COMMUNITY CATALYST

Commentary to the Health Care Institution Responsibility Model Act

Introduction to Community Catalyst

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality affordable health care for all. We provide assistance in policy analysis, training, community education, fundraising and organizational development to state and local consumer health care organizations.

In 1995, we began the Community Health Assets Project (CHAP), a national partnership with the West Coast Regional Office of Consumers Union. CHAP assists and provides technical advice to consumer groups, labor, legal service organizations, legislators, regulators and attorneys general reviewing transactions involving the conversion of nonprofit health care institutions to for-profit status. The goals of the project are (1) to protect nonprofit charitable assets and (2) to preserve health care services as the conversion takes place. Our work has contributed to an environment in which protective legislation has been passed in over twenty states, over $13 billion worth of charitable assets have been maintained in the nonprofit sector[1], and health services for vulnerable constituencies have been preserved in many communities.

As an outgrowth of our conversion-related work, we have begun to see new opportunities to raise the issue of community benefits. As in our conversion work, we recognize that regulatory oversight is essential to the promotion of accountability by health care institutions to the communities they serve. It is with this background that we began drafting the Health Care Institution Responsibility Model Act.

Introduction

For several years, consumer advocates, academics, health care services provider associations, regulators, legislatures and philanthropic foundations have weighed in on the increasingly important area of community benefits. [2, 3]

Our work on community benefits is guided by the recognition that in today's increasingly complex health care marketplace, people who are uninsured or who have special health care needs often depend on the free goods and services provided by local health care institutions. "Community benefits," are the unreimbursed goods, services and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved. Typically, community benefits are provided by health care institutions above and beyond their core obligations as health care providers and insurers. Community benefits comprise an

[1] Grantmakers in Health, Coming of Age (1999) at 1.
[2] See Appendix I for additional community benefits resources.
[3] Currently, there are thirteen (13) states with laws, regulations or guidelines containing community benefit requirements. See Appendix II for a guide.

important part of the health care safety net and can include free care for uninsured people and people with special health care needs, health promotion and disease prevention initiatives, and outreach to populations who suffer poor health as a result of health service under-utilization. Simply put, the policy around community benefits

> implies a broadening of obligation by health institutions beyond delivery of medical services for individuals, to improving the health of the community overall. It also implies engagement of vulnerable constituencies in determining priority community needs and governing the distribution of health system financial resources, whether at the institutional or governmental level.[4]

Institutional resources by themselves will never be sufficient to solve the direct services needs of the uninsured and the medically underserved. However, they do represent a substantial pool of funds that can strengthen the health care safety net and can be used creatively to improve access to care and address fundamental causes of poor health among vulnerable populations. Protecting and expanding the community benefit obligation among health institutions is particularly crucial in light of continued restructuring in the health sector, the absence of comprehensive state or federal reforms, and steady increases in the number of uninsured. As a practical matter, if even a small percentage of operating cash flow in many health institutions goes towards community benefits, this is still potentially a great deal of money and value, given the immense size of the system.

While community benefits are essential to the most vulnerable in our communities, they are still largely voluntary and ad hoc efforts. With few exceptions, there are only vague standards that health institutions must meet to fulfill community benefit obligations. Institutional commitments to provide community benefits vary considerably. As a result, the supply of essential health services for vulnerable populations is uneven from community to community and, at a local level, from neighborhood to neighborhood.

It is this background that provides the impetus for this Model Act. In establishing model requirements, we seek to provide a mechanism for monitoring the behavior of health care institutions with the twin goals of protecting access to essential health coverage and services and ensuring an appropriate public process for determining what, and how, services are provided. With these goals in mind, our objectives are:

- to achieve a degree of equality and fairness in the provision of community benefits among communities;
- to gain the participation of a full range of institutions in the health sector;
- to "raise the bar" for health care institutions as a whole; and

[4] Mark Schlesinger & Bradford Gray, *A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities*, Health Affairs (May/June 1998) at 153-154.

- to convey to health care institutions a sense of clarity about what is required of them.

Key Issues

I. Applicability: A Level Playing Field

The decision about which health care institutions ought to be responsible for community benefits obligations is one of the most hotly contested issues. Some argue that the community benefits obligation is derived primarily from valuable tax-exemptions and other favorable treatment and support, and therefore, community benefits laws should apply only to nonprofit and public health care institutions. According to this line of reasoning, for-profit health care institutions fulfill their obligation to the public by paying taxes.

