

YALE JOURNAL OF HEALTH POLICY, LAW, AND ETHICS

VOLUME XVI

Winter 2016

EXECUTIVE EDITORIAL BOARD

Editors-in-Chief

Nathan Nash

Kimberly Wachtler

Executive Editors

Elizabeth Dervan

Cynthia Tsay

Managing Editors

Maxwell Farina

Divya Srinivasan

Kara Stencel

Research Editor

Jeffrey Chen

SENIOR EDITORIAL BOARD

Articles Editors

Micha Sam Brickman Raredon

Cory Gordon

Nicholas Chedid

Submissions Editors

Julia Eichenfield

Asu Erden

Joya Sonnenfeldt, *Notes*

YALE JOURNAL OF HEALTH POLICY, LAW, AND ETHICS

VOLUME XVI**Winter 2016**

STAFF EDITORS

Susan Choy
Valerie Comenencia Ortiz
Casey Covarrubias
Eamon Duffy
Kelly Flanagan
Lyndsay Gavin
Jurema Gobena
Shoshanna Goldin
Diana Gonzalez
Nathan Guevremont
Dumingu Aparna Gomes
Yunsoo Kim
Theodore Lee
Scott Levy
Esther Lim
Claudia Lu

Maya Mahin
Roxana Mir
Lin Mu
Sara Nelson
Talya Presser
Rachel Reeves
Wenhao Sha
Faren Tang
Sophia Tonnu
Reetika Tripathi
Erin van Wesenbeeck
Medha Vyavhare
Michael Weaver
Tian Zhou
Constance Zou

ADVISORY BOARD

- Henry J. Aaron, Ph.D., *Senior Fellow, Brookings Institution*
- Lori B. Andrews, J.D., *Distinguished Professor of Law and Director of the Institute for Science, Law and Technology, Chicago-Kent College of Law*
- George J. Annas, J.D., M.P.H., *Professor, Boston University Schools of Law, Medicine, and Public Health*
- M. Gregg Bloche, M.D., J.D., *Professor of Law, Georgetown University, and Co-Director, Georgetown-Johns Hopkins Joint Program in Law & Public Health*
- Troyen A. Brennan, M.A., M.D., J.D., M.P.H., *Executive Vice President and Chief Medical Officer, CVS Caremark*
- Scott Burris, J.D., *Professor, Temple University School of Law*
- James F. Childress, Ph.D., *Professor, University of Virginia*
- Paul D. Cleary, Ph.D., *Dean and C.E.A. Winslow Professor of Epidemiology and Public Health, Yale University School of Public Health*
- Ruth R. Faden, Ph.D., M.P.H., *Philip Franklin Wagley Professor of Biomedical Ethics and Director, The Phoebe R. Berman Bioethics Institute, Johns Hopkins University*
- Lawrence O. Gostin, J.D., L.L.D., *Professor and Director, Center for Law and the Public's Health, Georgetown and Johns Hopkins Universities*
- Christine Grady, R.N., Ph.D., *Head, Section of Human Subjects Research, Department of Clinical Bioethics, National Institutes of Health*
- Dean M. Hashimoto, M.D., J.D., M.P.H., *Associate Professor of Law, Boston College, and Chief of Occupational and Environmental Medicine, Massachusetts General Hospital and the Brigham and Women's Hospital*
- Timothy S. Jost, J.D., *Robert L. Willett Family Professor of Law, Washington and Lee University School of Law*
- Ruth Katz, J.D., M.P.H., *Director, Health, Medicine and Society, Aspen Institute*
- David Kessler, M.D., J.D., *Dean, University of California, San Francisco School of Medicine, and Former Commissioner of the U.S. Food and Drug Administration*
- Alvin K. Klevorick, Ph.D., *John Thomas Smith Professor of Law and Deputy Dean of Yale Law School, Professor, Yale University Department of Economics*
- Stephen R. Latham, J.D., Ph.D., *Deputy Director, Yale's Interdisciplinary Center on Bioethics*
- Jerold R. Mande, M.P.H., *Director of Policy Programs, Yale University School of Medicine*
- Theodore R. Marmor, Ph.D., *Professor, Yale University School of Management and Yale Law School*
- Leslie Meltzer, J.D., M.Sc., *Greenwall Fellow in Bioethics and Health Policy, Georgetown University Law Center and the Johns Hopkins Bloomberg School of Public Health*
- Theodore W. Ruger, J.D., *Bernard G. Segal Professor of Law and Dean, University of Pennsylvania Law School*
- Elyn R. Saks, M.Litt., J.D., *Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences, University of Southern California Gould School of Law*

TABLE OF CONTENTS

ARTICLES

- 1 The Fitbit Fault Line: Two Proposals to Protect Health and Fitness
Data at Work**
Elizabeth A. Brown
- 51 Health and Taxes: Hospitals, Community Health and the IRS**
Mary Crossley

NOTE

- 111 The Antidotes to the Double Standard: Protecting the Healthcare
Rights of Mentally Ill Inmates by Blurring the Line Between *Estelle*
and *Youngberg***
Rose Carmen Goldberg

The Fitbit Fault Line: Two Proposals to Protect Health and Fitness Data at Work

Elizabeth A. Brown*

Abstract:

Employers are collecting and using their employees' health data, mined from wearable fitness devices and health apps, in new, profitable, and barely regulated ways. The importance of protecting employee health and fitness data will grow exponentially in the future. This is the moment for a robust discussion of how law can better protect employees from the potential misuse of their health data.

While scholars have just begun to examine the problem of health data privacy, this Article contributes to the academic literature in three important ways. First, it analyzes the convergence of three trends resulting in an unprecedented growth of health-related data: the Internet of Things, the Quantified Self movement, and the Rise of Health Platforms. Second, it describes the insufficiencies of specific data privacy laws and federal agency actions in the context of protecting employee health data from employer misuse. Finally, it provides two detailed and workable solutions for remedying the current lack of protection of employee health data that will realign employer use with reasonable expectations of health and fitness privacy.

The Article proceeds in four Parts. Part I describes the growth of self-monitoring apps, devices, and other sensor-enabled technology that can monitor a wide range of data related to an employee's health and fitness and the relationship of this growth to both the Quantified Self movement and the Internet of Things. Part II explains the increasing use of employee monitoring through a wide range of sensors, including wearable devices, and the potential uses of that health and fitness data. Part III explores the various regulations and agency actions that might protect employees from the potential misuse of their health and fitness data and the shortcomings of each. Part IV proposes two specific measures that would help ameliorate the ineffective legal protections that currently exist in this context. In order to improve employee notice of and control over the disclosure of their health data, I recommend the adoption of a mandatory privacy labeling law for health-related devices and apps to be enacted and enforced by the Federal Trade Commission (FTC). As a complementary measure,

* Assistant Professor of Business Law, Bentley University. The author wishes to thank Sharon Patton for her invaluable assistance with this Article.

I also recommend that be amended so that its protections extend to the health-related data that employers may acquire about their employees. The Article concludes with suggestions for additional scholarly discussion.

TABLE OF CONTENTS

TABLE OF CONTENTS.....	3
INTRODUCTION	5
I. EMPLOYEES GENERATE HEALTH AND FITNESS DATA THROUGH INCREASINGLY UBIQUITOUS SENSORS.....	7
A. HEALTH AND FITNESS DATA COLLECTION IS ON THE UPSWING.....	9
1. THE INTERNET OF THINGS	10
2. THE QUANTIFIED SELF MOVEMENT	10
3. THE EMERGENCE OF HEALTH DATA PLATFORMS	11
II. EMPLOYERS HAVE UNPRECEDENTED ACCESS TO EMPLOYEES’ HEALTH AND FITNESS DATA	13
A. NEW TECHNOLOGY FACILITATES EMPLOYEE HEALTH DATA COLLECTION	14
B. PROVIDERS AND PLATFORMS HELP AGGREGATE EMPLOYEE HEALTH DATA	16
C. USING EMPLOYEE HEALTH DATA TO INFORM EMPLOYMENT DECISIONS CREATES POTENTIAL LEGAL AND ETHICAL HAZARDS	19
III. FEDERAL LAW DOES TOO LITTLE TO PROTECT EMPLOYEE HEALTH DATA	21
A. EMPLOYEES MAY HAVE NO REASONABLE EXPECTATION OF PRIVACY IN SENSOR-GENERATED HEALTH DATA	22
B. FEDERAL REGULATION OF HEALTH AND FITNESS DATA COLLECTION IS FRAGMENTED AND INSUFFICIENT	24
1. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	24
2. THE AMERICANS WITH DISABILITIES ACT AMENDMENTS ACT	27
3. THE ELECTRONIC COMMUNICATIONS PRIVACY ACT	29
4. THE COMPUTER FRAUD AND ABUSE ACT	30
C. THERE IS NO EFFECTIVE FEDERAL AGENCY OVERSIGHT OF EMPLOYEE HEALTH AND FITNESS DATA COLLECTION	31
1. FOOD AND DRUG ADMINISTRATION REGULATION.....	32
2. FEDERAL TRADE COMMISSION REGULATION.....	33

D. DEVICE MAKERS AND APP DEVELOPERS PROVIDE TOO LITTLE INFORMATION TO PROTECT EMPLOYEES FROM DATA MISUSE.....	34
IV. TWO PROPOSALS WOULD RESTRICT EMPLOYERS’ MISUSE OF HEALTH DATA	36
A. THE FTC SHOULD REQUIRE STANDARDIZED, SUCCINCT PRIVACY LABELS ON HEALTH AND FITNESS APPS AND DEVICES	37
1. CURRENT WEBSITE PRIVACY POLICY REQUIREMENTS SUFFER FROM THREE CRITICAL DEFICIENCIES.....	37
2. INDUSTRY SELF-REGULATION OF PRIVACY POLICIES HAS FAILED, MAKING LEGISLATIVE INTERVENTION NECESSARY	39
3. THE BENEFITS OF MANDATORY PRIVACY LABELS WILL OUTWEIGH THE COSTS	42
B. EXTEND HIPAA’S DEFINITION OF COVERED ENTITIES TO INCLUDE EMPLOYERS, APP DEVELOPERS AND WEARABLE DEVICE MANUFACTURERS	46
C. SECURING EMPLOYEE HEALTH DATA REQUIRES ADDITIONAL STUDY AND DISCUSSION	47
CONCLUSION	48

INTRODUCTION

Imagine coming to work one day and finding that your employer has given everyone in the company a wearable Fitbit health monitor, free of charge. You pop the Fitbit on, grateful for another bit of help in managing the health concerns that nag at you persistently but which never quite rise to the top of your priority list. At your next performance review, your supervisor expresses concern about your anxiety levels. Although your work output is slightly off, she notes, there has been a correlation in your lack of sleep and exercise, and she suspects you are depressed. You wonder how your employer might know these things, whether or not they are true, and then you remember the Fitbit. Your supervisor then tells you that the promotion you had wanted is going to a colleague who is “better equipped to handle the demands of the job.” You interview for another job and are asked to provide access to the Apple Health account that centralizes the fitness data your iPhone apps collect.

Similar scenarios are likely to play out now and more frequently in the future as the personal health sensor market and employee monitoring trends continue to grow. Employers make key decisions based on employees’ biometric data, collected from specialized devices like a Fitbit or the health-related apps installed on mobile phones. BP, for example, adjusts its employees’ health care premiums depending on how much physical activity their wearable Fitbit devices monitor—devices that BP provides to thousands of employees, their spouses, and retirees for free.¹ These programs are not always optional. Employers are already starting to require their workers to submit health metrics or pay a fine. For example, CVS Pharmacy demands that every one of the 200,000 employees who use its health plan provide certain information about their weight, glucose levels, and body fat.² Although CVS calls its plan “voluntary,” covered workers who refuse to provide this information must pay a fine of \$50 per month.

Gathering employee data from health monitoring devices and apps provides a substantial benefit to employers and poses substantial risks to employees. The benefits include a relatively user-friendly means of improving health and, correspondingly, reducing workplace losses due to illness and absence. Incidence of obesity, adult-onset diabetes, and many other serious health conditions that have a behavioral component are a serious issue in the United States. Health

1 Parmy Olson & Aaron Tilley, *The Quantified Other: Nest and Fitbit Chase a Lucrative Side Business*, FORBES (Apr. 17, 2014, 4:30 AM), <http://www.forbes.com/sites/parmyolson/2014/04/17/the-quantified-other-nest-and-Fitbit-chase-a-lucrative-side-business>.

2 Steve Osunsami, *CVS Pharmacy Wants Workers’ Health Information, or They’ll Pay a Fine*, ABC NEWS (Mar. 20, 2013), <http://abcnews.go.com/blogs/health/2013/03/20/cvs-pharmacy-wants-workers-health-information-or-theyll-pay-a-fine>.

monitoring devices and apps claim great success in improving weight, BMI, and heart rate.

The risks to employees, however, include the potential for adverse employment decisions, discrimination, and invasions of privacy rights that no federal law currently prohibits. The increasing coalescence of fitness-related data from apps and devices makes it increasingly likely that employers will monitor and act on employee's health data. Each data point is valuable in itself, and even more so in combination. Greater access to both heart rate data and sleep patterns, for example, might give an employer more insight into an employee's overall health than either input alone. Legal scholars have started to ask whether such monitoring is sufficiently limited by existing laws.³ What limits employers from getting and using these data for various potentially undesirable (if not illegal) purposes?

In this Article, I argue that federal law does not do enough to protect employees' health and fitness data from potential misuse, while employers have every incentive to use these data in hiring, promotion, and related decisions and that two specific remedies would do much to curtail the improper use of employee health and fitness data.

This Article proceeds in four Parts. Part I describes the growth of self-monitoring apps, devices, and other sensor-enabled technology that can monitor a wide range of data related to an employee's health and fitness and the relationship of this growth to both the Quantified Self movement and the Internet of Things.⁴ Part II explains the increasing use of employee monitoring through a wide range of sensors, including wearable devices, and the potential uses of that health and fitness data. Part III explores the regulations and agency actions that might protect employees from the potential misuse of their health and fitness data and the shortcomings of each. Part IV proposes two specific measures that would help ameliorate the ineffective legal protections that currently exist. In order to improve employee notice of and control over the disclosure of their health data, I

3 See, e.g., Dennis D. Hirsch, *That's Unfair! Or Is It? Big Data, Discrimination and the FTC's Unfairness Authority*, 103 KY. L.J. 345, 345 (2015); Scott R. Peppet, *Regulating the Internet of Things: First Steps Towards Managing Discrimination, Privacy, Security and Consent*, 93 TEX. L. REV. 85, 93-95 (2014); Adam D. Thierer, *The Internet of Things and Wearable Technology: Addressing Privacy and Security Concerns Without Derailing Innovation*, 21 RICH. J.L. & TECH 6, 7 (2015); N. Nina Zivanovic, *Medical Information as a Hot Commodity: The Need for Stronger Protection of Patient Health Information*, 19 INTELL. PROP. L. BULL. 183, 185 (2015); see also Lauren Henry, *Information Privacy and Data Security*, 2015 CARDOZO L. REV. DE NOVO 107, 109 (discussing the complex relationship between the goals of data security and information privacy).

4 The technology described in Part I and throughout the Article can be used by any consumer, but I use the term "employee" because the focus of this Article is on the impact of such technological advances in the employment context.

recommend the adoption of a mandatory privacy labeling law for health-related devices and apps to be enacted and enforced by the Federal Trade Commission (FTC). As a complementary measure, I also recommend that Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁵ be amended so that its protections extend to the health-related data that employers may acquire about their employees. The Article concludes with suggestions for additional scholarly discussion.

I. EMPLOYEES GENERATE HEALTH AND FITNESS DATA THROUGH INCREASINGLY UBIQUITOUS SENSORS

The wearable health technology market is growing fast. Every January, technology cognoscenti descend on Las Vegas for the International Consumer Electronics Show (CES), one of the largest electronics shows in the world with over two million square feet of exhibition space.⁶ In 2014, the Wearable and Fitness sections took up a few hundred square feet of space at CES. In 2015, the Wearable and Fitness categories together took up almost half of the cavernous exhibition hall.⁷

The mobile health market includes a range of consumer devices equipped with sensors and software-based apps that help monitor and collect health-related data. That market is expected to grow eight-fold in less than ten years, from \$5.1 billion in 2013 to \$41.8 billion in 2023.⁸ The number of wearable fitness devices sold annually is expected nearly to triple between 2014 and 2018.⁹

One of the most popular examples is the Fitbit. Fitbit makes several versions of a wearable device that “tracks every part of your day—including activity, exercise, food, weight and sleep,” according to its website.¹⁰ Its flagship device is a sensor worn on the wrist, like a watch, that records the user’s heart rate and movement, among other data. Other Fitbit devices can be clipped to a user’s clothes or shoes and perform similar functions. Specifically, Fitbit devices record

5 The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

6 *CES by the Numbers*, CONSUMER TECH. ASS’N, <http://www.cesweb.org/Why-CES-/CES-By-the-Numbers.aspx> (last visited Dec. 1, 2015).

