Testimony Supporting S.B. No. 476: An Act Concerning the Office of Health Strategy's Recommendations Regarding Various Revisions to Community Benefits Programs Administered by Hospitals

Dashni Sathasivam, MPH, Karen Siegel, MPH, & Tekisha Dwan Everette, PhD
Public Health Committee
March 28th, 2022

Dear Senator Anwar, Representative Steinberg, Senator Hwang, Senator Somers, Representative Petit, and esteemed members of the Public Health Committee,

Please accept this testimony on behalf of Health Equity Solutions (HES), which is a nonprofit organization with a statewide focus on promoting policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

Health Equity Solutions supports this proposed legislation and strongly urges the committee to adopt the recommendations included here to further strengthen Connecticut's community benefit requirements. Federal community benefit requirements were designed as an accountability mechanism to ensure nonprofit hospitals contribute to the wellbeing of their communities in lieu of state and federal income and property taxes that would otherwise fund local resources and services.[1] Strengthening these regulations is one of the most promising options for addressing the stark inequities in medical debt.[2]

To date, 29 states[3] have passed laws strengthening community benefit programs.[4] ***Connecticut is the only Northeastern state that has yet to institute additional state community benefit requirements***. The benefits are clear. States with any form of strengthened community benefit law saw increases in community benefit spending.[5] Greater spending in community benefit programs has been associated with lower hospital readmission rates, which can lead to tangible reductions in health care costs and are an indicator of improved health.[6] ***Community benefit laws are important to advancing health equity because they strengthen the role of community voice in hospitals' community-based programming and mitigate hospital-driven medical debt that disproportionately affects Black, Latino/a, and other people of color***. Connecticut has an opportunity to learn from the experiences of other states and leverage community benefit programs as a tool to advance equity.

Community Benefit in Connecticut and the U.S.

Community benefit spending, as reported on the IRS 990 Form H, has gone down across the country since the enactment of the Affordable Care Act (ACA). Much of this reduction in community benefit spending reflects higher insurance coverage rates following the passage of the ACA and a corresponding decrease in the need for subsidized and free healthcare. However, other areas such as non-financial community benefit spending have not increased to make up for this reduction.[7] ***Connecticut has seen a decline in community benefit spending over the past 5 years, including expenditures on hospital financial assistance (also known as charity care). Overall spending on improving community health beyond the hospital's setting has remained consistently low***, hovering between 0.25% - 0.28% of total hospital expenditures from 2016 – 2020.[8]

Currently, the largest share of community benefit dollars is spent on financial community benefits, with these dollars going back to the hospital to make up for the costs of care provided to un- and under-insured people and Medicaid enrollees.[9] ***In Connecticut, hospitals spend more on internal financial contributions and less***

on community-based activities than the national average.[10] Approximately 75% of community benefit spending pays hospitals back for treating people who are uninsured or enrolled in Medicaid.[11] This doesn't account for the federal funding some hospitals receive to cover these costs.[12]

Examples of non-financial community benefits include lead abatement initiatives, supportive housing, legal aid, community health advocacy, and coalition building.[13,14] Massachusetts's state community benefit guidelines explicitly state that community benefit dollars can be used to fund community health workers, while hospitals in other states have reported investing their community benefits funds to support community-based organizations addressing needs prioritized by the communities they serve.[15, 16, 17] Community benefit dollars can address the social drivers of health and foster collaboration between hospitals and community-based organizations.

Stronger Regulations Lead to Increased Spending

On average, states with any type of additional community benefit laws saw an increase in spending of between $8.42 – $13.5 per $1,000 of total hospital operating expenses.[18] Greater specificity in reporting requirements was associated with the greatest growth/increase in spending and the increases occurred in the year following enactment.[19] **In Connecticut, a community benefit law could increase community benefit spending by an additional $101,192,605 - $162,244,675 per year.[20]**

Despite the pandemic-related challenges of 2020, 76% of Connecticut hospitals saw operating gains that year. While patient revenue decreased by $540 million, Connecticut hospitals received provider relief funds totaling $1.1 billion and saw $320 million in investment revenue and $40 million from patient care, collectively accruing assets totaling over $7.6 billion.[21] This suggests Connecticut hospitals can invest more in their communities without experiencing hardship.