Others counter that for-profits' ready access to capital balances out the tax advantages enjoyed by nonprofits. Proponents of this view argue that as for-profits gain market share – and put competitive pressure on their nonprofit counterparts – they must share in the obligation to provide community benefits in order to avoid putting nonprofits at a further disadvantage. Indeed, there is evidence that for-profit health care institutions increasingly view community benefits as their obligation. Some for-profits have agreed to continue services and levels of free care provided by nonprofits they acquired as a condition of entering a particular market. And, policy leaders have increasingly identified the public interest in health as carrying a requirement for consistent corporate behavior regardless of tax status.

We believe that in order to create a level playing field in an increasingly for-profit health care market, community benefits laws should apply to a variety of health care institutions in both the nonprofit and the for-profit sectors. Our Model Act reflects this thinking and the widely accepted notion that health care is a social good, not a commodity.

Moreover, we believe that community benefits is not merely the price nonprofits pay for retaining their tax-exempt status. Rather, nonprofits are subject to many other obligations or restrictions that are not imposed on for-profits. These include:

- the obligation to include community representatives in the governance of the institution
- limitations on board members' compensation
- the requirement that assets must be permanently dedicated to an exempt purpose

On the other hand, for-profit health care institutions' payment of taxes allows them the freedom to be entrepreneurial.

Rather than viewing community benefits as simply the "quid pro quo" for the tax benefits that nonprofits receive, we attempt to establish a community benefit model that reflects the reality of the marketplace. Nationally, 14% of hospitals are for-profit, 60% are nonprofit, and 26% are government-owned.[5] By only holding nonprofit hospitals to community benefits standards, we are exempting 40% of all providers. Moreover, HMOs in this country are overwhelmingly for-profit institutions.[6] In a

[5] Julio Mateo and Jaime Rossi, Consumers Union, White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Consolidations in California (1999) at 3, citing Rachel Kagon, *Merger Plans May Face Tough Court Challenge,* Oakland Tribune, Dec. 16, 1998, at 1.

[6] Nationally, more than two-thirds of HMOs are for profit, about three times the level in 1985. *Study Indicates Better Care Under Nonprofit Health Plans,* Medical Industry Today, July 19, 1999.

system where managed care companies and for-profit hospitals are changing the landscape of the health care marketplace, it is essential that these players assume their share of the obligation to serve the health care needs of vulnerable populations.

There are other practical reasons for holding all types of institutions accountable for community benefits. By including for-profits, consumers, regulators and legislators will be able to better assess whether conversions and/or other consolidations are a net gain or loss for the communities involved. Community benefit reporting can also be used as a tool to determine if all providers are carrying their fair share of the charity care load.

To be sure, nonprofit health care institutions should not be permitted to view their community benefits activities as fulfilling their entire obligation to the community. A nonprofit health care institution should be further required to report how its community benefits program fit into its overall charitable mission. Additionally, each nonprofit health care institution should be required to report on the inclusion of community representatives in its governance.

II. Standards of Accountability

There has been much debate over setting a performance standard for the provision of community benefits. Some advocate that health care institutions should provide community benefits at a set percentage of their operating budgets, gross patient revenues or direct written premiums. Others point out that creating a performance standard would result in the percentage becoming both a "ceiling" as well as a "floor" and thus, would discourage institutions from providing more than the required standard. Others argue that using a national Model Act to set a performance standard does not take into account the realities of a given state's situation or the financial condition of its health care institutions.

Almost all agree that setting a standard would make it politically difficult, if not impossible, to gain consensus. One of the most successful set of community benefits guidelines, from the Massachusetts Attorney General's office, declined to set a standard, but rather established "target goals." These target goals suggest that major nonprofit acute care hospitals provide community benefits in an amount up to 6% of total patient operating expenses (the recommended amount is lower for smaller institutions).

We determined not to specify a performance standard in the Model Act, though drafters may certainly elect to do so depending on local needs and circumstances. The decision was based on the considerations set forth in the previous paragraph, and to emphasize the collaborative process between health care institutions and the communities they serve. This view favors a "collective bargaining" approach, which assumes that a solid process and a true community-institutional partnership will ensure a positive outcome.