7 Daniel Cooper, *2015 Is the Year that Wearables Begin To Grow up*, ENGADGET (Jan. 10, 2015, 1:13 AM), <http://www.engadget.com/2015/01/10/2015-ces-wearables-wrap-up/>.

8 Carole Jacques, *Mobile Health Devices Market To Grow 8-Fold to \$41.8 Billion in 2023*, LUX RES. (July 1, 2014), <http://www.luxresearchinc.com/news-and-events/press-releases/read/mobile-health-devices-market-grow-8-fold-418-billion-2023>.

9 Fred Pennic, *Fitness Devices To Dominate the Wearables Market Until 2018*, HIT CONSULTANT (Nov. 25, 2014), <http://hitconsultant.net/2014/11/25/fitness-devices-to-dominate-the-wearables-market-until-2018>.

10 *Why Fitbit*, FITBIT, <https://www.Fitbit.com/whyFitbit> (last visited Dec. 1, 2015).

“sleep tracking,” “auto sleep detection,” continuous heart rate, floors climbed, and “active minutes,” although the specific combination of surveillance features depends on the model.¹¹ Some models also track the user’s GPS location.¹² The device works in conjunction with an app that displays these data and which can be accessed from a smartphone or a computer. The data display, or “dashboard,” allows the user to track their own activity, set goals, and earn “badges” for meeting specific activity goals.¹³ Fitbit dashboard users may monitor their calorie intake by using their smartphones to scan nutrition labels.¹⁴ The dashboard also syncs with the Aria, Fitbit’s “wi-fi smart scale,” for more comprehensive weight management.¹⁵ Fitbits are available in a range of models, each with different features and recommended retail prices.¹⁶

Fitbit makes just a few of the thousands of health-monitoring devices, which often work in conjunction with mobile phone apps like the Fitbit dashboard, that record personal health data. These devices are so popular that one in ten Americans over the age of eighteen now owns an activity tracker.¹⁷

Wearables can measure many other kinds of data that employers might consider relevant in management, such as wellbeing and mood. Zensorium’s Being, introduced at CES in 2015, is a watch-like device that indicates whether the wearer’s mood is Distress, Excited, Normal, or Calm.¹⁸ It is easy to imagine a supervisor’s interest in monitoring employees’ moods remotely, especially when those employees are engaged in heavily interpersonal roles like sales or customer service.¹⁹ Other wearable technology promises to influence mood directly. Thync, a company founded by neurobiology, neuroscience and consumer electronics experts from Harvard, MIT, and Stanford, developed a sensor that attaches to the temple and changes the wearer’s mental state either to energized

11 *Find Your Fit*, FITBIT, <https://www.Fitbit.com/compare> (last visited Dec. 1, 2015).

12 *Id.*

13 *Meet the App That’s All in One, for Everyone*, FITBIT, <https://www.Fitbit.com/app> (last visited Dec. 1, 2015). The dashboard can also be used without a sensor.

14 *Id.*

15 *Aria*, FITBIT, <https://www.Fitbit.com/aria> (last visited Dec. 1, 2015).

16 *Tory Burch for Fitbit*, FITBIT, <https://www.Fitbit.com/toryburch>, (last visited Dec. 1, 2015).

17 Dan Ledger & Daniel McCaffrey, *Inside Wearables: How the Science of Human Behavior Change Offers the Secret to Long-Term Engagement*, ENDEAVOUR PARTNERS 2 (2014), <http://endeavourpartners.net/assets/Wearables-and-the-Science-of-Human-Behavior-Change-EP4.pdf>. For an overview of the various types of consumer sensor devices, see Peppet, *supra* note 3, at 98-116.

18 Nicole Lee, *Zensorium’s ‘Being’ Is a Fitness Wearable that Promises To Track Your Mood as Well*, ENGADGET (Jan. 4, 2015, 9:40 PM), <http://www.engadget.com/2015/01/04/zensorium-being>.

19 For a discussion on employer use of health-related sensor data, see *infra* Section I.A.

or calm.²⁰

Apps that help measure aspects of health and fitness are growing exponentially as well. According to Google, the “health and fitness” category was the fastest growing app industry segment in 2014.²¹ Industry analysts estimate that there are now one hundred thousand mobile health apps available for Android and iOS, twice as many as there were in 2012.²² The global health and fitness mobile app market, now worth about \$4 billion, is expected to multiply six times to \$26 billion by 2017.²³ The Food and Drug Administration (FDA) estimates that 500 million smartphone users now use or will soon use at least one health care app.²⁴

As described above, there has been a tremendous rise in health and fitness data collection, and new technologies are being developed and brought to market frequently. These technologies present a number of shared legal issues and privacy concerns, but there are also distinct legal issues attending each kind of technology. This Article will focus its discussion on wearable health monitoring sensors, such as those located in devices like the Fitbit as well as those embedded in smart phones and their accompanying mobile apps. These personal health monitors pose a number of privacy concerns. In addition to these more general concerns, the use of fitness tracking devices in the employment setting gives rise to a distinct set of issues and questions. This Article will focus on these special harms that may exist when monitors are used by employers, distinct from the privacy issues that surround the monitors more generally.

A. Health and Fitness Data Collection is on the Upswing

Never have employers had so much new and valuable data about their workforce released to them within such a short time. When employees use wearable sensors to record health and fitness data, employers can often buy and analyze these data for a range of purposes, as described in more detail below. The rapidly increasing collection of health-related data from wearable devices and apps sits at the convergence of three trends: (1) the Internet of Things, (2) the

20 Kevin Bullis, *Device Changes Your Mood with a Zap to the Head*, TECH. REV. (Nov. 10, 2014), <http://www.technologyreview.com/news/532321/device-changes-your-mood-with-a-zap-to-the-head>; *Forward Thinking in Every Sense*, THYNC, <http://www.thync.com/about> (last visited Dec. 1, 2015).

21 Andy Boxhall, *2014 Is the Year of Health and Fitness Apps, Says Google*, DIGITAL TRENDS (Dec. 11, 2014), <http://www.digitaltrends.com/mobile/google-play-store-2014-most-downloaded-apps>.

22 *Id.*

23 *Id.*

24 *Mobile Medical Applications*, FOOD & DRUG ADMIN. (June 4, 2014), <http://www.fda.gov/Medicaldevices/digitalhealth/mobilemedicalapplications/default.htm#a>.

Quantified Self Movement and (3) the rise of the health data platform.

1. The Internet of Things

The Internet of Things (IoT) is the shorthand term given to the increasing interconnectivity of common objects.²⁵ Examples include refrigerators that detect when you are low on milk and populate grocery lists which pop up on your cell phone and beds that self-adjust to cool you down or heat you up, as needed, and remotely start your coffee maker within a certain time after you get up. By the end of 2015, some experts estimate that there will be twenty-five billion connected devices and that that number will double by 2020.²⁶ Three and a half billion sensors are in use now, and some predict that there will be trillions of sensors within ten years.²⁷

There is a gap, however, between the institutional embrace of the Internet of Things and public comfort levels. In a January 2015 survey by a Nielsen company, fifty-three percent of respondents said they were concerned that their data might be shared without their knowledge or approval—almost as many worried about the risk of security breaches. Of the 4000 survey respondents, fifty-one percent said they were concerned that their data could be hacked by other users.²⁸ Whether their personal data are shared intentionally or unintentionally, these numbers suggest that just over half of consumers are concerned about the loss of privacy that more interconnectedness may bring.

2. The Quantified Self Movement

The Quantified Self Movement refers to the increasing popular demand for devices that monitor and measure an enormous range of physical data about oneself, including heart rate, weight, blood sugar, sleep patterns, and diet.²⁹ Monitoring technology takes an increasingly wide range of forms, including shirts embedded with sensors as well as sensors that can be implanted on and under the skin.³⁰

25 Janna Anderson & Lee Rainie, *The Internet of Things Will Thrive by 2025* (May 14, 2014), www.pewinternet.org/2014/05/14/internet-of-things.

26 *Id.*

27 *TSensors Summit for Trillion Sensor Roadmap*, TSENSORS SUMMIT (2013), <http://tsensorssummit.org/Resources/Why%20TSensors%20Roadmap.pdf>.

28 Kim Gaskins, *What's Holding Back the Internet of Things?*, VENTURE BEAT (Jan. 18, 2015, 6:58 AM), <http://venturebeat.com/2015/01/18/whats-holding-back-the-internet-of-things>.

29 See, e.g., Dawn Nafus & Jamie Sherman, *This One Does Not Go Up to 11: The Quantified Self Movement as an Alternative Big Data Practice*, 8 INT'L J. COMM., 1784, 1788 (2014).

30 See, e.g., Daniel Cooper, *Hexoskin's Smart Shirt Feels Nice, but Can't Tell a Step*

As sensors migrate internally, it may also become harder to turn these sensors off or remove them, making it more difficult for employees to control the flow of health-related data to the outside world. Because these kinds of devices are harder to alter, they are potentially more valuable to employers, less susceptible to employee error, and more likely to raise serious privacy concerns.

3. *The Emergence of Health Data Platforms*

A third relevant trend is the centralization of fitness data collected from disparate sources through dedicated software platforms. The world's largest electronics manufacturers expect interest in health and fitness monitoring to continue its explosive growth and are making it easier for users to monitor themselves. Apple's Health app allows users to see all of their health and fitness data at a glance. As one observer put it, "you could use devices and apps from different companies—say a Nike FuelBand, a Withings Blood Pressure Monitor, and an iHealth Wireless Smart Gluco-Monitoring System—and have information from all of them gathered in the Apple Health app, which serves as a dashboard for your health and fitness data."³¹ Apple's competitor Samsung is also investing heavily in the symbiosis of disparate health and fitness monitors. In 2014, it announced the development of Samsung Architecture for Multimodal Interactions (SAMI), which centralizes data from various health-related apps and devices and makes it accessible to others, perhaps including employer-sponsored collectors.³²

Apple and Samsung have also introduced devices that complement the health data collection features of this software. Apple's iPhone 6 and iPhone 6 Plus feature an M8 motion co-processor chip that improves the phones' function

from a Curl, ENGADGET (Dec. 2, 2014, 12:00 PM), <http://www.engadget.com/2014/12/02/hexoskin-hands-on>; see also Daniel Cooper, *Your Next Smart Shirt will Make You Look Like an Extra from 'Tron'*, ENGADGET (Jan. 6, 2015, 4:56 PM), <http://www.engadget.com/2015/01/06/cambridge-consultants-xelflex>; Daniel Cooper, *EES Packs Circuits into Temporary Tattoos, Makes Medical Diagnostics Fashionable*, ENGADGET (Aug. 12, 2011, 11:52 PM), <http://www.engadget.com/2011/08/12/ees-packs-circuits-into-temporary-tattoos-makes-medical-diagnos>; Jon Fingas, *Sticky Sensors Will Monitor Your Body's Organs*, ENGADGET (Dec. 30, 2014, 2:18 AM), <http://www.engadget.com/2014/12/30/sticky-organ-sensors>.

³¹ Nicole Lee, *Apple: Putting Doctors, Trainers and Nutritionists in Your Pocket*, ENGADGET (June 3, 2014, 9:17 PM), <http://www.engadget.com/2014/06/03/apple-healthkit-fitness>.

³² See Mark Sullivan, *Samsung Wants 'SAMI' and 'Simband' To Be the Start of a New Biohealth Ecosystem*, VENTURE BEAT (May 28, 2014, 11:37 AM), <http://venturebeat.com/2014/05/28/samsung-announces-simband-biosensor-watch-reference-design>.

as a fitness monitor. The M8 allows the phones to detect what kind of physical activity the user is engaged in (e.g., running, biking, or walking) and estimate the distance traveled and even the altitude thanks to a built-in barometer.³³ Samsung has introduced the Simband, an open-hardware sensor that can collect a wide range of health and fitness data in conjunction with SAMI.³⁴ According to Samsung, “the combination of Simband-designed sensor technology and algorithms and SAMI-based software will take individual understanding of the body to a new level—for the first time giving voice to a deeper understanding of personal health and wellness.”³⁵ In early 2014, Samsung also unveiled the first mobile phone with an integrated heart rate monitor, its Galaxy S5.³⁶ The fact that Samsung and Apple both build fitness sensors into their flagship phones is a powerful indicator that more health data will be collected and potentially used by employers over time. Employers often provide phones to their employees, and Samsung and Apple are the world’s leading mobile phone manufacturers.³⁷

The aggregation of health data on phones is, in its core function, not that different from the aggregation of movement, sleep, and heart rate data on the Fitbit dashboard or a similar mobile app. On both phones and dedicated health wearables, an app can centralize a number of inputs with the goal of providing a more comprehensive overview of ostensibly related data than any single input could provide. On the Fitbit dashboard, these inputs may come from a Fitbit band, a synched Aria scale, or the user’s own typing. Apple and Samsung’s platforms coordinate inputs from a wider range of sources.

33 Ashley Feinberg, *The iPhone 6’s New M8 Chip Makes It a Truly Badass Fitness Tracker*, GIZMODO (Sept. 9, 2014, 1:32 PM), <http://gizmodo.com/the-iphones-new-m8-chip-makes-it-a-truly-badass-fitness-1632519058>.

34 See Nicole Lee, *Samsung Launches A Flexible Platform of Sensors for Wearables*, ENGADGET (May 28, 2014, 2:16 PM), <http://www.engadget.com/2014/05/28/samsung-launches-a-flexible-platform-of-sensors-for-wearables>. Interestingly, SAMI was developed in part by Luc Julia, a former Apple engineer. See Samuel Gibbs, *Samsung’s SAMI Project Is Led by Former Siri Engineer from Apple*, GUARDIAN (Nov. 11, 2013, 10:12 AM), <http://www.theguardian.com/technology/2013/nov/11/samsungs-sami-project-siri-engineer-apple>.

35 Michelle Maisto, *Apple, Samsung Taking Different Roads to Consumer Health Empowerment*, EWEK (June 9, 2014), www.eweek.com/mobile/apple-samsung-taking-different-roads-to-consumer-health-empowerment.html.

36 Michelle Maisto, *Samsung Unveils Galaxy S5, Gear Fit, Galaxy Gear 2, Gear 2 Neo at MWC*, EWEK (Feb. 25, 2014), <http://www.eweek.com/mobile/slideshows/samsung-unveils-galaxy-s5-gear-fit-galaxy-gear-2-gear-2-neo-at-mwc.html>.

37 Press Release, Gartner, Inc., *Gartner Says Smartphone Sales Surpassed One Billion Units in 2014* (Mar. 3, 2015), <http://www.gartner.com/newsroom/id/2996817>.

II. EMPLOYERS HAVE UNPRECEDENTED ACCESS TO EMPLOYEES' HEALTH AND FITNESS DATA

Employers have every incentive to collect as much data as they may, especially when doing so increases profitability. Fitbit invites employers to adopt its “Fitbit Wellness” program to track employees individually and in groups, “potentially reducing health care costs.”³⁸ Many employers encourage the use of wearable monitors as part of their corporate wellness programs, often in the hope that having healthier employees will help them negotiate discounted health care rates.³⁹ Minimizing health insurance costs is only one example of how employee data can improve the bottom line. Using health data to inform hiring and promotion decisions is another. The legality of the use of employee data is an increasingly important question in employment and privacy law.

The explosive growth of wearable device ownership makes it easier than ever for employers to collect health and fitness data about their employees. The people most likely to use those devices are those whom employers are most interested in evaluating. People in their late twenties and early thirties have the highest rates of ownership, with people age twenty-five to thirty-four accounting for twenty-five percent of survey respondents between age twenty-five to thirty-four reporting that they have an activity tracker.⁴⁰ Conversely, the lowest rates of ownership are, as one might expect, among those over sixty-five, with only seven percent of activity trackers owned by that group.⁴¹

The rates of health tracker ownership coincide nicely with the statistical likelihood of workplace influence. The group most likely to own a fitness tracker is also the group most likely to be filling junior management positions, while the group that is least likely to have these devices is most likely to be retiring from the workplace altogether. Younger workers are also more vulnerable to the lack of protection for sensor-generated health data because they are more likely to be in the workforce longer than older workers and therefore may provide more data over time. In that sense, the age cohort with the most to lose from employer misuse of health and fitness data is the one most susceptible to that misuse.