Support for Linking Community Benefit to Community-Identified Needs

Every three years, hospitals are required to conduct community health needs assessments (CHNAs) and create a related implementation strategy. ***HES supports linking community benefit programs to needs identified in CHNAs, as proposed in S.B. 476.*** Tying community benefit spending to needs identified by communities in CHNAs is a promising opportunity for advancing health equity.[22] Since triannual CHNAs are already a federally required process and recognized as a tool for health equity, linking these existing programs adds accountability without adding undue burden.[23,24,25] Currently, reporting for both programs is difficult both to find and to understand. Improving transparency is essential to promoting accountability.[26] Research suggests that measuring the degree to which nonprofit hospitals are meeting the identified needs or improving the health outcomes of their communities is a potential policy lever and incentive to improve performance.[27] Clearer, more accessible reporting allows communities to assess how resources are being directed and advocate for greater diversity and responsiveness of investments as needed.

Recommendations for Strengthening S.B. 476

Having analyzed the community benefit regulations across the United States and the related academic and grey literature, HES concludes that this proposal is a step in the right direction and could be significantly strengthened by adopting the following recommendations.

Strengthen the definition of "meaningful participation" by making it clearer and more inclusive: A recent review of community benefit literature revealed that community engagement varies widely among hospitals, the needs of minoritized communities are more likely to be overlooked, and there is a failure to identify and/or account for root causes driving community needs.[28] Setting a standard for community engagement for CHNAs

and community benefit programs is crucial to their success in reflecting community voice, building community power, and facilitating collaboration. The IRS offers a sweeping description of "Input Representing the Broad Interests of the Community,"[29] offering no shared or measurable definition of how communities are engaged to participate in these processes. It comes as no surprise that research finds a great deal of variation in community engagement efforts conducted by hospitals for these processes.[30, 31] Further, CHNAs with **greater community collaboration and participation have been found to yield a higher quality, more responsive assessment and bring greater attention to financial support for community health activities**.[32, 33,3435] Although community-based organizations —especially those led by and directly working with people of color—were found to be most effective in facilitating community engagement efforts for CHNA and community benefit programs, the value of their role and expertise was overlooked by hospital administrators.[36] Clarifying the definition of meaningful participation will improve the comparability of these processes across hospitals and promote best practices. HES respectfully requests the definition of meaningful participation to be updated with the changes in bold:

> "Meaningful participation" means that (A) residents of a hospital's community, including, but not limited to, residents of such community that experience the greatest health disparities, have an appropriate **and inclusive** opportunity to participate in such hospital's planning and decisions, (B) **opportunities to participate are culturally, linguistically, and logistically appropriate; (C)** community participation influences the hospital's planning **and implementation**, and **(D)** participants receive summary information about how input was or was not utilized by such hospital."

Improve the accessibility of hospital financial assistance: Financial assistance in Connecticut (2016 – 2019), has decreased by nearly $3.5 million ($3,458,329) from 2016-2019, while bad debt climbed by $45 million ($45,117,532) in the same period.[37] Need for affordable health care has not declined. Data from over 2,500 hospitals across the country found that in one year an estimated $2.7 billion in bills (45%) were sent to patients who likely qualified for free or discounted care.[38] In 2019, $10,681,231 of Connecticut's reported "bad debt" was from people whose bills were eligible for financial assistance.[39]