Definition Section

Administration (§101.1(a)); Department (§101.1(e)) – Although we have assigned jurisdiction to the Insurance Administration (for oversight of insurers) and to the Health Department (for health care services providers), drafters should check to make sure that this is relevant for their own state. In some states, there is split jurisdiction for health plans. Where such split jurisdiction exists, drafters should express a preference for the Health Department to assume oversight responsibility.

Community Benefits (§101.1(d)) -- Community benefits are the unreimbursed goods, services and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved. Using this definition, we arrived at a list of goods, services and resources that a health care institution may include in its community benefits reporting. Generally, they fall within the broad categories of free care, health promotion, disease prevention, and improving health access to communities in need.

While we did not list all of the activities that may be considered a community benefit, the Model Act provides some guidance on the parameters that could be set by Legislatures. Just because a health institution claims that a service is "of benefit to the community," does not mean that it is a valid community benefit. Indeed, the determination of what is a "true" community benefit must be based on a demonstrated link between the health needs of the community (as defined by the community health assessment) and the health care institution's community benefits plan.

Free Care (§101.1(d)(1); §101.1(f)) – Drafters are advised to include by reference any state statutes that contain requirements or guidelines for the provision of free care by health care institutions. Note that this may also be referred to as "charity care" in some states. (see p. 9 of this commentary for a further discussion of free care).

Below-Cost Care (§101.1(d)(8)) – There is great debate about whether health care institutions should be permitted to include below-cost care in their community benefits plans. Below-cost care primarily refers to shortfalls incurred as a result of the health care institution's decision to participate in any government subsidized health care program, including Medicare and Medicaid. Although most of the current state laws and guidelines permit the inclusion of such shortfalls[7], some commentators have noted that cost efficiencies resulting from managed care have brought cost and reimbursement levels much closer, so that it is more difficult for health care institutions to justify claiming any shortfall.[8] Further, in some highly competitive markets, it has been observed that Medicaid reimbursement rates have been adequate.[9]

Nonetheless, we recommend allowing below-cost care to be included in a community benefits report, provided that it is reported with an actual reimbursement-to-charge ratio. Further, we recommend requiring each health care services provider to report the lowest private sector contract it has negotiated. Both reporting requirements will provide regulators and communities

[7] The Massachusetts Attorney General's Guidelines disallow the inclusion of below-cost care.
[8] Kevin Barnett. The Future of Community Benefit Programming (1997) at 2-7 and 5-48.
[9] Id.

with more accurate information about the extent of claimed shortfalls and a basis for comparison amongst charges to various third-party payers.

Health Research, Education and Training (§101.1(d)(12)) – Many health care services providers, particularly teaching hospitals, devote enormous resources to health research, education and training. Although they typically include the unreimbursed costs of these programs in their community benefits plan and report, there is good reason to question a straightforward inclusion. First, research agendas may be extremely broad, with some projects having no direct value to the targeted community. Second, interns and residents serve to extend the available time and resources of physicians, thereby contributing to the health care services provider's bottom line.[10] Thus, we believe a more targeted approach is advisable. Health care services providers should be required to demonstrate the link between their research, education and training activities and the health care needs of the targeted community as indicated by the community health assessment. Only those activities that can be linked in this way should be reported by the health care institution to the Department or Administration as community benefits.

Health Care Institution (§101.1(g)); Health Care Services Provider (§101.1(h)); Insurer (§101.1(i)) – Because they vary from state to state, it is difficult to name all of the types of health care institutions that should provide community benefits. For purposes of simplification, we grouped them under the title of "health care services provider" or "insurer." However, drafters of legislation are advised to also include under the heading of "health care services provider," as applicable in each state, a variety of health care service providers such as:

- Acute care hospitals
- Surgical Centers
- Chemical Dependency Treatment Centers
- Nursing Homes
- Skilled Nursing Facilities
- Hospices
- Other diagnostic or therapeutic facilities or services
- Provider Sponsored Organizations (PSOs)
- Specialty Hospitals
- Birthing Centers

Further, drafters of legislation are advised to also include under the heading of "insurer," as applicable in each state, a variety of third party payors such as:

- Blue Cross Blue Shield plans
- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Commercial Insurers
- Provider Sponsored Organizations (PSOs)
- Mutual Insurance Companies

[10] Id. at 5-48, 5-49.