³⁸ *Fitbit Wellness*, FITBIT. <http://www.Fitbit.com/Fitbit-wellness> (last visited Dec. 1, 2015).

³⁹ Aditya Kaul & Clint Wheelock, *Wearable Devices for Enterprise and Industrial Markets: Executive Summary*, TRACTICA 3 (2015), <https://www.tractica.com/wp-content/uploads/2015/04/WDEI-15-Executive-Summary.pdf>; see also discussion *infra* Section II.A (explaining the financial incentives that encourage employers to establish wellness programs).

⁴⁰ Ledger & McCaffrey, *supra* note 17, at 3.

⁴¹ *Id.*

A. New Technology Facilitates Employee Health Data Collection

Employers are starting to collect a wide range of data from more ubiquitous and often mandatory wearable devices. The collection of health and fitness data is part of a larger trend toward electronic monitoring of individual employees. Hitachi, for example, now offers employers the Business Microscope, a kind of advanced employee security badge embedded with infrared sensors, a microphone sensor, and a wireless communication device. When two employees wear these badges within a certain distance of each other, the badges recognize each other, record face time and body and behavioral data, and send them to a server.⁴² The badges send management data about who talks to whom, how often, where, and with how much energy. It also tells employers how much time each employee spends out of their seats. A similar employee monitoring badge developed by Sociometric Solutions includes a microphone that assesses the tone of voice the employee uses as well as an infrared beam that determines the speaker's position relative to other badge-wearing employees.⁴³ The British grocery chain Tesco uses an armband containing a Motorola device to monitor its employees' productivity and to track when they take breaks.⁴⁴

Employers have strong financial incentives for adopting these monitoring technologies, both in the form of increased productivity and lower costs. One journalist notes that "while privacy concerns are an obvious issue," the system has been shown to improve productivity.⁴⁵ One retail seller reported a fifteen percent increase in average sales per customer after using the badges for ten days.⁴⁶ Another company was recently sued for firing an employee who uninstalled a required tracking app from her work phone.⁴⁷

Another financial incentive for monitoring employees is a potential reduction in health care costs. This incentive stems from employees' use of health and fitness data sensors like the Fitbit and sensor-enabled smartphones. For example, BP offers a program by which employees can cut \$1200 from their

42 Victoria Young, *Wearable Device Monitors Employee Productivity*, PSFK, (Feb. 10, 2014), <http://www.psfk.com/2014/02/wearable-employee-productivity-tracker.html>.

43 Vivian Giang, *Companies Are Putting Sensors on Employees To Track Their Every Move*, BUS. INSIDER (Mar. 14, 2013, 6:23 PM), <http://www.businessinsider.com/tracking-employees-with-productivity-sensors-2013-3>.

44 Claire Suddath, *Tesco Monitors Employees with Motorola Armbands*, BLOOMBERG (Feb. 13, 2013), <http://www.bloomberg.com/bw/articles/2013-02-13/tesco-monitors-employees-with-motorola-arm-bands>.

45 Victoria Young, *Hitachi Is Using Data Visualization To Increase Inter-Company Communication and Efficiency*, PSFK (Feb. 10, 2014), <http://www.psfk.com/2014/02/wearable-employee-productivity-tracker.html>.

46 *Id.*

47 Complaint at 3-4, *Arias v. Intermex Wire Transfer, LLC*, No. S1500CV284763 (Cal. Sup. Ct. May 5, 2015), 2015 WL 2254833.

annual insurance bills in exchange for wearing a Fitbit and logging a sufficient amount of physical activity.⁴⁸ When BP introduced this free Fitbit program in 2013, 14,000 employees, 6000 spouses, and 4000 retirees signed up.⁴⁹ Like other employers, BP faces rising health care costs and is looking for ways to reduce them. Although some may question the genuineness of an employer-sponsored discount on health insurance rates, insurers are starting to offer similar discounts directly. For example, John Hancock Insurance offered customers up to a fifteen percent discount on their insurance rates in exchange for healthful activity as measured by the Fitbits these customers agreed to wear.⁵⁰

Employers like BP, Cigna, and Autodesk also offer their employees the Fitbits for free or at substantially reduced rates in a program that they can describe as a “win-win” for both sides.⁵¹ The employers have a vested interest in their employees’ health, and the employees get a significant discount on a popular device. One effect of employer-monitored wearables may be increased or longer use of the device.⁵² As noted in a recent blog post, “[B]y encouraging employees to use their personal fitness devices in the right way, companies can motivate employees to continue using their wearables, and achieve lasting health benefits.”⁵³

Lowering health insurance costs is a powerful motivation for employers to provide fitness sensors. If enough of their employees wear Fitbits or similar devices, presumably increasing their fitness, employers may be able to negotiate lower health insurance costs because of the likely decrease in claims for their healthier employees. For example, Appirio, a Bay Area startup, negotiated a \$300,000 discount on its \$5 million insurance costs by agreeing to share employee health data with its insurer and showing that the staff’s health was improving.⁵⁴ Employees who lost weight using a fitness program that included uploading activity on their Fitbits shared that information on the company’s internal social network, and the program became increasingly popular. Forty

48 Adam Satariano, *Wear This Device So the Boss Knows You’re Losing Weight*, BLOOMBERG (Aug. 21, 2014, 1:26 PM), <http://www.bloomberg.com/news/articles/2014-08-21/wear-this-device-so-the-boss-knows-you-re-losing-weight>.

49 Olson & Tilley, *supra* note 1.

50 Tara Siegel Bernard, *Giving out Private Data for Discount in Insurance*, N.Y. TIMES (Apr. 8, 2015), <http://www.nytimes.com/2015/04/08/your-money/giving-out-private-data-for-discount-in-insurance.html>.

51 See David Nield, *Employee Wellness Programs Now One of Fitbit’s Fastest Growing Areas*, DIGITAL TRENDS (Apr. 19, 2014), <http://www.digitaltrends.com/mobile/employee-wellness-programs-now-one-Fitbits-fastest-growing-areas>.

52 See Ledger & McCaffrey, *supra* note 17, at 7.

53 Panpan Wang, *Employers Key to Helping Consumers Take Advantage of Wearables Trend*, JIFF (Sept. 16, 2014), <http://www.jiff.com/blog/2015/2/17/mqo9ufznmh66jkqtfanukc3hbqc3pyw>.

54 Satariano, *supra* note 48.

percent of Appirio's approximately 1000 employees upload their fitness data via their Fitbit devices.⁵⁵ Their progress was persuasive to the company's insurer. According to Appirio's CEO, Chris Barbin, "We had an initial batch of data about people who had lost weight, and people who had moved from high risk to moderate risk. When we could show all that information to our insurer, that's pretty powerful." Barbin noted that there are privacy protections for employees' uploaded fitness data, although he has not disclosed the specific parameters of those protections.⁵⁶

Insurers are working closely with employers to facilitate programs like these. United Health Group, Humana, Cigna, and Highmark have all developed programs that help their employer clients integrate wearable devices like the Fitbit into the workplace.⁵⁷ While encouraging preventive measures is nothing new, adopting wearable fitness sensors can help boost incentives for employees to upload proof of their physical activity.

This tech-assisted approach to employee wellness fits into a general trend of increased spending on health programs at work. According to one study, spending on corporate wellness incentives more than doubled between 2009 and 2014, with corporations now spending an average of \$594 per employee annually on such programs.⁵⁸ Wearable technology will continue to play an important role in this trend. By 2018, analysts predict that a third of fitness-tracking device sales will come from corporate wellness programs.⁵⁹

B. Providers and Platforms Help Aggregate Employee Health Data

In coming years, the amount of health-related information that can transfer from an employee to a wearable sensor will increase. Medical professionals champion the use of health data sensors, in part to improve the quality of medical treatment as doctors spend less time with patients than they have in the past.⁶⁰ Many predict that implantable or wearable sensors will send biometric data to a smartphone, continually supplementing a database of information that can help

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Health Care Survey Finds Spending on Corporate Wellness Incentives To Increase 15 Percent in 2014*, FIDELITY (Feb. 20, 2014), <http://www.fidelity.com/inside-fidelity/employer-services/health-care-survey-finds-spending> (describing an increase in spending of "more than double the average of \$260" reported in 2009).

⁵⁹ Adrian Kingsley-Hughes, *Wearables and Health Insurance: A Health Bar over Everyone's Head*, (Aug. 26, 2014, 10:25 AM), <http://www.zdnet.com/article/wearables-and-health-insurance-a-health-bar-over-everyones-head>.

⁶⁰ See, e.g., Anick Jesdanun, *Doctors Say Fitness Trackers, Health Apps Can Boost Care*, PHYS.ORG (Feb. 20, 2015), <http://phys.org/news/2015-02-doctors-trackers-health-apps-boost.html>.

monitor health conditions.⁶¹ According to Nathan Cortez, “Smartphones already are replacing stethoscopes and pagers as the most ubiquitous physician accessory.”⁶² Professor Cortez has created a typology of mobile health apps, many of which rely on sensors, currently in use.⁶³ He categorizes them as follows:

- (1) Connectors, which include apps that “connect smartphones and tablets to FDA-regulated devices, thus amplifying the devices’ functionalities.”⁶⁴
- (2) Replicators, which “turn the smartphone or tablet itself into a medical device by replicating the functionality of an FDA-regulated device.”⁶⁵
- (3) Automators and Customizers, which “use questionnaires, algorithms, formulae, medical calculators, or other software parameters to aid clinical decisions.”⁶⁶
- (4) Informers and Educators, encompassing “educational apps that primarily aim to inform and educate.”⁶⁷
- (5) Administrators, which “automate office functions” including “scheduling patient appointments.”⁶⁸
- (6) Loggers and Trackers, which “allows users to log, record and make decisions about their general health and wellness.”⁶⁹

It is this final category that is most relevant for purposes of this Article. The growth and development of the other categories, however, signals the increasing importance of mobile health technology in general.

The growing demand for health and fitness data will be driven as much by employers as by the medical profession. Device manufacturers and app developers recognize the importance of employers as a revenue stream. Fitbit began selling data in bulk to employers in 2010 along with software that facilitates the translation of data.⁷⁰ Through its Fitbit Wellness program, Fitbit now partners with “thousands” of employers to provide its wearable devices at a

61 See ERIC TOPOL, *THE CREATIVE DESTRUCTION OF MEDICINE* 162-63 (2012) (describing hypothetical nanosensor monitoring of patients’ blood to detect markers of heart disease or cancers for those at high risk of such diseases).

62 Nathan Cortez, *The Mobile Health Revolution?*, 47 U.C. DAVIS L. REV. 1173, 1177 (2014).

63 *Id.*

64 *Id.* at 1182.

65 *Id.* at 1184.

66 *Id.* at 1186.

67 *Id.* at 1188.

68 *Id.* at 1189.

69 *Id.*

70 See Parmy Olson, *Jawbone Jumps into Employee Fitness Monitoring*, FORBES (Dec. 11, 2014, 7:48 AM), <http://www.forbes.com/sites/parmyolson/2014/12/11/jawbone-employee-fitness-monitoring>.

discount along with software that allows the employers to see how active certain employees are.⁷¹ Its website promises that employers in the program can “monitor individual, team and company-wide progress.”⁷² The benefits of adopting a Fitbit Wellness program, according to the site, include the ability to “create a culture of well-being,” “increase employee productivity,” “improve employee health status,” and “boost acquisition and retention.”⁷³ In 2014, Fitbit’s CEO announced that sales to employers are “one of the fastest-growing parts of Fitbit’s business.”⁷⁴ Fitbit’s competitors are developing similar programs. In late 2014, Jawbone introduced UP for Groups, a program through which employers can buy Jawbone fitness trackers in bulk at a discount and use centralized software to track their use in the aggregate.⁷⁵

Previously, employers could track their employees’ activity, but only through an application programming interface (API).⁷⁶ Employers don’t have to go through device manufacturers like Fitbit or Jawbone, however, to collect health-related information about their employees. Startups including Pact, WelBe, and Jiff also sell software that allows employers to track and collect this kind of data from any wearable device.⁷⁷ WelBe’s website, for example, suggests that its software can monitor how much employees sleep, eat, drink, and exercise.⁷⁸ It coordinates input from sources including Fitbit, Garmin, MyFitnessPal, RunKeeper, and Jawbone.⁷⁹ WelBe offers what it ominously calls “wellbeing coordinators”—which presumably used to be human resources managers—the ability to “create aggregated biometric reports on the fly and take a deep dive into data on employees’ activity levels, financial fitness, challenge activities, and nutritional health.”⁸⁰ Data aggregators such as TicTrak and Foxing also collect information from various fitness trackers.⁸¹

App developers find it increasingly easy and rewarding to generate data that

71 *Id.*

72 *Fitbit Wellness*, *supra* note 38.

73 *Id.*

74 *See* Nield, *supra* note 51.

75 *See* Olson, *supra* note 70.

76 *Id.*

77 *Id.*

78 WELBE, <https://www.welbe.com> (last visited Dec. 1, 2015). On this site, an embedded video without narration entitled “How Do You Live Welbe?” shows a young woman whose every move, from the moment she wakes up in the morning, appears to be recorded. It is not clear exactly how each of these data points is being recorded, as we see her with a wearable device, entering information into an app on her phone.

79 Tom Rath, *A New Version of Eat, Move, Sleep, and the Welbe App*, O.C. TANNER (Jan. 19, 2015), <http://blog.octanner.com/editor-picks/a-new-version-of-eat-move-sleep-and-the-welbe-app>.

80 *See* WELBE, *supra* note 78.

81 *See* Ledger & McCaffrey, *supra* note 17, at 4.

can be centralized and transferred in this way. For example, Apple's introduction of HealthKit, in June 2014, simplified the aggregation and transfer of health related data. HealthKit is a tool that helps developers create apps that draw on a user's centralized health and fitness data, effectively allowing them to share data with and import data from other HealthKit-enabled apps.⁸²

While the most direct means of data collection at work is to use employer-provided devices and apps, employers could also collect data generated by employees' own devices. Employers have already shown a willingness to use employees' personal technology to their advantage, blurring the line between personal data and workplace device. The "Bring Your Own Device" (BYOD) movement has gained ground quickly.⁸³ Courts have yet to fully define the extent to which employers may legally collect non-work-related data from these devices.

C. *Using Employee Health Data To Inform Employment Decisions Creates Potential Legal and Ethical Hazards*

There is ample potential for employer misuse of current and future employees' health and fitness data.⁸⁴ These data could inform employment decisions in nearly unlimited ways. As Professor Peppet points out, smartphone sensors can provide data from which employers can infer "a user's mood, stress levels, personality type, bipolar disorder, demographics (e.g., gender, marital status, job status, age); smoking habits, overall well-being, progression of Parkinson's disease, sleep patterns, happiness, levels of exercise, and types of physical activity or movement."⁸⁵ It is easy to imagine a scenario where an

82 *The HealthKit Framework*, APPLE, INC. (Nov. 19, 2015), https://developer.apple.com/library/ios/documentation/HealthKit/Reference/HealthKit_Framework/index.html#//apple_ref/doc/uid/TP40014707.

83 Anisha Mehta, "*Bring Your Own Glass*": *The Privacy Implications of Google Glass in the Workplace*, 30 J. MARSHALL J. INFO. TECH. & PRIVACY L. 607, 607-08 (2014).

84 See, e.g., Karen Levy, *Relational Big Data*, 66 STAN. L. REV. ONLINE 73, 77 (2013) ("Fast-growing workplace wellness monitoring programs frequently use health indicators and behavioral data (derived, for instance, from a digital pedometer) to let employers and insurers keep tabs on the health of their workforce . . . Highly mobile employees like truck drivers . . . are increasingly monitored via fleet management and dispatch systems that transmit data about their driving habits, fuel usage, and location to a central hub in real time—practices that have engendered deep concerns about driver privacy and harassment."); Thierer, *supra* note 3, at 55 (noting that "new datasets" derived from interconnected devices "might be used . . . by employers for job-related purposes, or even by insurers to adjust user premiums"). At least one Canadian lawyer has introduced Fitbit data as evidence of decreased physical activity in a personal injury lawsuit . Samuel Gibbs, *Court sets legal precedent with evidence from Fitbit health tracker*, THE GUARDIAN (Nov. 18, 2014, 11:03 AM), <http://www.theguardian.com/technology/2014/nov/18/court-accepts-data-Fitbit-health-tracker>.