As the cost of health care continues to increase, Black, Latina/o and other households of color face disproportionate rates of medical debt and other inequities limiting opportunities for health.[40] Furthermore, 2018 data shows that medical debt was nearly double among households that experienced a hospital stay (31.3%) compared to households without (15.8%).[41] From 2007-2014 growth in hospital prices for inpatient and outpatient services outpaced growth in physician prices for those same services, with growing hospital facility fees driving this difference.[42]The UCONN Health Disparities Institute found that 81,136 lawsuits were initiated by hospitals and medical providers from 2011 – 2016, totaling $110,029,350 in outstanding debt.[43] In addition, a survey of Connecticut residents found communities of color had limited understanding of health insurance coverage, which means financial assistance options are less likely to be understood and navigated by these communities.[44] Further, 66% of respondents to a national survey said that people in debt to hospitals were generally not aware of or familiar with the charity care or financial assistance options available to them.[45] Thus, **HES recommends embedding improved access to financial assistance in the current proposal.**

To ensure residents eligible for financial assistance are indeed able to access these services, Connecticut should **adopt a universal financial assistance application** which patients can submit to any Connecticut hospital. A uniform hospital application would simplify patient access to financial assistance. HES recommends the application be created by the Connecticut Hospital Association and annually reviewed and approved by the Office of Health Strategy to ensure the form is both accessible and practical for patients and hospitals.[46] In addition, HES recommends a minor change to existing statute to clarify that any patient with an unpaid bill be screened for bed funds AND any other charity care or financial assistance programs that the hospital may offer.

Establish a community benefit spending floor. The pandemic and related disproportionate rates of COVID-19

infection and death experienced by Black, Latino, and American Indian communities have demonstrated the need for and value of local resources to maintain health in times of vulnerability.[47, 48] Connecticut's community benefit spending has declined over the past 5 years. Developing a unique spending floor requirement for each hospital based on previous trends in spending, priorities identified in CHNAs, and each hospital's financial circumstances increases transparency and is calibrated to avoid any undue burden on our hospitals.

Six states have established community benefit floors tied to property-tax exemptions or patient revenues.[49] HES recommends Oregon's approach, which calculates individual spending floors for each hospital to account for variation in patient populations and historic spending levels.[50] This ensures evenhandedness and accounts for the proportion of uninsured patients treated at each hospital.[51] A spending floor for community health improvement and community building activities, in particular, is one mechanism to rebalance community benefit spending. The majority of current community benefit spending supports clinical care received in hospital settings, while only 1.9% of community benefit dollars go towards activities to improve the community.[52]

HES notes this is the only of the recommendations embedded here to which we have heard opposition. In response, we engaged in significant research before including it here. Spending floors are not popular with hospitals, but they do appear to be effective, and we saw no evidence that they cause harm or undue burden in the early phases of implementation.

Increase accountability by clarifying reporting requirements

As noted above, transparent reporting can foster community-hospital collaboration, increase investment in community-based programs, and increase accountability. While the IRS defines community benefit spending categories, the guidance is ambiguous and current reporting is difficult to understand.[53] S.B. 476 partly addresses this, delineating components of reporting to make it more feasible to compare community benefit programs across hospitals, understand which programs and partners were included, or identify hospitals' work to support community health. Requiring reporting to show a connection between community benefit spending and needs identified in CHNAs helps communities to collaborate with hospitals and advocate for more effective investments. A survey of 179 nonprofit hospitals across the U.S. found that 65% of hospital CHNAs explicitly mentioned health disparities or health equity and 100% implicitly mentioned health equity. Yet, only 46% of hospital CHNAs prioritized health equity and only 9% cited activities to promote health equity.[54]

In addition to the reporting requirements included in S.B. 476 n on outcome metrics, ***HES recommends explicitly requiring demographic data, standardizing reporting of financial assistance, and consistently and explicitly embedding health equity.***[55, 56] These proposed changes strengthen clarity and would enable communities to see both the important work hospitals are doing and opportunities for improvement. At present, it can be challenging to parse the human impact of community benefit programs because of the esoteric, IRS-focused reporting structure. Detailed reporting elevates opportunities for hospitals to partner with community-based organizations to address social determinants of health through culturally and linguistically appropriate approaches.[57]

Specifically, reporting should explicitly require:

- financial assistance data disaggregated by race, ethnicity, and language[58]
- financial assistance data reported using a standardized calculation of 125% Medicare or Medicaid reimbursement rate (current reporting is based on hospital cost/charge ratios)[59]
- demographic data associated with health disparities, including race, ethnicity, primary language, disability status, sexual orientation, and gender identity reported utilizing the standard categories already reported to the state

The provisions of S.B. 476 requiring the Office of Health Strategy to publish an annual summary and analysis of community benefits program reporting and related ***annual public comment period*** create transparency and an important opportunity for communities and stakeholders to provide input and hold hospitals and Office of Health Strategy accountable. HES suggests an ***annual public hearing*** also be held to create a sustained feedback loop among hospitals, the Office of Health Strategy, and state residents.

Connecticut Deserves a Strong Community Benefit Law

2022 marks the third consecutive session that a version of this proposal has been raised and, while we recognize the constraints of a short session, ***HES urges swift passage of a strengthened version of S.B. 476***. S.B. 476 takes important steps, but it would be a missed opportunity to not also adopt the recommendations included here and increase the potential for these programs to promote health equity in our state. Stronger community benefit standards increase transparency, allowing residents of our state to hold hospitals and the Office of Health Strategy accountable for promoting health equity and listening to their needs. **Community benefit statutes have enormous potential to address disparities in medical debt, foster collaboration between communities and hospitals, and create a more transparent, equitable, and innovative health system.**

Thank you for the opportunity to testify in support of S.B. 476. Please reach out with any questions to Karen Siegel and Dashni Sathasivam at ksiegel@hesct.org, dashni@hesct.org, or 860.937.6437.

---

[1] Rubin, D. B., Singh, S. R., & Young, G. J. (2015). Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice. *Annual Review of Public Health*, *36*(1), 545–557. https://doi.org/10.1146/annurev-publhealth-031914-122357

[2] Perry M, Crear-Perry J., Romer C., & Adjeiwaa-Manu N. (2021) The Racial Implications of Medical Debt: How Moving Towards Universal Health Care and Other Reforms can Address Them. Retrieved from: https://www.brookings.edu/research/the-racial-implications-of-medical-debt-how-moving-toward-universal-health-care-and-other-reforms-can-address-them/

[3] Examples of statutes include: : OR, CA, ID, MA, WA, RI, IL, NV, PA, TX, UT, MD, ME, WA, and VT

[4] Inniss, B., & Tan, B., et al., (June 2016). Hospital Community Benefits after the ACA Trends in State Community Benefit Legislation, November 2015-May 2016. The Hilltop Institute. https://hilltopinstitute.org/our-work/hospital-community-benefit/hospital-community-benefit-state-law-profiles/

[5] Johnson, E. K., Hardy, R., Santos, T., Leider, J. P., Lindrooth, R. C., & Tung, G. J. (2019). State Laws and Nonprofit Hospital Community Benefit Spending. *Journal of Public Health Management and Practice*, *25*(4), E9. https://doi.org/10.1097/PHH.0000000000000885

[6] Chaiyachati, K. H., Qi, M., & Werner, R. M. (2020). Nonprofit hospital community benefit spending and readmission rates. Population health management, 23(1), 85-91

[7] Genevieve Kanter et al., Association of State Medicaid Expansion with Hospital Community Benefit Spending, JAMA Network Open (May 29, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766544

[8] Miller, B. (2021). *State of Connecticut Community Benefit Report*. Office of Health Strategy. https://portal.ct.gov/-/media/OHS/SIM/Work-Stream-Updates/Community-Benefit-Report_Connecticut-Hospitals_2020_Final.pdf

[9] FY 2018 tax returns from Connecticut nonprofit hospitals

[10] Connecticut Office of Health Strategy 2021. Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2020. Hartford, CT: Connecticut Office of Health Strategy https://portal.ct.gov/-/media/OHS/HSP/FSReport_2020.pdf

[11] FY 2018 tax returns from Connecticut nonprofit hospitals. HES Analysis based on FY 2019 as a % of total community benefit spending.