Drafters are encouraged to consider carefully which institutions should be included. These decisions will be based upon state-specific information about which institutions have resources as well as the political environment. Drafters may conclude, based on these considerations, that certain categories of health care institutions should be specifically exempted.

Finally, for clarity's sake, it is essential to reference the enabling statute for each type of health care institution. If there are different statutes for nonprofit and for-profit institutions, be sure to cite to both. (see pp. 3-4 of this commentary for further discussion of a level playing field).

Basic Requirements

I. Mission Statement

The creation of a mission statement is an important first step towards implementing a solid community benefits program. First, it affirms the commitment of the governing board of the institution to its community benefits obligations. Second, by requiring a declaration that senior management will be responsible for oversight and implementation of the community benefits plan, it places responsibility at the highest organizational level. This helps to foster a shared sense of purpose and responsibility. It also reassures community representatives that they will be collaborating with officials who can make commitments on their institution's behalf. Seven of the existing community benefits laws and guidelines require institutions to create new mission statements or amend existing ones to reflect a commitment to serving community interests.[11]

II. Defining the Community

It is essential to the success of a community benefits program to define the intended beneficiaries. Focusing on a clearly defined and identifiable segment of the community makes it easier for both the institution and the community to evaluate and measure the impact of a community benefits program or service. The Model Act permits the definition of the community to be based on geography or other population-based categories such as race/ethnicity, income, age, or by disease affinity groups such as people with AIDS or diabetes.

Defining the community early in the process will help the health care institution target key stakeholders who should be involved in the community health assessment.

III. Community Health Assessment

A community health assessment is a vital tool used to identify where resources are available and where they are needed. It should:

- take into account existing data from community health or other public agencies;
- seek to identify barriers and systemic reasons for poor health status;
- target uninsured or underserved people in the institutions' service areas; and

[11] See the laws, regulations and/or guidelines in California, Indiana, Massachusetts, New Hampshire, New York and Texas.

- inventory and re-examine existing community benefit efforts by the institution and by other institutions.

The process for conducting the community health assessment is as important as the assessment itself. Health care institutions must collaborate with community representatives in the planning and implementation of any community health assessment. The assessments should have both a qualitative (data collection through interviews, focus groups and surveys) and quantitative (statistical public health data) aspects. Health care institutions should work with the community in deciding:

- what type of data will be collected;
- who will be interviewed and surveyed;
- what the interviews and surveys will include;
- who will conduct the survey;
- how the barriers to care will be identified; and
- who will analyze and write the assessment.

After the data collection is complete, the Model Act requires health care institutions to provide an opportunity for the community to review and comment on the assessment before it is finalized. This is important to ensure that the assessment squares with the community's perception of available resources and unmet needs, that it accurately reflects the community's views, that needs were accurately prioritized and that the data was adequately analyzed and presented.

To prevent duplication and unnecessary expenditure of resources, we encourage health care institutions to collaborate where possible/practical in conducting community health assessments and to make use of any existing assessments. This does not relieve any health care institution from the requirement of preparing it's own assessment unique to the community it serves.

IV. Community Benefits Plan

The development and submission of a community benefits plan is critical. If done well, the plan will serve as the guiding force for the implementation of a successful community benefits program.

Reporting Requirements

Another hotly debated issue with regard to community benefits is that of measurement or reporting standards. In order for regulators and communities to monitor and compare health care institutions' programs within their states, it is essential for health care institutions to report the value of their community benefits in a consistent and fair manner.

The issue is treated differently in a number of different laws and guidelines.[12] Although we left it to the regulators to design a standard reporting format, the Model Act includes guidance about what information should be provided by each health care institution. In deciding what information to require, we opted to use commonly used accounting standards in order to avoid imposing an undue burden on health care institutions. In other words, we sought to have health care institutions report

[12] See, e.g., the laws, regulations and/or guidelines in Massachusetts, Texas, and Utah; see also The Catholic Health Association of the United States, Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint (1989).

the value of contributed community benefits on the same basis as they account for the cost of such services for their own internal bookkeeping purposes. This will inflate or overstate the value as it is based on the retail charge for free care services provided, and the amount of overstatement will not be uniform across all reporting entities. We therefore suggest requesting, or utilizing, the cost-to-charge ratio for each entity in order to gain a true understanding of the value of services provided.