85 Peppet, *supra* note 3, at 115-16 (footnotes omitted).

employer, having to decide which of two candidates to promote, reviews each candidate's sleep patterns, physical activity, calorie intake, or mood—any or all of which can be monitored and measured remotely—and decides based at least in part on these data. When employers use the health and fitness data they collect to make employment decisions, including hiring and promotion, there is cause for concern.⁸⁶

As discussed further in the next Part, the legal frameworks we rely on to prohibit discrimination are of little use here. Evaluating an employee for a promotion based on the employer's assessment of the likelihood that the employee will develop an unspecified health condition later in life, for example, based on the candidate's monitored physical activity levels, would not invoke disability law because no specific disability is invoked or perceived.⁸⁷ Making employment choices based even in part on sleep patterns, nutritional intake, or smoking—all of which can be measured by mobile sensors—may look like discrimination to a non-lawyer. Lawyers might analyze a potential discrimination claim by asking whether the employee was targeted because of membership in a protected class under Title VII of the Civil Rights Act,⁸⁸ such as race or religion, or a disability as defined by the Americans with Disabilities Act (ADA).⁸⁹ However, non-lawyers may not use that analytical framework. Treating an employee or job candidate differently because of physical activity levels or sleep patterns—conditions which may correlate to lower productivity levels and/or higher health insurance costs in the future—may seem wrong to a non-lawyer and indeed may well be unethical.⁹⁰ However, federal anti-discrimination laws do not protect employees against decisions made on these bases; rather, these laws only reach employees who fall within a protected class.⁹¹

86 *Id.* at 118-119 ("Impulsivity and the inability to delay gratification – both of which might be inferred from one's exercise habits – correlate with alcohol and drug abuse, disordered eating behavior, cigarette smoking, higher credit-card debt, and lower credit scores. Lack of sleep – which a Fitbit tracks – has been linked to poor psychological well-being, health problems, poor cognitive performance, and negative emotions such as anger, depression, sadness, and fear. Such information could tip the scales for or against" a job candidate) (citations omitted); see also Dennis D. Hirsch, *That's Unfair! Or is it? Big Data, Discrimination and the FTC's Unfairness Authority*, 103 KY L.J. 345, 350-352 (2014-2015) (describing potential discrimination resulting from use of health-related Big Data); Jessica L. Roberts, *Protecting Privacy to Prevent Discrimination*, 56 WM. & MARY L. REV. 2097, 2122 (May 2015) (noting potential for discrimination when access opens to private information).

87 Peppet, *supra* note 3, at 125-26.

88 Civil Rights Act of 1964, Pub. L. No. 88-352, § 703, 78 Stat. 241, 255-57 (1964) (codified as amended at 42 U.S.C. § 2000e-2 (2012)).

89 Americans with Disabilities Act (ADA) of 1990, Pub. L. No. 101-336, § 102(a), 104 Stat. 327, 331-32 (codified as amended at 42 U.S.C. § 12112(a) (2012)).

90 See *supra* note 86 and accompanying text.

91 See, e.g., ADA § 102(a).

There are other risks as well. Employers who collect health and fitness data are susceptible to security breaches, possibly leading to the unauthorized distribution of data. Such security breaches are on the rise. According to one survey, there were over 300,000 reported cases of medical identity theft in 2013, a nineteen percent increase over the previous year.⁹²

There is also the danger that in-house staff may manipulate the data collected for a variety of reasons. Employees are unlikely to check the accuracy of the health-related data their employers collect. Most people do not verify the accuracy of their health records at all. In a 2013 survey, fifty-six percent of respondents admitted that they do not check their medical records to determine if the health information is accurate at all.⁹³

III. FEDERAL LAW DOES TOO LITTLE TO PROTECT EMPLOYEE HEALTH DATA

Mobile sensors can gather various types of data. These include the kind of direct health data that a medical device might record (such as blood pressure or heart rate) as well as non-health data, such as the employees' specific location data (for example, using a GPS). This Article examines the legal protection available to employees concerning the use of their health-related data. I believe that the greatest concerns lie with the possible employer misuse of extrapolated or indirect health data such as physical activity, sleep patterns, and heart rate.

While several federal laws appear to prohibit employers' potential misuse of health and fitness data, significant gaps remain in the federal protection of these data.⁹⁴ Many federal agencies and laws might address this growing problem, but none do so effectively. While states have a variety of data privacy laws, this Article focuses instead on the shortcomings of federal law in the protection of employees across the country. Adverse employment decisions using these data may fall outside existing federal anti-discrimination protections; accordingly, it is critical to examine the extent to which federal law otherwise protects employees from employer decisions of this kind.⁹⁵

92 2013 Survey on Medical Identity Theft, PONEMON INST. 2 (2013), <https://clearwatercompliance.com/wp-content/uploads/2013/10/2013-Medical-Identity-Theft-Report-FINAL.pdf>.

93 *Id.* at 13.

94 As discussed *infra* in Section III.B.

95 State laws can provide important protections as well, but the extent to which they may do so falls outside the scope of this Article.

A. Employees May Have No Reasonable Expectation of Privacy in Sensor-Generated Health Data

An important preliminary question is whether there is any right of privacy in health-related information beyond specific regulatory protections.

Some have observed that consumers have ever-decreasing expectations of privacy.⁹⁶ The increasing use of personal devices at work is further eroding these expectations of privacy.⁹⁷ Recent studies show, however, that many people still fear losing privacy, especially as it becomes easier to transmit information through technology. In a 2015 survey, privacy and security were respondents' top concerns about the Internet of Things.⁹⁸ More than half expressed concern that their data might be shared without their knowledge or approval. In addition, most people expect their health data to be kept somewhat private by HIPAA,⁹⁹ which may weigh in favor of finding that society values data privacy more than HIPAA actually protects it.

When employers give their employees electronic devices for work purposes, the employers arguably have greater legal access to the data on those devices than anyone else. In *City of Ontario v. Quon*, the Supreme Court held that public employees using devices provided by their employers for work purposes have little reasonable expectation of privacy in doing so.¹⁰⁰ While *Quon* concerned a government employer, the Court made it clear that the rapid pace of technological change would have made a sweeping holding on the scope of technological privacy at work imprudent. "Prudence counsels caution before the facts in the instant case are used to establish far-reaching premises that define the existence, and extent, of privacy expectations enjoyed by employees when using employer-provided communication devices," wrote Justice Kennedy in the majority opinion.¹⁰¹ "A broad holding concerning employees' privacy

96 See, e.g., Kate Murphy, *We Want Privacy, but Can't Stop Sharing*, N.Y. TIMES (Oct. 4, 2014), <http://www.nytimes.com/2014/10/05/sunday-review/we-want-privacy-but-cant-stop-sharing.html>.

97 Stephen Wu, *Employee Privacy in the Dawn of the Mobile Revolution*, RECORDER (Feb. 22, 2013), <http://www.therecorder.com/id=1202588380082/Employee-Privacy-in-the-Dawn-of-the-Mobile-Revolution?slreturn=20151027170150>.

98 *Privacy and Security in a Connected Life: A Study of US, European and Japanese Consumers*, PONEMON INST. 1 (2015), http://www.trendmicro.com/cloud-content/us/pdfs/security-intelligence/reports/rt_privacy_and_security_in_a_connected_life.pdf.

99 See, e.g., *National Consumer Health Privacy Survey 2005: Executive Summary*, CALIFORNIA HEALTHCARE FOUNDATION 1 (2005), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ConsumerPrivacy2005ExecSum.pdf>.

100 560 U.S. 746, 747 (2010).

101 *Id.* at 748.

expectations vis-à-vis employer-provided technological equipment might have implications for future cases that cannot be predicted.”¹⁰²

The Supreme Court has yet to issue a detailed ruling as to whether there is a reasonable expectation of privacy over the health and fitness data employers collect from their employees. Since *Quon* was decided in 2010, however, lower courts have grappled with the extent of privacy in connection with electronic devices. Most of the leading cases have come from the Bay Area, where both Fitbit and Jawbone are headquartered. In 2014, the Northern District of California dismissed an employee’s claims that his former employer violated the Wiretap Act, Stored Communications Act, California anti-hacking and privacy laws, or invaded his privacy by accessing the employee’s electronic communications through an Apple account he had created in connection with employer-provided devices.¹⁰³ The facts of that case are unusual, however, in that the employee caused the communications to be transmitted to the employer through his voluntary actions, undercutting any expectation of privacy he may have had.¹⁰⁴ The same court allowed a class action lawsuit to proceed against Google for sharing customers’ personal information with app vendors without the customers’ authorization.¹⁰⁵ That decision may undercut the ability of employers, or of Fitbit or Jawbone, to share employees’ fitness data with a third party, depending on its final resolution.

A final case that privacy scholars will follow as it develops is *Arias v. Intermex Wire Transfer*. In May 2014, Intermex Wire Transfer allegedly fired Myrna Arias after she uninstalled an app called Xora, which tracked her location twenty-four hours a day, from her work-issued phone.¹⁰⁶ In May 2015, Arias sued Intermex for invasion of privacy among other claims.¹⁰⁷

In the absence of binding precedent on the specific issue of employee privacy in

¹⁰² *Id.* at 760.

¹⁰³ *Sunbelt Rentals, Inc. v. Victor*, 43 F. Supp. 3d 1026 (N.D. Cal. 2014).

¹⁰⁴ *Id.* at 1035 (“The facts alleged demonstrate that [Victor, the employee] failed to comport himself in a manner consistent with objectively reasonable expectation of privacy. By his own admission, Victor personally caused the transmission of his text messages to the Sunbelt iPhone by syncing his new devices to his Apple account without first unlinking his Sunbelt iPhone. As such, even if he subjectively harbored an expectation of privacy in his text messages, such expectation cannot be characterized as objectively reasonable, since it was Victor’s conduct that directly caused the transmission of his text messages to Sunbelt in the first instance.”).

¹⁰⁵ *Svenson v. Google, Inc.*, No. 13-cv-04080-BLF, 2015 WL 1503429 (N.D. Cal. Apr. 1, 2015); *cf. In re Zynga Privacy Litig.*, 750 F.3d 1098 (9th Cir. 2014) (dismissing class action claims against Facebook and Zynga because users’ record information conveyed to third parties was not substantive communication as protected by certain federal statutes).

¹⁰⁶ Complaint at 3-4, *Arias v. Intermex Wire Transfer, LLC*, No. S1500CV284763 (Cal. Sup. Ct. May 5, 2015), 2015 WL 2254833.

¹⁰⁷ *Id.* at 4-5.

health-related data collected from mobile sensors, the protections afforded by specific federal regulation, or lack thereof, become even more important.

B. Federal Regulation of Health and Fitness Data Collection Is Fragmented and Insufficient

Americans have a general sense that their personal health information should be secure. Doctors' offices regularly present us with HIPAA notices that provide a sense of reassurance about the privacy of our health records. HIPAA does not adequately protect the kind of health and fitness data generated by popular health and fitness devices and apps nor do any of several other federal laws that might at first appear to protect these data, as discussed in more detail below. These gaps in regulatory coverage deserve greater scholarly and public attention.

1. The Health Insurance Portability and Accountability Act

HIPAA was designed to protect the confidentiality of patients' health information.¹⁰⁸ HIPAA, however, does not protect the kind of health and fitness data that wearable technology or fitness apps might collect.¹⁰⁹ When a Fitbit or iPhone app tells an employer how much an employee has exercised, what her heart rate is, or how high her blood sugar levels are, those data do not fall within the scope of HIPAA protection.

According to the U.S. Department of Health and Human Services (HHS), HIPAA "provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information."¹¹⁰ The "covered entities" include health care providers, health plans (including insurers and health maintenance organizations (HMOs)), and health care "clearinghouses" that translate health information from one format to another.¹¹¹ Certain HIPAA laws also apply to the "business associates" that covered entities hire to help them carry out health care functions. HIPAA only restricts what covered entities and their business associates can do. Other entities and individuals are not so restricted.

Additionally, HIPAA protects "[i]ndividually identifiable health

108 The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

109 See Timothy S. Hall, *The Quantified Self Movement: Legal Challenges and Benefits of Personal Biometric Data Tracking*, 7 AKRON INTELL. PROP. J. 27, 29-30 (2014).

110 *Understanding Health Information Privacy*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/privacy/hipaa/understanding> (last visited Dec. 1, 2015).

111 45 C.F.R. § 160.103 (2015).

information,” which is a subset of “health information.”¹¹² “Health information” is defined as:

any information, including genetic information, whether oral or recorded in any form or medium, that

- (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.¹¹³

The statute goes on to define “individually identifiable health information” as the “subset of health information” that:

- (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - (i) That identifies the individual; or
 - (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.¹¹⁴

Given these parameters, the kind of health-related data collected by mobile sensors such as Fitbits, smartwatches, and phones could fall under the definition at least of “health information” if it is “received” by a “health plan” or “employer.” As Professor Hall has observed, however, the “disclosure of individually identifiable biometric data by the company that manufactures the device, sells the app, or runs the website aggregating the data does not violate HIPAA’s Privacy Rule as it currently stands.”¹¹⁵ In other words, if the data are passed from the individual to a third party that is not a “health care provider, health plan, employer, or health care clearinghouse” nor an agent for any such entity, the data fall outside of the statutory HIPAA protections. App

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ See Hall, *supra* note 109, at 30.

manufacturers and website managers may qualify as such third parties and therefore may not be bound by HIPAA.

Another potential flaw in HIPAA's protection scheme is its limitation to "individually identifiable" data. When such data are aggregated for export and analysis, it arguably loses HIPAA protection because it is no longer individually identifiable. On the other hand, employers could use these data to infer a great deal about individual users; in essence, the data could be re-identified, or re-engineered to link back to an individual person.¹¹⁶ This process, also known as "sensor fusion," is now commonly used to collate and synthesize data about a single individual from multiple sources.¹¹⁷ When HIPAA was passed in 1996, it was more difficult to re-identify data that had been unlinked to an individual user, but recent technological developments have made it easier to re-identify data.¹¹⁸ The expansion of data available about each of us from a range of sources, including where we take our phones and what websites we visit, facilitates the re-identification process. Data analysts and computer scientists are continually finding new ways to re-identify data by combining various de-identified data pieces with such public information.¹¹⁹ Whether HIPAA protects such re-identified data has yet to be determined in court.

A final inadequacy of HIPAA as a source of protection for health data is that it provides no private right of action to plaintiffs who feel their privacy rights have been violated under the act. The Clinton Administration supported the inclusion of a private right of action for patients under HIPAA, but Congress chose not to act on these recommendations.¹²⁰ Only the HHS Office for Civil Rights may investigate and impose civil and criminal penalties against a health care provider for violations of HIPAA.¹²¹

116 N. Nina Zivanovic, *Medical Information as a Hot Commodity: The Need for Stronger Protection of Patient Health Information*, 19 INTELL. PROP. L. BULL. 183 (2015); see also *Re-Identification: Concerning the Re-Identification of Consumer Information*, ELEC. INFO. PRIVACY CTR., <https://epic.org/privacy/reidentification> (noting that "data can easily be re-identified, such that the sensitive information may be linked back to an individual.") (last visited Dec. 1, 2015).

117 See, e.g., T. Phan et al., *Sensor Fusion of Physical and Social Data Using Web SocialSense on Smartphone Mobile Browsers*, INST. ELECTRICAL & ELECTRONIC ENGINEERS 1 (2014), <http://ieeexplore.ieee.org/stamp/stamp.jsp?tp=&arnumber=6866555&tag=1>.

118 Paul Ohm, *Broken Promises of Privacy: Responding to the Surprising Failure of Anonymization*, 57 UCLA L. REV. 1701, 1706 (2010).

119 Paul M. Schwartz & Daniel J. Solove, *The PII Problem: Privacy and a New Concept of Personally Identifiable Information*, 86 N.Y.U. L. REV. 1814, 1841 (2011).

120 Joshua D.W. Collins, *Toothless HIPAA: Searching for a Private Right of Action to Remedy Privacy Rule Violations*, 60 VAND. L. REV. 199, 222-23 (2007).

121 See Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (Dec. 28, 2000) (codified at 45 C.F.R. pts. 160, 164); see also *Acara v. Banks*, 470 F.3d 569, 571 (5th Cir. 2006) (holding no private cause of action for disclosure of PHI).