[12] For information about the amount of funding received by Connecticut hospitals to offset these costs, see: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Hospital-Reimbursement/Medicaid-Hospital-Reimbursement/DSH-Audits-and-SPAs
For an explanation of these funds, see: https://www.macpac.gov/subtopic/disproportionate-share-hospital-payments/

[13] Catholic Health Association. (2020). Community Benefit Categories and Definitions. https://www.chausa.org/docs/default- source/community-benefit/guide-for-planning-2020/cb_guide-for-planning_2020_categories_and_definitions.pdf?sfvrsn=0

[14] National Center for Healthy Housing. (2014). *Hospital Community Benefits: Opportunities for Healthy Homes* (Brief #2; Healthcare Financing for Healthy Homes). https://nchh.org/resource/technical-brief_hospital-community-benefits_opportunities-for-healthy-homes/

[15] Massachusetts Office of Attorney General. (2018). *The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals*. p. 16). https://www.mass.gov/files/documents/2018/02/07/Updated%20Hospital%20Community%20Benefits%20Guidelines.pdf

[16] Belliard, J. C., & Daly, M. (2019). *Community Benefit Report – 2019 & Implementation Strategy 2019-2020*. Loma Linda University Health. https://lluh.org/sites/lluh.org/files/docs/about-us/LLUH-CB-Report-2019.pdf

[17] *Community Benefit 2021 Report and 2022 Plan*. (2021). St. John's Regional Medical Center and St. John's Hospital Camarillo. https://www.dignityhealth.org/content/dam/dignity-health/documents/cb-reports-2021/St-Johns-Hospitals-CBreport2021-Final.pdf

[18] Johnson, E. K., Hardy, R., Santos, T., Leider, J. P., Lindrooth, R. C., & Tung, G. J. (2019). State Laws and Nonprofit Hospital Community Benefit Spending. *Journal of Public Health Management and Practice*, *25*(4), E9. https://doi.org/10.1097/PHH.0000000000000885

[19] Swift, O., & Colon, R. (2021). Community Benefit Report Spending and Content Analysis. *The Journal of Applied Business and Economics*, *23*(6), 116–133. https://www.proquest.com/docview/2583603434/abstract/C7D0665B95274C63PQ/1

[20] HES calculation using FY 2019 hospital operating expenses retrieved from: Miller, B. (2021). *State of Connecticut Community Benefit Report*. Office