Another key element of achieving a uniform reporting standard is to require reporting on an institution-by-institution basis. This means that larger health care systems with a multi-corporate structure should report for each individual institution and not on an aggregate basis, thereby improving the ability of regulators and communities to evaluate each health care institution's community benefits program.

Public Comment and Input; Public Records; Standing of Parties

It is a basic tenet of community benefit best practices that the process of developing a community benefits program must be collaborative. In order to facilitate this process, it is essential that documents be open and available to the public. Thus, we included opportunities for public comment and input at a number of stages: the development of the community health assessment, the development of the community benefits plan and the filing of the annual report. Central to meaningful community input is the ability of persons to take issue with an institution's community benefits report. Therefore, the Model Act allows persons to file dissenting reports, which provide the basis for standing not only for future adjudicative hearings but also for further judicial appeals.

Free Care[13]

For millions of uninsured people, community benefits -- and, in particular, free care -- represent critical last resort access to health care. However, since so few standards exist across the country, each health care services provider generally creates its own free care policy. The impact is that free care (like other community benefits) is different from institution to institution and access to health care for the uninsured varies from community to community.

We have recognized the critical importance of free care by designating a separate section of the Model Act to include guidelines about how health care institutions should provide free care. Our objectives were to require health care providers to:

- create a written policy for the provision of free care;
- provide written eligibility criteria that are easily understood by applicants;
- include a system for advertising the free care program to the uninsured in a clear and non-threatening manner; and
- exclude bad debt charges in their community benefits annual report.

[13] For additional information about free care policies, see The Access Project, The Free Care Safety Net Fact Sheet (1999).

It is essential that health care institutions exclude bad debt from their free care calculation.[14] First, not all services are provided to those who are unable to pay. For example, when insurance companies refuse to pay policyholders' medical bills, it increases bad debt for health care services providers and benefits only the insurance companies. In these cases, patients are not receiving free care because they, or their employers, are paying insurance premiums. Second, all industries have bad debt; it is simply a cost of doing business.

The Model Act addresses some of the most important issues relating to a health care provider's free care policies and reporting. However, there are other aspects of a free care policy that are not as easily dealt with in a Model Act, but drafters in individual states may choose to address in their own bills. These include:

(1) What services are covered under the free care policy – doctors' services, lab work, prescription drugs? Is every available effort made to provide comprehensive services as free care, and not just emergency care? Does the health care services provider have an on-site pharmacy and staff physicians who could provide free services?
(2) When is free care eligibility determined – before or after services are provided? Are patients billed while they wait for an eligibility decision?

Subsidized Care

[14] A number of state free care policies require that free care be distinguished from bad debt. See, e.g., **Washington**, Wash. Admin. Code §246-453 (1997); **New Jersey**, 27 N.J.R. 1995 (1995); **Maine**, CodeMe. R. § 10 144 150 (1997); **Massachusetts**, Code of Mass. Regulations 114.6CMR 10 et seq. (October 1998); see also, American Institute of Certified Public Accountants, Audit and Accounting Guide: Health Care Organizations (1997) at 99; Minnesota Hospital and Healthcare Partnership, A Benefit to the Community: Accounting for Uncompensated Care (Sept. 1999) at 6-7 (viewed at http://www.mhhp.com/issues/uncomp.htm).

Like free care, subsidized care represents an important method of providing access to health care services for the uninsured and underinsured. There is debate, however, around the issue of the standard to be used for billing a person receiving subsidized care. Some suggest that the person's liability should be a percentage of actual costs or the lowest discounted rate negotiated with managed care providers. However, this formulation may still result in an unreasonably high bill for an uninsured or underinsured person and therefore become simply another barrier to access. Instead of choosing an arbitrary percentage, we suggest in our Model Act that a person's liability should be based on his/her income or ability to pay. The difference between the payment and the actual cost may be included in the institution's community benefits calculation.

Monitoring and Enforcement

It is widely understood that a law is only as good as its enforcement. In drafting the Model Act, we sought to clearly designate the public officials charged with monitoring and enforcing the law and to state what penalties apply when a violation is found. Nearly all thirteen states with community benefit laws and guidelines name a state official to oversee the community benefits process. The public officials represent a variety of different offices: public health officials (California, Minnesota, New York, Texas), Attorneys General (Massachusetts, New Hampshire, Pennsylvania), the tax department (Utah, West Virginia), the state department (Indiana) or the Superior Court (Georgia). We chose the public health department to oversee health care services providers and the insurance administration to oversee insurers, but the choice may vary from state to state depending on the type of institution and state circumstances.

