <http://link.springer.com/content/pdf/10.1007%2Fs11293-009-9183-9.pdf> [http://perma.cc/6QSR-MBYZ].

263. Jeff Lagasse, *Rural Hospitals Struggling, Serving Populations with Many Health Disparities, Report Finds*, HEALTHCARE FIN. (Jul. 5, 2017), <http://www.healthcarefinancenews.com/news/rural-hospitals-struggling-serving-populations-many-health-disparities-report-finds> [http://perma.cc/PL8C-X79N].

financial pressure on nonprofits will be keenly felt in over-crowded hospitals, particularly emergency departments, resulting in understaffing, equipment shortages, and delays, ultimately reducing hospitals' ability to provide critical care.²⁶⁴

One particularly poignant example of unprofitable service cuts is the reduction of obstetrics services. One study published in 2017 found that 54% of rural counties did not have a hospital with obstetrics services.²⁶⁵ However, this particular problem is not just the result of a general lack of hospitals; rather many hospitals are specifically shedding their obstetric services based on harsh, but practical, financial calculations. Not only are costs rising in the labor and delivery space, but moreover, Medicaid reimbursement rates for births tend to be relatively lower than other healthcare services. This is particularly problematic because half of all births in rural hospitals are funded by Medicaid. Further, as populations age, hospitals have a strong financial incentive to provide health services catered to an aging population, rather than maternity care.²⁶⁶ In this regard, nonprofit hospitals that have non-financial motivators such as a charitable mission, as well as regulatory compulsion, may be better positioned to continue providing critical, even if unprofitable, OBGYN services.

At the same time, by disfavoring the nonprofit entity form, the TCJA will likely reduce the provision of uncompensated care more broadly. As demonstrated by public outrage at hospital patient dumping, as well as the IRS's prolonged efforts to require healthcare "public benefit,"²⁶⁷ hospital charity care is both a socially expected and legally important commitment. However, the reality is that there are un- and under-insured populations in

264. See generally Robert A. Barish et al., *Emergency Room Crowding: A Marker of Hospital Health*, 123 *TRANSACTIONS AM. CLINICAL & CLIMATOLOGICAL ASSOC.* 304 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540619> [<http://perma.cc/SM2Q-Q9R7>].

265. Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, *AAMC NEWS* (Oct. 31, 2017), <http://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun> [<http://perma.cc/PPW6-R22X>].

266. *Revealing the Scope of Rural OB Unit Closures*, *NAT'L RURAL HEALTH ASSOC.* (Dec. 6, 2017), <http://www.ruralhealthweb.org/blogs/ruralhealthvoices/december-2017/revealing-the-scope-of-rural-ob-unit-closures> [<http://perma.cc/GZZ5-SGJZ>].

267. See *supra* notes 80-92 and accompanying text.

the United States who experience health emergencies, and someone needs to bear the cost of their care. Through EMTALA and Medicaid, Americans have designated hospitals and the federal government as those entities. However due to the federal government's limited support, hospitals ultimately serve as "insurers of last resort." Recent studies have found that nonprofits "predominately bear" this burden.²⁶⁸ When there are increases in uninsured populations, costs at nonprofit hospitals are primarily affected, while for-profit hospitals remain largely unaffected.²⁶⁹ Similarly, when a hospital closes, nearby nonprofit hospitals bear a greater share of the burden of uncompensated-care spillover.²⁷⁰

However, no matter how mission-driven nonprofits may be,²⁷¹ it is unrealistic to expect large private organizations such as hospitals to bear costs beyond their means indefinitely, particularly when there is an alternative legal framework—the for-profit entity form—that would greatly reduce their charity burden. By making nonprofit tax exemptions less valuable, the TCJA pushes nonprofits towards conversion or a stronger profit-orientation. This will likely result in reduced provision of uncompensated care, as well as reduced charity care more broadly defined in terms of taking on bad debt and providing services in less profitable communities.²⁷² In this way the TCJA acutely fails to account for hospital market dynamics when it simultaneously cuts for-profit taxes and increases taxes on non-profits.

C. *Foregone Preventative Community Health Engagement*

Finally, the TCJA may cause nonprofit hospitals to forgo preventive community health engagement and outreach. By shifting federal tax breaks from nonprofits to for-profits, the TCJA takes away resources from

268. Garthwaite, *supra* note 21, at 5.

269. *Id.*

270. *Id.*

271. See Esra Eren Bayindir, *Hospital Ownership Type and Treatment Choices*, 31 J. HEALTH ECON. 359, 362 (2012), <http://www.sciencedirect.com/science/article/abs/pii/S0167629612000045> [<http://perma.cc/3EB5-MZFW>] (noting that nonprofit hospitals have different objectives than for-profit hospitals and exhibit less profit-seeking behavior in treatment choices for less profitable patients).