of Health Strategy. https://portal.ct.gov/-/media/OHS/SIM/Work-Stream-Updates/Community-Benefit-Report_Connecticut-Hospitals_2020_Final.pdf
[21] Connecticut Office of Health Strategy 2021. Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2020. Hartford, CT: Connecticut Office of Health Strategy https://portal.ct.gov/-/media/OHS/HSP/FSReport_2020.pdf
[22] Carroll-Scott, Amy, Rosie Mae Henson, Jennifer Kolker, and Jonathan Purtle. 2017. "The Role Of Nonprofit Hospitals In Identifying And Addressing Health Inequities In Cities." *Health Affairs* 36(6):1102–9. doi: 10.1377/hlthaff.2017.0033.
[23] Ainsworth D, Diaz H, Schmidtlein MC. Getting more for your money: designing community needs assessments to build collaboration and capacity in hospital system community benefit work. Health Promotion Practice. 2013;14(6):868–75.
[24] Mathews AL, Coyle BS, Deegan MM. Building community while complying with the Affordable Care Act in the Lehigh Valley of Pennsylvania. Prog Community Health Partnership. 2015;9(1):101–12.
[25] Cain CL, Orionzi D, O'Brien M, Trahan L. The power of community voices for enhancing community health needs assessments. Health Promotion Practice. 2016;18(3):437–43.
[26] Brinkerhoff, D. W. (2004). Accountability and health systems: Toward conceptual clarity and policy relevance. Health Policy and Planning, 19(6), 371–379. https://doi.org/10.1093/heapol/czh052
[27] Rothbart, M. W., & Yoon, N. (2021). Do Minimum Charity Care Provision Requirements Increase Nonprofit Hospital Performance? Examining Hospitals' Responses to Regulatory Changes. *Journal of Public Administration Research and Theory*, *muab025*. https://doi.org/10.1093/jopart/muab025
[28] Rozier MD (2020) Nonprofit Hospital Community Benefit in the U.S.: A Scoping Review From 2010 to 2019. Front. Public Health 8:72. doi: 10.3389/fpubh.2020.00072
[29] Internal Revenue Service. 2021. "Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3)." Retrieved March 11, 2022. https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3
[30] Beatty K, Wilson K, Cleclor A, Stringer L. (2015) Collaboration among Missouri nonprofit hospitals and local health departments: content analysis of community health needs assessments. Am J Public Health. 105: S337– 44. doi: 10.2105/AJPH.2014.302488
[31] Becker KL. (2015) Conducting community health needs assessments in rural communities: lessons learned. Health Promotion Practice. 16:15–9. doi: 10.1177/1524839914555887
[32] Carlton EL, Singh SR. (2018) Joint community health needs assessments as a path for coordinating community-wide health improvement efforts between hospitals and local health departments. Am J Public Health. 108:676–82. doi: 10.2105/AJPH.2018.304339
[33] Franz B, Skinner D, Kelleher K. The impact of the affordable care act on hospital-led community health evaluation in the U.S. Appalachian Ohio region. J Eval Clin Pract. (2017) 23:882–7. doi: 10.1111/jep.12749
[34] Kuehnert P, Graber J, Stone D. Using a Web-based tool to evaluate a collaborative community health needs assessment. J Public Health Manag Pract. (2014) 20:175–87. doi: 10.1097/PHH.0b013e31829dc1e5
[35] Kuehnert P, Graber J, Stone D. Using a Web-based tool to evaluate a collaborative community health needs assessment. J Public Health Manag Pract. (2014) 20:175–87. doi: 10.1097/PHH.0b013e31829dc1e5
[36] Curtis, J., & Lang, H. (2018). *Building Local Capacity To Engage Hospitals Through Community Benefit: Lessons And Learnings From Three Communities*. Community Catalyst. https://www.communitycatalyst.org/resources/publications/document/CC-Community-Benefit-Report-FINAL.pdf
[37] Miller, B. (2021). *State of Connecticut Community Benefit Report*. Office of Health Strategy. https://portal.ct.gov/-/media/OHS/SIM/Work-Stream-Updates/Community-Benefit-Report_Connecticut-Hospitals_2020_Final.pdf
[38] Rau, J. (2019, October 14). Patients Eligible For Charity Care Instead Get Big Bills. *Kaiser Health News*. https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills/
[39] Annual nonprofit hospital reports filed to Internal Revenue Service, retrieved on May 7, 2019. The bad-debt figures are actual amounts, and the portion involving patients potentially eligible for charity care are estimates the IRS requires hospitals to calculate.
[40] Tozzi, J. (2021, November 22). Medical Debt Is Crushing Black Americans, and Hospitals Aren't Helping. Bloomberg.Com. https://www.bloomberg.com/news/features/2021-11-22/medical-debt-collection-tactics-disproportionately-hit-black-americans
[41] Neil Bennett, Jonathan Eggleston, Laryssa Mykyta, & Briana Sullivan. (2021, April 7). 19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away. (Figure 3.) *America Counts, US Census Bureau*. https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html
[42] Cooper, Z., Craig, S., Gaynor, M., Harish, N. J., Krumholz, H. M., & Van Reenen, J. (2019). Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14. Health Affairs, 38(2), 184–189. https://doi.org/10.1377/hlthaff.2018.05424
[43] Villagra, V. et al., (2019). *When Hospitals and Doctors Sue Their Patients: The Medical Debt Crisis Through a New Lens*. UConn Health Disparities Institute. https://health.uconn.edu/health-disparities/wp-content/uploads/sites/260/2019/06/HDI-Issue-Brief_When-Hospitals-and-Doctors-Sue-Their-Patients.pdf
[44] Villagra, V. G., Bhuva, B., Coman, E., Smith, D. O., & Fifield, J. (2019). Health insurance literacy: Disparities by race, ethnicity, and language preference. The American Journal of Managed Care, 25(3), e71–e75. http://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_03_2019_Villagra%20final.pdf
[45] Community Catalyst & National Consumer Law Center. (2021). *Medical Debt Survey Results*. https://www.communitycatalyst.org/initiatives-and-issues/initiatives/community-benefit-economic-stability-project/NCLC-CC-Med-Debt-Survey-01.21-1.pdf
[46] Community Catalsyt. (2015). *Principles for Improving Community Economic Stability through Hospital Billing Policies*.
[47] Putterman, A. (2020, April 8). Black and Latino residents hit particularly hard by COVID-19 in Connecticut, as experts fear disparities will widen. Hartford Courant. https://www.courant.com/coronavirus/hc-news-coronavirus-covid-19-racial- disparities-0407-20200408-jsrg2au2fnab5fbxhpu4ioqmb4-story.html
[48] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID -19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1166–1169.DOI: http://dx.doi.org/10.15585/mmwr.mm6934e1external icon
[49] Spending floors exist in: IL, NV, PA, TX, UT, and OR.
[50]Office of Health Analytics, O. H. A. (2021). *Community Benefit Minimum Spending Floor Methodology Announcement for Hospital Fiscal Years 2022 and 2023*. https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/FY22-23-Spending-Floor-Announcement.pdf
[51] Geri Cramer et al., The Progress of U.S. Hospitals in Addressing Community Health Needs, 107 AM. J. PUB. HEALTH 2 (2017), 255- 261. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2016.303570?casa_token=7IzQGK-9Se0AAAAA%3AbytPxS46sn2QutNHJ9K5-