2. *The Americans with Disabilities Act Amendments Act*

The Americans with Disabilities Act Amendments Act (ADAAA) expands the ADA's protections against employment discrimination on the basis of an actual or perceived disability.¹²² Much of the fitness data that sensors generate and employers collect, however, neither constitutes nor correlates with a disability as defined under the ADAAA.¹²³

The ADAAA might limit employers' data collection practices in other ways, however. As noted earlier, the drugstore chain CVS requires its employees to submit to personal health data collection or to pay a fine. Is this kind of disclose-or-pay requirement legal? Current case law suggests that it is.¹²⁴ One legal barrier might be the ADAAA's provision that employers cannot make "disability-related" inquiries or require prospective or current employees to undergo medical examinations unless they are job-related or subject to a business necessity exception. An inquiry is "disability-related" if an individual's response to the inquiry could reasonably be expected to disclose the presence of a protected disability. Once employment begins, the employer can make disability-related inquiries or require employees to submit to medical examinations only if they are "job-related and consistent with business necessity."¹²⁵

The ADAAA provides a safe harbor for employers' medical testing requirements in three situations, generally in connection with health insurance plans. Employers may make disability-related inquiries or require employees to submit to medical examinations in the following situations:

- (1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or

during a deposition); *Univ. of Colo. Hosp. v. Denver Pub. Co.*, 340 F. Supp. 2d 1142, 1145 (D. Colo. 2004) (finding no HIPAA private cause of action because the statute created enforcement means for aggrieved persons); *O'Donnell v. Blue Cross Blue Shield of Wyo.*, 173 F. Supp. 2d 1176, 1179-80 (D. Wyo. 2001) (holding no express or implied private cause of action exists under HIPAA).

122 Americans with Disabilities Act Amendments Act (ADAAA) of 2008, Pub. L. No. 110-325, § 5(a), 122 Stat. 3553, 3557 (codified as amended at 42 U.S.C. § 12112(a) (2012)).

123 Peppet, *supra* note 3 at 125-26 (noting that, for example, one's heart rate, on its own, does not necessarily indicate a "disability" as defined by statute. Nor does calorie expenditure, daily activity, or most of the other data commonly recorded by wearable health devices discussed in this article.).

124 *See supra* notes 100-107 and accompanying text.

125 42 U.S.C. § 12112(d)(4)(A) (2012); 29 C.F.R. § 1630.14(c) (2015).

- similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
- (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
 - (3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.¹²⁶

None of these safe harbor provisions may be used as a subterfuge to avoid the underlying anti-discriminatory purposes of the ADAAA.¹²⁷

At least one court has ruled that employers may subject employees to a penalty for failing to submit to health screenings without violating the ADAAA. In 2012, the Eleventh Circuit Court of Appeals decided that Florida's Broward County did not run afoul of the ADAAA when it deducted \$20 from each bi-weekly paycheck of employees who refused to submit to a wellness program.¹²⁸ The county's wellness program required employees to complete both a confidential health risk assessment questionnaire and a confidential biometric screening. An employee, Bradley Seff, claimed that these requirements violated the ADAAA's prohibitions against required medical screenings. His claim resulted in a class-action lawsuit against the county.

The Court of Appeals affirmed the District Court's decision in favor of Broward County, finding that its wellness program fell within the ADAAA's safe harbor provision because it was a term of the county's benefit plan even though the wellness program was not a formal, written term of the county's plan.¹²⁹ Neither the District Court nor the Court of Appeals addressed the question of whether the \$20 surcharge for noncompliance in each pay period made the program involuntary. This precedent suggests that the ADAAA will not limit employers' ability to require employees to submit health and fitness data as a condition of employment.

126 42 U.S.C. § 12201(c) (1)-(3) (2012). Paragraphs (1), (2), and (3) "shall not be used as a subterfuge to evade" the underlying anti-discriminatory purposes of the ADAAA.

127 *Id.* at (c)(3).

128 *Seff v. Broward Cnty*, 691 F.3d 1221 (11th Cir. 2012).

129 *Id.* at 1224 (holding that the employee wellness program need not be "explicitly identified in a benefit plan's written documents to qualify as a 'term' of the benefit plan within the meaning of the ADA's safe harbor provision.").

Since *Seff*, courts have started to consider the extent of employees' rights in biometric data in litigation brought by the Equal Employment Opportunity Commission (EEOC) over corporate wellness programs. For example, in September 2014, the EEOC sued Flambeau, Inc., a Wisconsin-based plastics manufacturer, after Flambeau declined to pay any of the medical insurance costs for an employee who refused to complete certain biometric tests and a health risk assessment.¹³⁰ Compliant Flambeau employees, according to the EEOC, were only required to pay twenty-five percent of their premium cost.¹³¹ The EEOC had filed a similar lawsuit the previous month against another Wisconsin employer, Orion Energy Systems, which allegedly fired an employee who refused to submit to Orion's corporate wellness program.¹³²

While these cases do not exactly mirror the privacy concerns articulated here, they may be instructive on the extent to which employees may protect health-related data collected from wearable sensors in the future.

3. *The Electronic Communications Privacy Act*

Another potential basis of legal protection is the Electronic Communications Privacy Act (ECPA), which makes it a crime to intercept or use electronic communications.¹³³ It is unlikely that the ECPA would limit employers' use of health data collected from employees.¹³⁴ One scholar, writing before health and fitness devices became common, concluded that the ECPA would not protect data contained in radio frequency identification (RFID) tags and read by RFID scanners.¹³⁵ He concluded that the transmitted data would not be an "electronic communication" within the scope of the ECPA.¹³⁶ Another obstacle to using the ECPA in this context is that it explicitly exempts "tracking devices," which it defines as "electronic or mechanical device[s] which permits the tracking of the movement of a person or object."¹³⁷ Because fitness devices like Fitbits and

130 Complaint, *EEOC v. Flambeau, Inc.*, No. 3:13-cv-00638 (W.D. Wis. Sept. 30, 2014).

131 Press Release, *EEOC Lawsuit Challenges Flambeau Over Wellness Program*, EEOC (Oct. 1, 2014), <http://www.eeoc.gov/eeoc/newsroom/release/10-1-14b.cfm>.

132 *EEOC v. Orion Energy Systems*, 1:14-cv-01019 (E.D. Wis. 2014); Press Release, *EEOC Lawsuit Challenges Orion Energy Wellness Program and Related Firing of Employee* (Aug. 20, 2014), <http://www.eeoc.gov/eeoc/newsroom/release/8-20-14.cfm>.

133 18 U.S.C. § 2511 (2012).

134 § 2511(2)(d) (allowing an exception if one party gives prior consent to such interception, such as through an employment contract).

135 Lars S. Smith, *RFID and Other Embedded Technologies: Who Owns the Data?*, 22 SANTA CLARA COMPUTER & HIGH TECH L.J. 695 (2006).

136 *Id.* at 752.

137 *Id.* at 753 (citing 18 U.S.C. §§ 2510(12)(C), 3117(b) (2012)). When the term "tracking device" was defined in 1986, however, wearable health sensors as we know them

fitness apps installed on mobile phones are equipped with sensors, as most mobile phones are, they would likely qualify as “tracking devices,” and therefore fall outside the scope of the ECPA.

4. *The Computer Fraud and Abuse Act*

The Computer Fraud and Abuse Act (CFAA) might also limit wearable device monitoring at work.¹³⁸ Although no court has yet determined whether a wearable fitness sensor qualifies as a “computer” within the meaning of the CFAA, relevant precedent suggests that a court would do so.

Under the CFAA, a computer is:

[A]n electronic, magnetic, optical, electrochemical, or other high speed data processing device performing logical, arithmetic, or storage functions, and includes any data storage facility or communications facility directly related to or operating in conjunction with such device, but such term does not include an automated typewriter or typesetter, a portable hand held calculator, or other similar device.¹³⁹

When asked to determine whether a cell phone qualifies as a “computer” within the meaning of the CFAA, the Court of Appeals for the Eighth Circuit ruled that it did.¹⁴⁰ According to the Eighth Circuit, the CFAA’s definition is “exceedingly broad” and “captures any device that makes use of a electronic data processor, examples of which are legion.”¹⁴¹ The rapid growth of technology, it noted, made it likely that more and more devices would qualify as computers for CFAA purposes over time. “As technology continues to develop,” said the court, the CFAA’s computer definition “may come to capture still additional devices that few industry experts, much less the Commission or Congress, could foresee.”¹⁴²

If employers access data from wearable devices or from the apps installed on their employees’ mobile phones without employees’ knowledge or consent, are they violating the CFAA? If the devices in question qualify as “computers” within the CFAA’s “exceedingly broad” definition of that term, it would appear so. No court has yet addressed this specific question. Its resolution would likely

today were not widely used. See Pub. L. No. 99-508, § 108(a), 100 Stat. 1848, 1858 (1986) (codified as amended at 18 U.S.C. § 3117(b) (2012)).

138 Computer Fraud and Abuse Act of 1986, Pub. L. No. 99-474, 100 Stat. 1213 (codified as amended at 18 U.S.C. § 1030 (2012)).

139 18 U.S.C. § 1030(e)(1) (2012).

140 *United States v. Kramer*, 631 F.3d 900, 903 (8th Cir. 2011).

141 *Id.* at 903.

142 *Id.* at 903-04.

depend in part on whether the employer had engaged in fraud or abuse in connection with those devices or apps, which presumably would depend on the validity and extent of employee consent to the monitoring. The more commonplace such monitoring becomes, however, the harder it will be for employees to prove a lack of at least implied consent.

C. There Is No Effective Federal Agency Oversight of Employee Health and Fitness Data Collection

Several government agencies might play a role in protecting health and fitness data from employer misuse, including the FTC and the FDA.¹⁴³ This overlap of interests provides both an opportunity for interagency cooperation as well as a danger of redundant and inconsistent approaches to such regulation. As Professors Jim Rossi and Jody Freeman point out, shared regulatory space presents the challenge of coordination.¹⁴⁴ When more than one agency has authority to regulate an area, such coordination is necessary “to minimize inconsistency, maximize joint gains, plug gaps, and prevent systemic failures.”¹⁴⁵ Professors Rossi and Freeman describe several forms of coordination, including consultation provisions, interagency agreements, joint policymaking, and centralized White House review.¹⁴⁶ In response, Eric Biber has pointed out the need for more empirical scholarship on the ways in which agencies interact with each other and with outside entities in order to make such coordination more effective.¹⁴⁷

As discussed above, however, HIPAA, the most relevant regulatory framework overseen by HHS, may not extend to employers’ use of health and fitness data collected from most mobile devices and apps, especially if an intermediary is used to collate and/or analyze the data. Judging from the explicit scope of its guidance, the FDA appears to be less concerned with the privacy

143 See, e.g., Cora Han, Senior Attorney, Div. of Privacy & Identity Prot., Fed. Trade Comm’n, Remarks at the Internet of Things Workshop 165 (Nov. 19, 2013), http://www.ftc.gov/sites/default/files/documents/public_events/internet-things-privacy-security-connected-world/final_transcript.pdf (introducing the Panel on Connected Health and Fitness).

144 Jim Rossi & Jody Freeman, *Agency Coordination in Shared Regulatory Space*, 125 HARV. L. REV. 1131, 1145 (2012).

145 *Id.* at 1149.

146 *Id.* at 1155.

147 Eric Biber, *The More the Merrier: Multiple Agencies and the Future of Administrative Law Scholarship*, 125 HARV. L. REV. F. 78 (2012) (“Research on [inter-agency operations] (whether by legal scholars or political scientists) will also require a lot more empirical research or understanding of how agencies function, and what motivates bureaucrats and political appointees.”).

implications of mobile technology than its effectiveness in improving health.¹⁴⁸ The FTC is the most appropriate government agency to regulate the collection and use of employee health data, but serious questions remain about the effectiveness of its efforts in this area.

1. Food and Drug Administration Regulation

In January 2015, the FDA issued draft guidance on its plans to regulate certain “general wellness products,” which may include fitness devices and software programs.¹⁴⁹ The FDA’s guidance distinguishes between apps that effectively turn a mobile phone into a medical device and “general wellness products.”¹⁵⁰

Many of the health and fitness apps and devices that might transmit data of interest to employers fall into the FDA’s “general wellness products” category. As illustrations of what might fall into this category, the FDA includes “a portable product that claims to monitor the pulse rate of users during exercise and hiking.”¹⁵¹ The Fitbit might be an example. The FDA classifies this as a “general wellness product” because “claim relates only to exercise and hiking and does not refer to a disease or medical condition” and because “the technology for monitoring poses a low risk to the user’s safety.” Other examples of “general wellness products” include “a mobile application that solely monitors and records daily energy expenditure and cardiovascular workout activities to “allow

148 See, e.g., *Mobile Medical Applications, Guidance for Industry and Food & Drug Administration Staff*, FOOD & DRUG ADMIN. 13 (2015), <http://www.fda.gov/downloads/MedicalDevices/.../UCM263366.pdf> (“FDA intends to apply its regulatory oversight to only those mobile apps that are medical devices and whose functionality could pose a risk to a patient’s safety if the mobile app were to not function as intended.”).

149 See *General Wellness Policy for Low Risk Devices, Draft Guidance for Industry and Food & Drug Administration Staff*, FOOD & DRUG ADMIN. (2015), <http://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm429674.pdf>. Covered devices “may include exercise equipment, audio recordings, video games, software programs and other products that are commonly, though not exclusively, available from retail establishments (including online retailers and distributors that offer software to be directly downloaded).” *Id.* at 2. One Washington-based law firm suggested that the FDA’s draft guidance was motivated by the need to clarify the distinctions between more traditionally regulated medical devices and the fast-growing market of “general wellness products” that may be used for a range of health tracking purposes. *FDA Publishes Draft Guidance Describing General Wellness Claims*, COVINGTON & BURLING LLP (Jan. 26, 2015), https://www.cov.com/~media/files/corporate/publications/2015/01/fda_publishes_draft_guidance_describing_general_wellness_claims.ashx.

150 *General Wellness Policy for Low Risk Devices*, *supra* note 149, at 2.

151 *Id.* at 7.

awareness of one's exercise activities to improve or maintain good cardiovascular health" and "a mobile application [that] monitors and records food consumption to manage dietary activity for weight management and alert the user, healthcare provider, or family member of unhealthy dietary activity."¹⁵²

The FDA suggests that it has no plans to regulate these "general wellness products."¹⁵³ The device and both kinds of apps that appear as examples of these products could generate data that an employer might intercept, but those concerns are beyond the scope of the FDA's regulatory authority. Even if the FDA were to regulate these products, its primary concern would not be the potential for health and fitness data collection and sharing. The FDA's regulatory focus is the effectiveness and accuracy of these devices and apps rather than the privacy implications of their use.¹⁵⁴

Professor Cortez has called for the FDA to become more engaged in the regulation of mobile health and fitness technology.¹⁵⁵ Indeed, two weeks after issuing its guidance on "general wellness devices," the FDA issued further guidance on "Mobile Medical Applications."¹⁵⁶ Recommendations included creating a new office for mobile medical technologies to educate consumers about apps that have health consequences for users and developing a requirement that app developers disclose the sources of medical information and calculations the app uses.¹⁵⁷ The FDA's more publications, however, suggest that the agency will not take any significant role in monitoring or restricting the use of employees' health and fitness data in the workplace.

2. Federal Trade Commission Regulation

The FTC also has the potential regulation of wearable health sensors in its sights. In January 2015, the FTC released a Staff Report called "Internet of Things: Privacy & Security in a Connected World." The report summarized findings that it had developed over the previous fourteen months, beginning with a workshop in November 2013. Privacy was a main topic of discussion

¹⁵² *Id.* at 6.

¹⁵³ Thomas Sullivan, *FDA Device Guidance: General Wellness Policy for Low Risk Devices*, POL'Y & MED. (Jan. 29, 2015), [http:// www.policymed.com/2015/01/fda-device-guidance-general-wellness-policy-for-low-risk-devices.html](http://www.policymed.com/2015/01/fda-device-guidance-general-wellness-policy-for-low-risk-devices.html).

¹⁵⁴ See Hall, *supra* note, 109, at 32.

¹⁵⁵ Cortez, *supra* note 62, at 1180-81 (recommending that the FDA "confront its past regulatory failures and push itself into a regulatory 'feedback loop' in which the agency can identify past shortcomings and correct them going forward"); see also Nathaniel R. Carroll, *Mobile Medical App Regulation*, 7 ST. LOUIS U. J. HEALTH L. & POL'Y 415, 423 (2014). But cf. Thierer, *supra* note 3, at 71 (cautioning against overregulation of wearable technologies).

¹⁵⁶ See *Mobile Medical Applications*, *supra* note 148.