272. See generally Schlesinger & Gray, *supra* note 71.

nonprofit hospitals. Fewer resources lead to fewer services, but what services are the most likely to go? Unlike emergency room care, and to some extent care for un- and under-insured patients, preventive community health engagement is not legally mandated. Consequently, this charitable activity—potentially the most effective and cost-efficient approach to healthcare—²⁷³can be the first to be dropped or simply forgotten in the face of financial difficulties.²⁷⁴ It does not help that preventive care is particularly hard to implement and maintain since it is difficult to track, takes effect over the long term, requires innovation, and consumes additional resources. As some have observed, “the most difficult parts of nonprofits’ historic mission to preserve are the community orientation, leadership role, and innovation that nonprofit hospitals and health plans have provided out of their commitment to a community beyond those to whom they sell services.”²⁷⁵ This is particularly unfortunate since research has shown that preventive care generally is critically important for improving community health.²⁷⁶

IV. POLICY RECOMMENDATIONS

While tax reform, the mixed-entity hospital market, and distributive healthcare consequences are complicated topics, I have three simple, but

273. See generally *Missed Prevention Opportunities*, in *THE HEALTHCARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY 219* (Pierre L. Yong et al. eds., 2010), <http://www.ncbi.nlm.nih.gov/books/NBK53914> [<http://perma.cc/6ZXN-HGNW>]; but see Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 *NEW ENG. J. MED.* 661, 663 (2008), <http://www.nejm.org/doi/full/10.1056/nejmp0708558> [<http://perma.cc/CW8S-J4NF>] (noting that some preventative care measures can increase costs).

274. Jack Needleman, *Nonprofit to For-Profit Conversions by Hospitals, Health Insurers, and Health Plans*, 114 *PUB. HEALTH REPS.* 108, 108 (1999), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308449> [<http://perma.cc/8LXD-85DL>].

275. *Id.*

276. Alia Paavola, *The Importance of Preventive Care Strategies in a Changing Healthcare Environment*, *BECKER'S HOSP. REV.* (Sept. 19, 2017), <http://www.beckershospitalreview.com/population-health/the-importance-of-preventive-care-strategies-in-a-changing-healthcare-environment.html> [<http://perma.cc/CLJ5-SKGA>].

frequently overlooked, policy recommendations for policymakers drafting legislation that touch on these areas. They are as follows.

A. Evaluate How Policies (Especially Tax Reform) Will Impact Mixed-Entity Markets

First, it is critical for policymakers to carefully study and evaluate how federal policies will affect mixed-entity markets. The hospital market in particular is a definitively mixed-entity market that divides providers into two very different tax and regulatory schemes. Unless policymakers carefully evaluate the differences, dynamics, and trends between different entity forms, federal policies risk generating undesired and detrimental behavior changes such as organization closures and entity conversions.

Moreover, tax policy like the TCJA changes more than just tax brackets, rates, exemptions, and deductions. Tax reform fundamentally shifts resources and market advantages from congressionally chosen losers to favored winners. Tax incidence also has effects beyond those on whom it is imposed. Thus, even though few provisions in the TCJA directly address healthcare, the Act nevertheless carries significant implications for the hospital industry, as well as healthcare provision more broadly. This will likely be true of future policies as well. Accordingly, policymakers must be cognizant of the pre-existing legal framework underlying the hospital marketplace, especially when they adjust other parts of the frame. Otherwise, as with the TCJA, policymakers might inadvertently or unnecessarily reduce healthcare provision for America's most disadvantaged populations and communities.

B. Do Not Underestimate the Unique Role of Nonprofit Hospitals

Second, given today's market conditions and regulatory framework, nonprofit hospitals fulfill critical healthcare needs across the country through their charity care, diverse geographic locations, service provision, and patient mix. Policymakers should be cognizant of how nonprofit hospitals help cover gaps in the American healthcare system and ensure that these institutions are preserved, not threatened, by new federal policies. While neither nonprofit nor for-profit entity forms may be inherently better or worse than the other, under our current system, nonprofits form a majority of hospitals in the United States and provide disproportionate services and care to populations that need it the most.

Thus, policymakers should seek to avoid imposing unnecessary difficulties on nonprofit hospitals by, for instance, imposing unexpected

financial burdens, creating uncertainty over regulatory changes, and mandating burdensome compliance reporting. Rather, policymakers should prioritize preserving tax-exemption benefits in exchange for community benefits, or alternatively, consider means of inducing for-profits to help bear some of the charity care burdens currently laid on nonprofits.