75VSDHcLLlxVFpYr6ioGq-wueuPr0Q2JWLZRhPpDfXefbMLv5KR5xY

[52] Miller, B. (2021). *State of Connecticut Community Benefit Report*. Office of Health Strategy. (Table 4, FY 2019) https://portal.ct.gov/-/media/OHS/SIM/Work-Stream-Updates/Community-Benefit-Report_Connecticut-Hospitals_2020_Final.pdf

[53] "Modifying Hospital Community Benefit Tax Policy: Easing Regulation, Advancing Population Health", Health Affairs Blog, December 1, 2016. DOI: 10.1377/hblog20161201.057691

[54] Carroll-Scott, A., Henson, R. M., Kolker, J., & Purtle, J. (2017). The Role Of Nonprofit Hospitals In Identifying And Addressing Health Inequities In Cities. Health Affairs, 36(6), 1102–1109. https://doi.org/10.1377/hlthaff.2017.0033

[55] Rozier MD (2020) Nonprofit Hospital Community Benefit in the U.S.: A Scoping Review From 2010 to 2019. Front. Public Health 8:72. doi: 10.3389/fpubh.2020.00072

[56] Rubin, D. B., Singh, S. R., & Jacobson, P. D. (2013). Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption. *American Journal of Public Health*, *103*(4), 612–616. https://doi.org/10.2105/AJPH.2012.301048

[57] Carroll-Scott, A., Henson, R.M, Kolker, J. & Purtle, J.. (2017) "The Role Of Nonprofit Hospitals In Identifying And Addressing Health Inequities In Cities." *Health Affairs* 36(6):1102–9. doi: 10.1377/hlthaff.2017.0033.

[58] Community Catalyst. (2015). *Principles for Improving Community Economic Stability through Hospital Billing Policies*. https://www.communitycatalyst.org/resources/publications/document/Principles-for-Improving-Financial-Assistance-0615-FINAL.pdf

[59] "The 125 Percent Solution: Fixing Variations In Health Care Prices", Health Affairs Blog, August 26, 2014. DOI: 10.1377/hblog20140826.041002