¹⁵⁷ *Id.*

throughout the workshop, as its title suggests, but participants' views were far from uniform. According to the Staff's subsequent report,

Participants debated how the long-standing Fair Information Practice Principles ("FIPPs") of notice, choice, access, accuracy, data minimization, security, and accountability should apply to the IoT space. While some participants continued to support the application of all of the FIPPs others argued that data minimization, notice, and choice are less suitable for protecting consumer privacy in the IoT.¹⁵⁸

In that workshop, the FTC devoted one of four panels to "Connected Health and Fitness," examining the "growth of increasingly connected medical devices and health and fitness products."¹⁵⁹

In the January 2015 report, FTC staff acknowledged the danger that "unauthorized access to data collected by fitness and other devices that track consumers' location could endanger consumers' physical safety."¹⁶⁰ A greater risk, however, is the danger that employers could use data collected by those devices to make adverse decisions about and invade the privacy of its employees. Scott Peppet, a participant in the workshop and a professor at the University of Colorado Law School, noted the potential dangers of using such data to make employment decisions at the workshop, but FTC staff declined to adopt his larger concern.¹⁶¹

D. Device Makers and App Developers Provide Too Little Information to Protect Employees from Data Misuse

Can the health and fitness industry protect employee data well enough without regulatory intervention? Judging from the current state of the marketplace, I suspect not. The manufacturers of fitness devices that collect data currently face few restrictions on what data they can collect and how they can monetize it. Of course, sales from consumers provide one income stream, but downstream sales of data may be much more profitable. The potential profit from collecting, analyzing, repackaging, and selling health-related data to employers and/or marketers is barely limited by law. As it stands, app and device makers can now access a wide range of users' health-related data without those users' consent.

158 *Internet of Things: Privacy & Security in a Connected World*, FED. TRADE COMM'N 19 (2015), <https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-staff-report-november-2013-workshop-entitled-internet-things-privacy/150127iotrpt.pdf>.

159 *Id.* at 3.

160 *Id.* at 13.

161 *Id.* at 16, 43-45. For a more expansive discussion of these concerns, see Peppet, *supra* note 3.

Scholars are beginning to ask important questions about the extent to which app developers and device manufacturers must disclose their data collection and sharing practices.¹⁶² It can be hard for employees to find out how those personal health data are used or shared. Many health-related devices and apps lack clear indications of what they may be done with the data collected.

Technology providers pay at least lip service to protecting health-related data. In marketing its Health app, Apple reassures consumers that it takes their privacy concerns to heart:

The information you generate about yourself is yours to use and share. You decide what information is placed in Health and which apps can access your data through the Health app. When your phone is locked with a passcode or Touch ID, all of your health and fitness data in the Health app is encrypted. You can back up data stored in the Health app to iCloud, where it is encrypted while in transit and at rest.¹⁶³

There is a dichotomy, however, between industry assurances of consumer privacy and the rigors of the structures that would actually keep data private.

Apple encourages HealthKit developers to be transparent about their use of consumer data by asking them to “clearly disclose to the user how you and your app will use their HealthKit data.”¹⁶⁴ This appears to be a suggestion rather than a contractual requirement. Apple itself distinguishes this and other “guidelines” from its “requirements” and urges HealthKit developers to make sure they comply with the latter.¹⁶⁵

Apple does have contractual requirements regarding privacy that all app developers must follow, whether or not they use HealthKit.¹⁶⁶ According to

162 See, e.g., Tobias Dehling et al., *Exploring the Far Side of Mobile Health: Information Security and Privacy of Mobile Health Applications on iOS and Android*, 3 JMIR MHEALTH UHEALTH 1 (2015) (concluding that appropriate security measures need to be devised so that users can benefit from seamlessly accessible, tailored mobile health apps without potentially serious information security and privacy infringements); Anne Marie Helm & Daniel Georgatos, *Privacy and mHealth: How Mobile Health ‘Apps’ Fit into a Privacy Framework Not Limited to HIPAA*, 64 SYRACUSE L. REV. 131 (2014) (analyzing the privacy problems relevant to the different types of mobile health apps); Jennifer Bretts et al., *Same Issues, New Devices: Is Smartphone App Privacy Groundhog Day for Regulators?* (June 4, 2013) (unpublished manuscript), <http://ssrn.com/abstract=2351189> (arguing that the lack of transparency and self-regulatory enforcement demonstrated by app permission exploitation shows the potential for continued circumvention of privacy regulation).

163 *Health: An Innovative New Way To Use Your Health and Fitness Information*, APPLE, <https://www.apple.com/ios/whats-new/health> (last visited Dec. 1, 2015).

164 See *The HealthKit Framework*, *supra* note 82.

165 *Id.*

166 *App Store Review Guidelines*, APPLE § 17 (2015), <https://developer.apple.com/app-store/review/guidelines>.

Apple, the only apps that require a privacy policy are those that “collect, transmit, or have the capability to share personal information . . . from a minor” and those that “include account registration or access a user’s existing account.”¹⁶⁷ HealthKit developers are subject to the additional requirement that they “must provide a privacy policy,” but Apple does not mandate the content, appearance, or placement of such a policy.¹⁶⁸

Apple also prohibits developers using the HealthKit framework from storing users’ health information in iCloud and from using “data gathered from the HealthKit API for advertising or other use-based data mining purposes other than improving health, medical, and fitness management, or for the purpose of medical research.”¹⁶⁹ Apple also notes that it will reject any app that “share[s] user data acquired via the HealthKit API with third parties without user consent.”¹⁷⁰

If an app developer were to violate these terms, however, it is not clear that the consumer whose data were sold would have a right of action against either Apple or the developer. Consumers may be incidental beneficiaries of these terms, but it is unlikely that a court would find that they had standing to sue either a developer for failing to follow them or Apple for failing to insist on them.

An alternative remedy could be to compel employers to disclose the extent to which they collect and use health data in employment decisions. It is hard to imagine how companies might be subjected to such a rule and how it might be enforced. As a further complication, it may be difficult to determine what impact, if any, health-related data may have on an employment decision *ex post facto*. Deciding what uses of health data are permissibly work-related may be especially challenging when the employer bears the cost of health insurance.

IV. TWO PROPOSALS WOULD RESTRICT EMPLOYERS’ MISUSE OF HEALTH DATA

The lack of effective legal protection against the potential misuse of employee health data described in the preceding sections requires creative solutions. I propose two such solutions. One is designed to improve employee notice and decision-making about the disclosure of health and fitness data to employers by clarifying the terms and extent of such disclosure in advance. The other addresses the problem from the employer’s end by limiting the potential collection and use of data.

¹⁶⁷ *Id.* §§ 17.4, 17.5.

¹⁶⁸ *Id.* § 27.7.

¹⁶⁹ *Id.* § 27.4.

¹⁷⁰ *Id.* § 27.5.

A. The FTC Should Require Standardized, Succinct Privacy Labels on Health and Fitness Apps and Devices

An important regulatory question is the extent to which app makers should be required to provide clear information about their privacy policies as a condition of use. One solution might be the implementation of a mandatory labeling regime for all apps and devices that collect health-related information. The labeling proposed here would provide all consumers, including the employees that are the focus of my concern in this article, with a more realistic and practical means of limiting access than they currently have.

1. Current Website Privacy Policy Requirements Suffer from Three Critical Deficiencies

A privacy labeling rule would correct many of the deficiencies from which current privacy policies suffer. While websites are currently required to have privacy notices, these notices are not an effective means of providing employees with meaningful choice about how their data would be shared. There are at least three problems with privacy policies as they currently appear on health and fitness-related websites.¹⁷¹ First, it can be hard to locate them, especially on multi-page websites. Second, they are difficult and time-consuming to read. Third, they have inconsistent terms and scopes, making it hard to compare their practices.

One legal scholar has pointed out that a major problem with the privacy notices associated with health and fitness devices is that they are hard to find.¹⁷² Professor Peppet describes his experience of opening a Breathometer device he had purchased, which measures blood alcohol content. The device came with a seventeen-page manual for using the device and opening the associated app, but the manual made no mention of a privacy policy.¹⁷³ Nor did the app itself when installed or the device upon startup. Nothing on the device, app, or manual disclosed whether the device collected any data other than blood alcohol content test results. In other words, it was not readily visible to the user. It did not disclose how any collected data might be stored, transferred, sold, or deleted. “Only by visiting the company’s website, scrolling to the very bottom, and clicking the small link for ‘Privacy Policy,’” Professor Peppet writes, “can one

¹⁷¹ Most wearable monitors, whether they are dedicated devices like a Fitbit or an integrated sensor in a smartphone, work in conjunction with apps rather than websites. Most products, however, also have related websites. Many app platforms, including Apple Health, require apps to post privacy notices. See, e.g., *Privacy*, APPLE, <https://www.apple.com/privacy/privacy-built-in> (last visited Dec. 1, 2015).

¹⁷² See Peppet, *supra* note 3, at 89-90.

¹⁷³ *Id.*

learn that one's blood-alcohol test results are being stored indefinitely in the cloud, cannot be deleted by the user, may be disclosed in a court proceeding if necessary, and may be used to tailor advertisements at the company's discretion."¹⁷⁴ In sum, privacy policies associated with fitness devices may be so difficult to locate, requiring an effort that borders on research, that one might argue that they do not provide consumers with effective notice at all.

Not all health-related data collectors provide even this much information. Software manufacturer WelBe, whose products allow employers to aggregate employee health data from various sources, offers even less information about its privacy filters to the public. One has to scroll all the way to the bottom of the webpage to find a small link called "Privacy Policy."¹⁷⁵ Clicking on that link brings up the "O.C. Tanner Company Privacy Policy," which applies to all websites operated by what is apparently WelBe's parent company rather than to the WelBe products themselves.¹⁷⁶

A second problem is that, even once they are found, it takes an unreasonably long time to read the notices. By one account, if someone were to read the privacy policy on every website she visits at least once a year, she would spend approximately 244 hours a year reading privacy policies.¹⁷⁷ Most privacy policies are cumbersome and difficult to interpret. The FTC itself has criticized the effectiveness of industry-generated privacy notices, observing that "the notice-and-choice model, as implemented, has led to long, incomprehensible privacy policies that consumers typically do not read, let alone understand."¹⁷⁸ It is unrealistic to expect lengthy, obscure policy notices to provide the kind of meaningful choice that consumers want and that privacy legislation aims to provide.

Privacy policies may vary widely in substance even when such policies are required. Recognizing that consumers may have concerns about the privacy of their health data, Apple notes that "apps that access HealthKit are required to have a privacy policy," although it does not mandate the specific parameters of the policy.¹⁷⁹ In its instructions for developers, Apple refers them to two government websites for "guidance." One is a "Personal Health Record model

¹⁷⁴ *Id.* at 90.

¹⁷⁵ See WELBE, *supra* note 78.

¹⁷⁶ *Company Privacy Policy*, O.C. TANNER CO., https://www.awardselect.com/privacy/p_en_US.html (policy effective Sept. 19, 2013).

¹⁷⁷ Aleecia M. McDonald & Lorrie Faith Cranor, *The Cost of Reading Privacy Policies*, 4 ISJLP 540, 560 (2008).

¹⁷⁸ *Protecting Consumer Privacy in an Era of Rapid Change*, FED. TRADE COMM'N iii (2010), <https://www.ftc.gov/sites/default/files/documents/reports/federal-trade-commission-bureau-consumer-protection-preliminary-ftc-staff-report-protecting-consumer/101201privacyreport.pdf>.

¹⁷⁹ See *The Healthkit Framework*, *supra* note 82.

(for non-HIPAA apps),” which links to the HealthKit’s suggestions for a model privacy notice.¹⁸⁰ The other site is described as the “HIPAA model (for HIPAA covered apps)” and links to HHS privacy notice rules.¹⁸¹ Apple does not, however, help developers determine whether their products are covered by HIPAA or not and consequently which set of guidelines they should follow.

2. Industry Self-Regulation of Privacy Policies Has Failed, Making Legislative Intervention Necessary

Consumer products sold in the United States are required to carry warranties that meet certain legibility requirements, pursuant to the Magnuson-Moss Warranty Act.¹⁸² In passing that Act, Congress intended to make sure that consumers could get complete information about warranty terms and conditions, thereby helping them to make more informed purchases.¹⁸³ The Magnuson-Moss Warranty Act also allows consumers to compare warranty coverage among products before buying and promote competition on the basis of warranty coverage. By clarifying the sellers’ obligations, the Act also makes it easier for consumers to pursue a remedy for breach of warranty in the courts.

One could argue that the same policy concerns underlie the need for clear data disclosure policies. Why should data disclosure policies be more difficult to interpret than warranties? The potential losses consumers could suffer as a result of the unauthorized use of their data—especially the health-related data that arguably would be protected under HIPAA if it were used by “covered entities”—could well exceed the potential financial losses that the Magnuson-Moss Warranty Act sought to limit.

The FTC appeared to be moving toward just such a labeling requirement. In 2012, FTC Chairman Jon Leibowitz announced, in 2012, plans to develop what the agency called a “Privacy Nutrition Label” for data collection and use.¹⁸⁴ As

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² Magnuson-Moss Warranty-Federal Trade Commission Improvement Act, Pub. L. No. 93-637, 88 Stat. 2183 (1975) (codified as amended at 15 U.S.C. § 2301-12 (2012)).

¹⁸³ S. REP. NO. 93-151, at 2 (1973) (“[T]his bill aims to increase the ability of the consumer to make more informed product choices and to enable him to economically pursue his own remedies when a supplier of a consumer product breaches a voluntarily assumed warranty or service contract obligation.”); 120 CONG. REC. 40711 (1974) (statement of Sen. Moss) (“By making warranties of consumer products clear and understandable through creating a uniform terminology of warranty coverage, consumers will for the first time have a clear and concise understanding of the terms of warranties of products they are considering purchasing.”).

¹⁸⁴ Josephine Liu, *FTC Working on Privacy “Nutrition Label”*; *Industry Focusing on Icons*, INSIDE PRIVACY (Oct. 25, 2012), <http://www.insideprivacy.com/united-states/federal-trade-commission/ftc-working-on-privacy-nutrition-label-industry-focusing-on-icons>.

envisioned at the time, this label would have contained “five essential terms” related to privacy although the FTC was still in the process of identifying those terms in conjunction with the Bureau of Consumer Protection. The FTC had considered adopting some form of standardized privacy labels, modeled after nutrition labels, as early as July 2001.¹⁸⁵ Since Leibowitz resigned from the FTC in 2013, however, there has been no further mention of government-mandated privacy labels for apps.¹⁸⁶

The food labeling laws Congress has passed in recent years provide an apt analogy. The FDA enforces a complex series of food labeling laws that apply to all food products sold in the United States.¹⁸⁷ Beginning in the early twentieth century, certain furniture and bedding makers were required to label their products so that the public would know what materials were used inside (e.g., horse hair).¹⁸⁸ Labeling requirements have continued to evolve and extend in response to social changes. In late 2014, noting that Americans now “eat and drink about one-third of their calories away from home,” the FDA announced new labeling rules that require certain restaurant chains to label menu items with nutritional information and all vending machines to provide calorie count labels for each item sold.¹⁸⁹ The rules extend nutrition label requirements in order to “help consumers make informed choices for themselves and their families.”¹⁹⁰

If the FDA can adapt labeling requirements to help consumers make more informed choices, it stands to reason that the FTC can develop privacy label requirements for health-related devices and apps for the same purpose. Although food consumption and data disclosure differ in some key ways, mandating the provision of more information about each can only help the consumer.

In its 2015 report on the IoT, the FTC agreed that “[w]hatever approach a company decides to take, the privacy choices it offers should be clear and prominent, and not buried within lengthy documents.”¹⁹¹

185 *Id.*

186 In June 2015, however, the FTC did propose to amend required privacy disclosures for motor vehicle dealers pursuant to the Gramm-Leach-Bliley Act, which would allow dealers to post these notices online. *See, e.g.*, 16 C.F.R. pt. 313 (2015).

187 *See, e.g.*, 21 C.F.R. § 101 (2015).

188 *See Law Label Learning Center*, AM. L. LABEL, <http://www.americanlawlabel.com/law-label-learning-center/products> (last visited Dec. 1, 2015).