Relatedly, policymakers should avoid treating all nonprofit hospitals as a single monolithic entity. As of 2016, there were 2,849 nonprofit hospitals in America.²⁷⁷ These institutions are situated in different geographic regions, take in unique patient mixes, and face hospital-specific financial challenges. Hospitals also vary widely in terms of size and complexity, ranging from hospitals with just a few beds²⁷⁸ to enormous hospital systems managing over one hundred hospitals.²⁷⁹ Moreover, hospitals carry different reputations and develop unique brands which can impact patient mix.²⁸⁰ Patient mixes can vary greatly in terms of the proportion of un- or under-insured patients and publicly insured patients on the one hand, and high acuity or wealthy privately-insured patients on the other. Patient mixes in turn can affect revenue and overall hospital financial status.

Consequently, policymakers should take care to disaggregate how policies will impact various cross-sections of hospitals. Legislators especially need to take care to support DSH, CAH, and other specially designated safety net hospitals, as many of these hospitals carry the weight of entire communities on their shoulders. Furthermore, given the federal structure of our country, legislators should be cognizant of and responsive to hospital differences across state lines. By simply remembering to disaggregate rather than lump nonprofit hospitals together, policymakers can make big strides towards closing rather than exacerbating healthcare disparities across the country.

277. *U.S. Hospitals Fast Facts*, *supra* note 57.

278. *Number of Beds in Registered Hospitals in the U.S. in 2016, by Hospital Size*, STATISTA (2018), <http://www.statista.com/statistics/459783/total-hospital-bed-numbers-in-the-us-by-hospital-size> [<http://perma.cc/8KTX-LVV7>].

279. Alyssa Rege, *5 Largest Nonprofit Health Systems with the Most Hospitals*, BECKER'S HOSP. REV. (Dec. 12, 2017), <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/5-largest-nonprofit-health-systems-with-the-most-hospitals.html> [<http://perma.cc/HK87-V36A>].

280. *See, e.g.*, Angelini, *supra* note 26.

C. Consider Implementing Legislation Promoting For-Profit and Nonprofit Collaboration

While it is currently impossible to replicate a nonprofit entity within a for-profit entity under corporate organizational law, Congress and state governments could respectively explore options for securities legislation and corporate organizational forms that encourage hospital joint-ventures that preserve the positive externalities of the nonprofit entity. In the same way that the JOBS Act²⁸¹ has made it easier for “emerging growth companies”—smaller, newer companies—to access the capital markets, perhaps Congress could pass similar legislation to facilitate access to equity capital for hospital joint-ventures with strong nonprofit structures. Similarly, given that many states have passed benefit corporation acts enabling for-profit companies to incorporate nonprofit societal goals into their charter,²⁸² there is a world of possibilities for corporate forms that can better bring together the charitable benefits of nonprofits with the financial benefits of for-profits hospitals. While these are ideas for future publications to examine in depth, fundamentally, the deleterious impact of the TCJA on the mixed hospital market shows a critical need for more innovative, but also nuanced, policies that address both nonprofit and for-profit hospital entities without pitting them against each other.

V. CONCLUSION

All federal policies should be assessed for their impact on mixed-entity markets such as the hospital market before being implemented. This is especially true for tax reform, which strikes at the very heart of the difference between for-profit and nonprofit entities: tax exemption.²⁸³

281. See *Emerging Growth Companies*, SEC (Nov. 30, 2017), <http://www.sec.gov/smallbusiness/goingpublic/EGC> [<http://perma.cc/3TU3-W9WL>].

282. See *2013 State by State Summary Chart*, BENEFIT CORP., (last visited Feb. 21, 2019), http://benefitcorp.net/sites/default/files/documents/State%20by%20State%20Analysis_0.pdf [<http://perma.cc/6ZC3-BAN5>] (summarizing benefit corporation laws).

283. See Schlesinger & Gray, *supra* note 71; Charles F. Jensen, *Tax Cut and Jobs Act Changes Will Impact Tax Exempt Organizations*, LEXOLOGY (Dec. 28, 2017), <http://www.lexology.com/library/detail.aspx?g=85b8db3b-4ead-44f0-a9cd-803de811cc90> [<http://perma.cc/TD43-L46P>].

Unfortunately, the drafters of the Tax Cuts and Jobs Act of 2017 failed to carefully scrutinize the disparate effect of the bill's provisions on the hospital market, and instead bluntly sought to give for-profit corporations more tax breaks. Consequently, the Act decisively tilts the hospital market towards for-profit entities. This has ramifications that have yet to fully play out but will almost certainly place the largest burdens on the smallest and financially weakest nonprofit hospitals and the vulnerable populations they serve. The TCJA could have avoided much of this unequal burden-shifting through more careful research and drafting. However, now that the TCJA has been passed, legislators should learn from the bill's shortcomings and take care to ensure that future policies are not blind to the dynamics of a critical mixed-entity market like the hospital market. Only in this way can policies be implemented to enable both nonprofit organizations and for-profit corporations to thrive in a mixed-entity market for the benefit of all Americans.