Currently, four states have penalties for violating community benefits requirements -- Indiana, Pennsylvania, Texas and New Hampshire. We chose a penalty provision similar to that enacted in Indiana and Texas, where health care services providers are assessed a penalty not to exceed $1,000 for each day they fail to file a community benefits annual report. In Pennsylvania, a penalty not to exceed $500 is imposed on any entity that does not file an annual report. In New Hampshire, the director of charitable trusts may assess an administrative fine of up to $1,000 (plus attorneys fees and costs) on institutions for failing to submit a community benefits plan or make it available to the public in the prescribed manner.

Conclusion

To be sure, community benefits is a concept that is neither quickly recognizable nor easily quantifiable. There is a wealth of opinions in today's health care sector about what may be included in a community benefits program, who should be providing them, how much should be provided, and how these activities should be recognized by state regulators and legislators.

Though the debate surrounding each of these issues is enough to make one conclude that legislators and regulators should simply not get involved (and, in fact, only a minority of state legislators or regulators have entered this fray), the stakes are simply too high. There are over 44 million people in our country without insurance. Many more have inadequate coverage. Community benefits represents the only access to health care services for many of these people.

Drafting a community benefits bill will require great thought about the types of health care institutions in your state, the health care needs of the people in your state (particularly those who are

uninsured or underserved), and a vast array of political considerations unique to your state, (including the position and relative strength of the hospital association or the insurance sector).

Despite the difficulties, the effort is worthwhile. By working to enact community benefits legislation, communities will design new tools for monitoring the behavior of their local health care institutions and for building a more accountable health care system that is responsive to their unique health needs.

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APPENDIX I:

COMMUNITY BENEFITS RESOURCES

The Access Project, Defending Community Benefits in a Changing Health Care World (February 1999).

The Access Project, The Free Care Safety Net Fact Sheet (February 1999).

Kevin Barnett, The Future of Community Benefit Programming (1997).

The Catholic Health Association of the United States, Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint, (1989).

Coalition for Nonprofit Health Care, Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations (July 1999).

Community Catalyst, *Community Benefits in a Changing Health Care Market,* States of Health, Vol. 7, No. 5 (July 1997).

Community Catalyst, Compendium of State Community Benefits Laws, Regulations and Guidelines (November 1999).

Mark Schlesinger and Bradford Gray, *A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities,* Health Affairs (May/June 1998) 152-168.

Mark Schlesinger et. al, *A Broader Vision for Managed Care, Part II: A Typology of Community Benefits,* Health Affairs (September/October 1998) 26-49.

Natalie Seto and Bess Karger Weiskopf, The Access Project, *Community Benefits: Creating Opportunities for Action in Healthcare Change* (January 2000) (anticipated).

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APPENDIX II:

STATE LAWS, REGULATIONS AND GUIDELINES

California, Cal. Health & Safety Code § 127340, *et. seq.*

Georgia, Ga. Code Ann. §§ 14-3-305, 31-7-90.1

Idaho, 1999 Idaho Sess. Laws 126 Idaho Code § 63-602D

Indiana, Ind. Code § 16-21-9-1, *et. seq*.

Massachusetts, Attorney General's Community Benefit Guidelines for Nonprofit Acute Care Hospitals, June 1994

Massachusetts, Attorney General's Community Benefit Guidelines for Health Maintenance Organizations, February 1996

Minnesota, Minn. Stat. § 144.698 and § 62Q.07

New Hampshire, 1999 N.H. Laws 0924 N.H. Rev. Stat. §7:32-c, *et. seq.*

New York, N.Y. Pub. Health Law § 2803-1

Pennsylvania, 10 Pa. Cons. Stat. § 371, *et. seq.*

Rhode Island, R.I. Gen. Laws § 23-17-43

Texas, Tex. Health & Safety Code Ann. § 311.042, *et. seq*.

Utah, Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards, Dec. 18, 1990

West Virginia, W.Va. Code State R. tit. 110, § 24.1