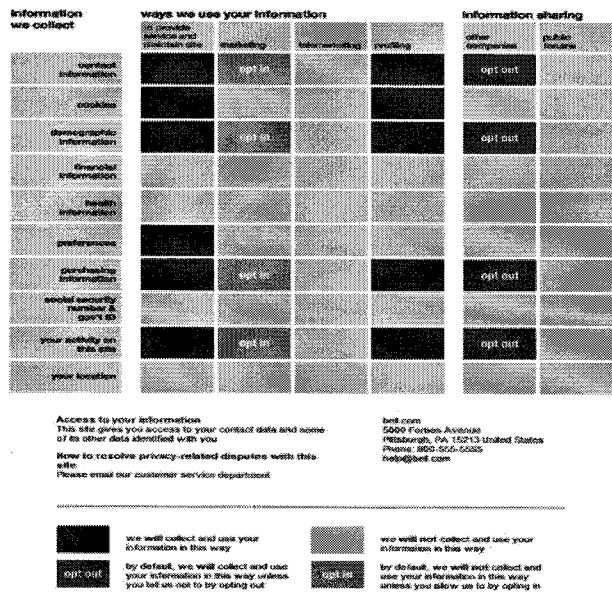
189 *See Menu and Vending Machines Labeling Requirements*, FOOD & DRUG ADMIN., <http://www.fda.gov/Food/IngredientsPackagingLabeling/LabelingNutrition/ucm217762.htm> (last visited Dec. 1, 2015).

190 *See Overview of FDA Labeling Requirements For Restaurants, Similar Retail Food Establishments and Vending Machines*, FOOD & DRUG ADMIN., <http://www.fda.gov/Food/IngredientsPackagingLabeling/LabelingNutrition/ucm248732.htm> (last visited Dec. 1, 2015).

191 *See Internet of Things*, *supra* note 161, at v.

There has been extensive research on the best formats for privacy nutrition labels already.¹⁹² Researchers at Carnegie Mellon and other universities have developed privacy labels that indicate, at a glance, how a provider might use or share each of several kinds of information.¹⁹³ Here is a sample of such a label:

FIGURE: SAMPLE STANDARDIZED PRIVACY LABEL¹⁹⁴



192 See, e.g., Corey A. Ciocchetti, *The Future of Privacy Policies: A Privacy Nutrition Label Filled with Fair Information Practices*, 20 JOHN MARSHALL J. COMPUTER & INFO. L. 1 (2008); Lorrie Cranor et al., *Spring Symposium: Data Privacy and Transparency in Private and Government Data Collection: Panel 1: Disclosure and Notice Practices in Private Data Collection*, 32 CARDOZO ARTS & ENT. L.J. 784 (2014); Daniel Parisi, *Mobile App Privacy: Developing Standard and Effective Privacy Tools for Consumers*, 15 N.C. J.L. & TECH. ONLINE ED. 240 (2014).

193 See, e.g., *Privacy Nutrition Labels: Example Policy*, CYLAB USABLE PRIVACY & SECURITY LABORATORY, <http://cups.cs.cmu.edu/privacyLabel/>; Patrick Gage Kelley et al., *A "Nutrition Label" for Privacy*, CYLAB USABLE PRIVACY & SECURITY LABORATORY (2009), <http://cups.cs.cmu.edu/soups/2009/proceedings/a4-kelley.pdf>; see also KLEIMANN COMM'N GRP., INC., *EVOLUTION OF A PROTOTYPE FINANCIAL PRIVACY NOTICE* (Feb. 28, 2006), www.ftc.gov/privacy/privacyinitiatives/ftcfinalreport060228.pdf.

194 See *Sample Privacy Label*, CYLAB USABLE PRIVACY & SECURITY LABORATORY, <http://cups.cs.cmu.edu/privacynutrition-label-05-2009/current/1.php> (last visited Dec. 1, 2015). For a legend and more technical explanation of the figure, see *id.* Reprinted with the kind permission of Lorrie Cranor, Associate Professor, Computer Science and Engineering & Public Policy and Director, CyLab Usable Privacy and Security Laboratory at Carnegie Mellon University.

By providing standardized labels that are easy both to read and compare, providers would make it easier for consumers to make meaningful choices about the data they share. Apps and devices should be required to carry concise, effective privacy labels for this purpose. The privacy nutrition labels developed by the Cylab Usable Privacy and Security (CUPS) program at Carnegie Mellon University, led by Lorrie Faith Cranor, could provide an excellent starting point.¹⁹⁵

While the CUPS model might serve as an initial framework, those in the legal community should consider two improvements. First, the standard data privacy label as it appears on websites should allow employees to click directly on the provisions to opt out of each kind of disclosure. The employees should receive an internet address along with the wearable that points them to an accompanying website. This site should describe the ways in which the data collected from the wearables should be used, abbreviated in the form of a label such as that shown above, and facilitate the opt-out process for each type of use. The labels' original architects envisioned this kind of opt-out provision but could not implement it when it was introduced due to a lack of standards for opt-out mechanisms.¹⁹⁶

Second, a graphic version of this label should appear on the external packaging of all wearable fitness devices, just as nutrition labels must appear on the outside of packaged food sold in the United States. In a survey of twenty popular IoT consumer devices, not one of them included privacy indicia on the box.¹⁹⁷ The provision of an external, easy to read label, accessible to the consumer before the purchase, will help inform and improve purchasing decisions about products that can collect and share health data.

3. *The Benefits of Mandatory Privacy Labels Will Outweigh the Costs*

Professor Peppet suggests that regulators "seek industry consensus on best practices for where and when to give consumers notice about privacy and data issues."¹⁹⁸ He proposes a number of different measures that firms should commit to, including how to notify consumers about potential uses of their personal data, the location and capabilities of any sensors embedded within connected devices,

195 Other privacy label ideas have been proposed as well, such as Aza Raskin's development of a set of privacy icons at Mozilla. See, e.g., Aza Raskin, *Privacy Icons: Alpha Release* (Dec. 27, 2010), www.azaraskin.com/blog/post/privacy-icons.

196 Lorrie Faith Cranor, *Necessary but Not Sufficient: Standardized Mechanisms for Privacy Notice and Choice*, 10 J. TELECOMM & HIGH TECH L. 273, 289-90 (2012).

197 See Peppet, *supra* note 3, at 141. In fact, none of the surveyed devices made reference to a privacy policy on an associated website anywhere in the packaging materials or user guides. *Id.*

198 *Id.* at 163.

the data such sensors collect, and the length of time such data will be stored.¹⁹⁹ His recommendations, however, turn on the presumption that firms should be encouraged rather than required to adopt the policies he describes.²⁰⁰

I respectfully disagree with Professor Peppet's suggestion that firms can or should regulate themselves by developing standard policies. Other scholars have noted that industry is unlikely to develop more effective privacy notice and choice policies unless there is an incentive to do so.²⁰¹ The FTC itself has questioned the effectiveness of encouraging the industry collecting and using health data to self-regulate, noting in 2010 that "industry efforts to address privacy through self-regulation 'have been too slow, and up to now have failed to provide adequate and meaningful protection.'"²⁰² Lorrie Cranor notes that the state of privacy protections in 2012 closely resembled the state of such protections in 1996 when commentators first launched efforts to standardize website privacy practices.²⁰³ According to Professor Cranor, "The experience over the past fifteen years demonstrates that privacy user empowerment tools and notice and choice mechanisms are insufficient to protect privacy . . . [E]nforcement mechanisms are needed to ensure that users' choices are respected."²⁰⁴ Corey Ciocchetti has proposed such an enforcement mechanism in the form of federal legislation that would require collectors of personally identifiable information to provide "specific notice of intended third party recipients and their proposed uses prior to disclosure" as well as a private right of action.²⁰⁵

Suggesting new legislative remedies in scholarly articles is often seen as too cumbersome to be realistic. In this case, however, a legislative remedy may be the only realistic way to improve the protection of health-related data in the

199 *Id.* at 163-64.

200 *See id.* at 162-63 ("I would urge regulators and privacy advocates to encourage Internet of Things firms to adopt a simple principle: . . . These basic reforms to Internet of Things privacy policies are meant to begin a conversation between regulators, consumer advocates, privacy scholars, and corporate counsel. . . . [T]his conversation will take time and consensus building between regulators and market players.").

201 *See* Cranor, *supra* note 196, at 295; *see also* Cranor et al., *supra* note 192, at 788-89 (noting that incentive problems hampered the adoption of Platform for Privacy Preferences despite apparent industry consensus).

202 Press Release, Fed. Trade Comm'n, FTC Staff Issues Privacy Report, Offers Framework for Consumers, Businesses, and Policymakers (Dec. 1, 2010), <https://www.ftc.gov/news-events/press-releases/2010/12/ftc-staff-issues-privacy-report-offers-framework-consumers>.

203 *See* Cranor, *supra* note 196, at 275-76.

204 *Id.* at 304-05.

205 Ciocchetti, *supra* note 192, at 343; *see also* ROBERT SLOAN & RICHARD WARNER, UNAUTHORIZED ACCESS: THE CRISIS IN ONLINE PRIVACY AND SECURITY 99-101 (2013) (discussing how informational norms could govern online business in greater detail).

employment context. Voluntary programs to develop data privacy disclosures have done little to improve consumer or employee protection. Recommendations that rely on industry to make it easier for consumers to limit the data that industry potentially can sell have, perhaps unsurprisingly, failed repeatedly over the last two decades. As Lauren Henry Scholz observed:

The data-gathering company has an incentive to conceal or deemphasize its personal information collection practices, which otherwise may discourage consumers from providing personal data. Typically, consumers cannot differentiate between a product or business practice that has strong data security and privacy provisions from one lacking such provisions. Consumers who desire greater privacy protections thus will be unable to select and pay more for a product that is better in that respect. Therefore, market actors do not have an incentive to provide such products.²⁰⁶

Another benefit of legislation is the corresponding enforcement power. Enforcement presumably would address not only the provision of privacy labels but their accuracy as well. There is reason to suspect that app developers and website providers might misrepresent their practices absent such enforcement. Scholars found that websites voluntarily posting privacy policies in order to comply with an earlier web standard, Platform for Privacy Preferences, frequently misrepresented their privacy policies in order to get more favorable placement within the web browser Internet Explorer.²⁰⁷ While consumers could also sue providers for fraud, the potential costs of doing so and problems of quantifying injury from invasions of privacy may deter that kind of litigation.²⁰⁸ Developing a labeling requirement like this will pose challenges. None of these challenges outweigh the significant benefits that a privacy labeling program would provide.

One problem in implementing this type of privacy label program is that there is already a competing—although not mandatory—privacy labeling regime. The Office of the National Coordinator for Health Information Technology has

206 Lauren Henry Scholz, *Institutionally Appropriate Approaches to Privacy: Striking a Balance between Judicial and Administrative Enforcement of Privacy Law*, 51 HARV. J. ON LEGIS. 193, 195 (2014).

207 Pedro Giovanni et al., *Token Attempt: The Misrepresentation of Website Privacy Policies Through the Misuse of P3P Compact Policy Tokens*, CYLAB (2010), www.cylab.cmu.edu/files/pdfs/tech_reports/CMUCyLab10014.pdf.

208 In December 2011, a judge dismissed a class action against Amazon for misrepresenting privacy policies because the plaintiffs failed to allege the minimum financial harm required with sufficient specificity. See Order Granting Defendant's Motion to Dismiss, *Del Vecchio v. Amazon.com, Inc.*, No. C11-366-RSL (W.D. Wash. June 1, 2012); Venkat Balasubramani, *The Cookie Crumbles for Amazon Privacy Plaintiffs*, TECH. & MARKETING L. BLOG (Dec. 2, 2011), http://blog.ericgoldman.org/archives/2011/12/the_cookie_crum.htm.

established a Personal Health Record (PHR) Model Privacy Notice. Its goal is to provide a template that a “web-based PHR company can use to succinctly inform consumers about its privacy and security policies.”²⁰⁹ By its terms, the PHR Model Privacy Notice is not required of companies that collect health data online, although it was apparently inspired by mandatory labeling regimes.²¹⁰ Like the CUPS label, the PHR Model Privacy Notice “is meant to be similar to other consumer-oriented ‘labels’ that have been developed for other industries, such as the nutrition facts label for food and the Model Privacy Notice developed for the financial services industry for compliance with the Gramm-Leach-Bliley Act.”²¹¹

A second challenge of such a regime is that the additional labeling may add cost, which ultimately will be passed on to the purchaser. The cost of changing product packaging to include standardized packaging labels is likely to be minimal, however, especially relative to the cost of consumer electronics. Since every product will bear the same cost, no provider will be at a competitive advantage or disadvantage vis-à-vis these costs. Finally, research has shown that consumers are willing to pay a bit more to buy goods from more secure sites when they were given information about how the sites shared their data.²¹²

Reaching consensus on a privacy labeling regime may be difficult. Several federal agencies are likely to play some role in developing such a regime, which therefore will require inter-agency collaboration. There is precedent, however, for multiple government agencies working together to develop a comparable labeling requirement. Eight government entities collaborated and jointly announced the final Model Privacy Notice required by the Gramm-Leach-Bliley Act. The Act requires financial organizations to send this notice to their customers.²¹³ The eight entities were required to work jointly on the model notice

209 *Personal Health Record (PHR) Model Privacy Notice*, HEALTH IT, <http://www.healthit.gov/policy-researchers-implementers/personal-health-record-phr-model-privacy-notice> (last visited Dec. 1, 2015).

210 Office of the Nat’l Coordinator for Health Info. Tech., *About the PHR Model Privacy Notice: Background, Development Process and Key Points*, HEALTH IT 2 (2011), <http://www.healthit.gov/sites/default/files/phr-model-privacy-notice-backgrounder-final.pdf> (“Like the FDA nutrition facts label, the Model Notice is intended to enable companies to present complex information in a manner that is accessible, consistent, and conducive to informed choice. Unlike the FDA nutrition facts label, use of the Model Notice is voluntary.”).

211 *Id.*

212 See Cranor, *supra* note 196, at 292-93.

213 These were the Federal Reserve Board, the Office of Comptroller of the Currency, the Federal Deposit Insurance Corporation, the Office of Thrift Supervision, the National Credit Union Administration, the Federal Trade Commission, the Securities and Exchange Commission, and the Commodity Futures Trading Commission. See 79 Fed. Reg. 64,057 (Oct. 28, 2014) (to be codified at 12 C.F.R. pt. 300).

by Section 728 of the Financial Services Regulatory Relief Act of 2006.²¹⁴

If those entities can work together to develop a model notice (which took the form of a table), then there is reason to believe that the FTC, the Federal Communications Commission (FCC), the FDA, and other interested agencies should reasonably be able to cooperate on a model health data privacy label. The FTC's leadership on this issue may also facilitate interagency cooperation. While other agencies have an interest in the development of privacy labels and should be consulted, the FTC has the clearest mandate both to lead the regulation and to enforce it.

A final shortcoming of this solution is that it does little to address the concerns of employees who are required to wear health and fitness sensors, and therefore have limited choice in the devices they use. If employers choose the devices for their employees, through corporate programs like Fitbit Wellness or Jawbone's UP for Groups, such a privacy regime may be even less protective. Improving the information available to employees about the monitoring systems used, however, will make these practices more transparent.

B. Extend HIPAA's Definition of Covered Entities to Include Employers, App Developers and Wearable Device Manufacturers

My second recommendation would restrict employers' use of health and fitness data more than federal laws currently do. While I believe that a legislative solution is necessary for reasons described below, this Article does not propose entirely new legislation to curtail the use of these data. A regulatory structure is already in place for the protection of health-related data in the form of HIPAA. As discussed above, the current definition of "covered entities" under HIPAA excludes device manufacturers and app developers. Including these entities in a revised definition of "covered entities" would extend protection against the misuse of employees' health-related data. Similarly, expanding the definition of "[i]ndividually identifiable health information" to data generated by mobile health and fitness sensors, including those built into mobile phones and smart watches as well as dedicated fitness devices, would bring more of these data within the scope of HIPAA protection.

Much of the administrative detail that would be needed to protect employee health and fitness data also exists in HIPAA. The Security Rule, for example, specifies steps that covered entities must take to ensure the confidentiality and integrity of electronic personal health information.²¹⁵ It also protects against the

²¹⁴ Financial Services Regulatory Relief Act of 2006, Pub. L. No. 109-351, 120 Stat. 1966.

²¹⁵ HIPAA Security Rule, 45 C.F.R. pts. 160, 164(A), 164(C) (2003).

uses and disclosure of such information.²¹⁶ In fact, the HIPAA Security Rule is one of the most detailed and prescriptive of all U.S. information security laws.²¹⁷ The Health Information Technology for Economic and Clinical Health (HITECH) rules that amend existing HIPAA obligations provide sufficient coverage to extend the protection of data to entities that work with employers, for example, by collecting or interpreting employee health data for those employers. Under the HITECH rules, such entities may be considered Business Associates and therefore be subject to certain restrictions on the use and transfer of personal data.²¹⁸

Finally, Congress should amend HIPAA to provide a private right of action. As one scholar has pointed out, such a provision would be similar to, and no less justified than, the private right of action Congress included in the Fair Credit Reporting Act for negligent disclosures by credit agencies.²¹⁹

C. Securing Employee Health Data Requires Additional Study and Discussion

Neither of the two solutions proposed here is sufficient—alone or taken together—to completely protect personal health-related data from potential employer misuse. These suggestions will not resolve all of the legal and ethical problems concerning employers’ acquisition of employees’ health and fitness data described in this Article. For example, if the FTC were to require privacy nutrition labels like the ones suggested here, there presumably would be no private right of action. Employees whose health and fitness data were shared in a manner inconsistent with the privacy product labeling could not seek redress directly from the manufacturer or developer, but would instead have to rely on the FTC to enforce its directives. Since the FTC retains enforcement discretion, an employee may not have a remedy against the manufacturer or employer. In addition, neither solution resolves the underlying problem of potential vagueness as to what constitutes protectable information.

The legality of health data privacy at work should also be part of a larger discussion about the modern value of privacy in general. As Kate Murphy wrote in a widely shared *New York Times* essay, people both value privacy and cannot

216 HIPAA Privacy Rule, 45 C.F.R. pts. 160, 164(A), 164(E) (2003).

217 *Getting the Deal Through: Data Protection and Privacy in 26 Jurisdictions Worldwide* 2014, HUNTON & WILLIAMS LLP (2014), http://www.hunton.com/files/Publication/1f767bed-fe08-42bf-94e0-0bd03bf8b74b/Presentation/PublicationAttachment/b167028d-1065-4899-87a9-125700da0133/United_States_GTDT_Data_Protection_and_Privacy_2014.pdf.

218 78 Fed. Reg. 5566 (Jan. 25, 2013) (to be codified at 45 C.F.R. pts. 160 & 164).

219 Fair Credit Reporting Act, Pub. L. No. 91-508, 84 Stat. 1114 (1971) (codified as amended in scattered sections of 12 and 15 U.S.C. (2012)); Zivanovic, *supra* note 3, at 199.

seem to stop sharing information.²²⁰ As Murphy noted, a three-year German study showed a privacy paradox in that the more people disclose about themselves, at least on social media, the more privacy they desire.²²¹ While there may be a benefit to measuring the biometric data of workers, employers risk sacrificing the quality of their work. According to Murphy,

Privacy research in both online and offline environments has shown that just the perception, let alone the reality, of being watched results in feelings of low self-esteem, depression and anxiety. Whether observed by a supervisor at work or Facebook friends, people are inclined to conform and demonstrate less individuality and creativity. Their performance of tasks suffers and they have elevated pulse rates and levels of stress hormones.²²²

These studies have another implication that employers should value. They suggest that performance suffers when employees experience a loss of privacy. Of course, employers need to monitor their employees to a certain extent as they have always done. What this research suggests, however, is that an increase in biometric and health data collection may correlate with a decrease in work performance quality.

CONCLUSION

Health data collected from wearable technology may affect employment decisions and status in ways that U.S. law has never before permitted. Business analysts predict that the amount of employee-generated health and fitness data will rise exponentially over the next several years. At the same time, employers' ability to collect, analyze and act on these data are essentially unfettered by law. Employers have every incentive to use these data for a variety of purposes. Many of them are finding new ways to do so now, aided by insurers and data providers. Employees have little legal protection from employment practices that hinge on access to their health and fitness data. While the use of these data may be risky for the monitored employees, there may be no federal basis of liability for employers for any consequent harm. Employees therefore face a growing risk, with no clear legal remedy.

While the legal risks associated with employer use and collection of employee health and fitness data are starting to attract scholarly attention, better solutions are needed. In this Article, I have proposed two specific solutions that

220 See Murphy, *supra* note 96.

221 PRIVACY ONLINE: PERSPECTIVES ON PRIVACY AND SELF-DISCLOSURE IN THE SOCIAL WEB (Sabine Trepte & Leonard Reinecke, eds. 2011), <http://www.springer.com/computer/general+issues/book/978-3-642-21520-9>.

222 Murphy, *supra* note 96.

would offer monitored employees more notice, choice and remedy regarding these practices. A mandatory privacy labeling law for fitness devices and health-related apps would help employees to better understand the health data that employers can access from their use. Extending the terms of HIPAA to cover employers as well as medical professionals and health and fitness data generated from popular mobile sensors as well as more traditional medical records, would align expectations of health privacy with a legal right to that privacy. While neither solution is perfect, they provide a basis for further discussion of the best ways to address this growing problem.

Health and Taxes: Hospitals, Community Health and the IRS

Mary Crossley*

Abstract:

The Affordable Care Act created new conditions of federal tax exemption for nonprofit hospitals, including a requirement that hospitals conduct a community health needs assessment (CHNA) every three years to identify significant health needs in their communities and then develop and implement a strategy responding to those needs. As a result, hospitals must now do more than provide charity care to their patients in exchange for the benefits of tax exemption. The CHNA requirement has the potential both to prompt a radical change in hospitals' relationship to their communities and to enlist hospitals as meaningful contributors to community health improvement initiatives. Final regulations issued in December 2014 clarify hospitals' obligations under the CHNA requirement, but could do more to facilitate hospitals' engagement in collaborative community health projects. The Internal Revenue Service (IRS) has a rich opportunity, while hospitals are still learning to conduct CHNAs, to develop guidance establishing clear but flexible expectations for how providers should assess and address community needs. This Article urges the IRS to seize that opportunity by refining its regulatory framework for the CHNA requirement. Specifically, the IRS should more robustly promote transparency, accountability, community engagement, and collaboration while simultaneously leaving hospitals a good degree of flexibility. By promoting alignment between hospitals' regulatory compliance activities and broader community health improvement initiatives, the IRS could play a meaningful role in efforts to reorient our system towards promoting health and not simply treating illness.

* Professor, University of Pittsburgh School of Law. This Article originated in a project completed for the San Francisco Department of Public Health, supported by the Robert Wood Johnson Foundation through its Public Health Law Scholar-in-Residence Program. I thank Peter Jacobson, Wendy Parnet, Sara Rosenbaum, and Lu-in Wang for their helpful comments. My thanks also go to Stephen Matvey and Jessica Ton for their research assistance. All errors are my own.

TABLE OF CONTENTS

TABLE OF CONTENTS..... 52

INTRODUCTION 54

I. HOSPITAL TAX EXEMPTION AND COMMUNITY OBLIGATION..... 60

 A. THE HOLLOW COMMUNITY BENEFIT STANDARD..... 61

 B. SCHEDULE H: WHAT DATA REVEALS ABOUT COMMUNITY BENEFIT..... 62

 C. THE ACA CHANGES HOSPITALS’ OBLIGATIONS 65

II. A REGULATORY FRAMEWORK FOR IMPROVING COMMUNITY HEALTH.. 66

 A. WHAT “COMMUNITY?” 67

 B. WHICH NEEDS? 68

 C. WHOSE INPUT? 70

 1. OPPORTUNITIES FOR COLLABORATION 71

 D. TRANSPARENCY AND ACCOUNTABILITY 72

 E. A LINGERING QUESTION: COMMUNITY BENEFIT AND COMMUNITY HEALTH NEEDS 73

 1. DOES § 501(R) COMPLIANCE FULLY SATISFY THE COMMUNITY BENEFIT STANDARD? 73

 2. WHEN WILL “COMMUNITY BUILDING ACTIVITIES” COUNT AS COMMUNITY BENEFIT?..... 75

III. HOSPITALS AND POPULATION HEALTH: EMBRACING CONVERGENCE?. 76

 A. ALIGNMENT WITH THE ACA’S BROAD GOALS..... 76

 B. CONVERGENCE AND ALIGNMENT WITH PUBLIC HEALTH OBJECTIVES 77

 C. BARRIERS TO ALIGNMENT 79

 D. HOSPITALS’ REACTION AND ITS IMPORTANCE 80

 E. HOSPITALS’ ATTENTION TO POPULATION HEALTH 83

 1. ADVICE FROM THE AMERICAN HOSPITAL ASSOCIATION 83

 2. HOSPITALS PURSUING POPULATION HEALTH: SOME EXAMPLES..... 85

IV. THE OPPORTUNITY GOING FORWARD..... 89

 A. THE IRS AS HEALTH POLICY MAKER 89

 B. FOUR VALUES TO PROMOTE 92

1. TRANSPARENCY 92

2. ACCOUNTABILITY 96

3. COMMUNITY ENGAGEMENT 100

4. COLLABORATION: WHERE IT ALL COMES TOGETHER 103

C. FROM WHAT TO HOW 107

CONCLUSION 109

INTRODUCTION

Nothing is certain except death and taxes, it has been said, an adage suggesting that the Grim Reaper and the Internal Revenue Service (IRS) are similarly inevitable and dreadful. A provision of the Affordable Care Act¹ (ACA), however, gives the IRS an opportunity to adopt health—rather than death—as its new sidekick. Specifically, the health reform law charges the IRS with implementing a provision requiring tax-exempt hospitals to assess the health needs of the communities they serve and to respond to the needs they find. How the IRS interprets and implements this statutory requirement will influence whether the steps hospitals take to satisfy this new condition of federal tax exemption contribute to improving the health of their communities, or whether hospitals' compliance efforts do little more than consume significant time and resources simply to preserve a tax advantage.

Nearly five years after the ACA's passage, the IRS promulgated final regulations on the Community Health Needs Assessment (CHNA) requirement on December 29, 2014.² These regulations make important strides in guiding hospitals towards meaningful contributions to community health, but leave some questions unanswered. This Article will examine the CHNA requirement as the latest chapter in an ongoing saga regarding hospital tax-exemption standards and recommend values the IRS should focus on as it continues to guide hospitals. By promoting transparency, accountability, community engagement, and collaboration in its implementation of the CHNA requirement, the IRS should encourage hospitals to play a more meaningful role in improving the health of communities nationwide.

On one hand, the story of hospital tax exemption presents a cautionary tale for policymakers and fiscal monitors. The annual value of federal tax exemption for hospitals was estimated at over six billion dollars more than a decade ago,³ and a recent estimate placed the value of the federal exemption at thirteen billion dollars.⁴ It remains unclear exactly what public benefit justifies forgoing such

1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter ACA], *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

2 Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602).

3 CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 5 (2006) [hereinafter CBO REPORT], www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf.

4 Sara Rosenbaum et al., *The Value of the Nonprofit Hospital Tax Exemption Was \$24.6 Billion in 2011*, 34 HEALTH AFF. 1225, 1228 (2015) (reporting \$24.6 billion as the combined value of federal state and local tax exemptions).

significant tax revenue from hospitals, some (but not all) of which enjoy hefty operating incomes and margins.⁵ On the other hand, exempting from taxation institutions that play a meaningful role in meeting community needs may be a sound investment, especially when some (but not all) hospitals face financial stresses resulting in part from an increasingly competitive health services sector⁶ and hospitals' location in underserved communities. Available data support each of these perspectives, but the paucity of data regarding hospital behavior and public benefit itself has figured centrally in the debate over hospital tax exemption.⁷

Although the IRS has used a "community benefit" standard for hospital tax exemption for nearly fifty years, it has not employed quantitative measures or concrete directives to establish benchmarks for exemption.⁸ In that time period, IRS revocations of hospitals' exempt status for failure to provide community benefit were virtually unheard of.⁹ Debates over hospital tax exemption have erupted periodically, but only in the past decade has the IRS begun to require more specific reports from hospitals on what community benefit they actually provide.¹⁰ The picture emerging from these reports confirmed the conventional

5 See, e.g., Kris B. Mamula, *UPMC Increases Revenue, Margin in Tough Environment*, PITT. BUS. J. (Aug. 21, 2014), <http://www.bizjournals.com/pittsburgh/news/2014/08/21/upmc-increases-revenue-margin-in-tough-environment.html> (reporting a \$190 million operating income for the University of Pittsburgh's health system).

6 See Alexa Ura, *Texas Hospitals Say They've Lost Insured Patients to Urgent Care*, N.Y. TIMES (Aug. 28, 2014), <http://www.nytimes.com/2014/08/29/us/texas-hospitals-say-theyve-lost-insured-patients-to-urgent-care.html>.

7 Cf. Susannah Camic Tahk, *Tax-Exempt Hospitals and Their Communities*, 6 COLUM. J. TAX L. 33, 35 (2014) (characterizing the tax-exempt hospital sector as a "virtual black box").

8 See *infra* Section II.A.

9 Cf. Mark C. Westenberger, *Tax-Exempt Hospitals and the Community Benefit Standard: A Flawed Standard and a Way Forward*, 17 FLA. TAX REV. 407, 409 (2015) (characterizing the community benefit standard as "effectively creat[ing] a per se exemption for all nonprofit hospitals"). Some states, by contrast, have been more vigorous in enforcing their own tax exemption standards for hospitals. Illinois, in particular, has actively sought to revoke exemptions of hospitals that it asserted were not providing sufficient charity care. See Bruce Japsen, *Tax Man Cometh for Hospitals That Flout Charity Care Mission*, FORBES (Apr. 20, 2012), <http://www.forbes.com/sites/brucejapsen/2012/04/30/tax-man-cometh-for-hospitals-that-flout-charity-care-mission>.

10 Internal Revenue Serv., Dep't of the Treasury, OMB No. 1545-0047, Schedule H (Form 990), Hospitals (2010) [hereinafter Schedule H], <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>. According to 2013 data provided by the American Hospital Association, 58% of community hospitals have not-for-profit corporate status. See *Fast Facts on U.S. Hospitals*, AM. HOSP. ASS'N, <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml> (last visited Dec. 2, 2015) (also reporting that for-profit hospitals account for 21% and state or local government owned hospitals account for 20% of the total). It is these nonprofit hospitals that can achieve tax-exempt status under § 501(c)(3) of the I.R.C. and are thus subject to the

wisdom in health policy circles: nonprofit hospitals' reported community benefit expenditures most often involved charity care, i.e., care for patients unable to pay in full for the hospitals' services, or offsets for claimed losses from treating Medicaid patients.¹¹ Thus, hospitals' actions to satisfy the *community* benefit standard most often benefited individual members of the public, and the benefit to the *community* lay in the aggregation of those individual benefits.

The ACA changed the tax-exemption landscape for hospitals, imposing additional conditions of tax-exempt status specific to hospitals. Some affect how hospitals interact with individual patients who may be unable to pay for services, but one directs hospitals to pay attention to the health needs of their communities. The new § 501(r) of the Internal Revenue Code (I.R.C.) requires tax-exempt hospitals to conduct a CHNA at least once every three years, to make a report of that assessment publicly available, and to adopt a plan for responding to the needs identified.¹² Community health assessments are standard fare for health departments. A CHNA typically involves the collection and analysis of quantitative and qualitative data in order to understand the health issues a specific community faces and to inform strategies for addressing those issues.¹³ Most hospitals in the United States had probably never conducted a CHNA prior to the ACA's requirement.¹⁴ Thus, these hospitals face a new and largely unfamiliar condition for federal tax exemption.

One might view the new CHNA requirement as simply an attempt to ensure that hospitals provide some real community benefit as the *quid pro quo* for the tax benefits they receive. Indeed, conducting a CHNA and reporting on it do

community benefit requirement and to the new requirements under § 501(r).

11 See Rosenbaum et al., *supra* note 4, at 1226; Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519 (2013); *infra* Section I.B for further discussion.

12 26 U.S.C. § 501(r)(3) (2012).

13 See *Acronyms and Glossary of Terms Version 1.0*, PUB. HEALTH ACCREDITATION BD. 8 (2011), <http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf> (defining community health assessment as “a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community’s health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation”).

14 Prior to the ACA, eleven states required some form of community health assessment as a condition of state hospital tax exemption. Gayle D. Nelson et al., *Hospital Community Benefits After the ACA: Policy Implications of the State Law Landscape*, HILLTOP INST. (2013), <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-PolicyImplicationsIssueBrief7-Sept2013.pdf>.

demand tangible new actions from hospitals. The CHNA requirement, however, has the potential to prompt a more radical change in hospitals' role in promoting health and in their relationship to their communities. The requirement encourages hospitals to become involved in not only the treatment, but also the prevention of ill health. It directs a hospital to shift its gaze outward, to engage with its surrounding community, and to consider how the hospital might play a role in meeting the health needs of that community—that *group* of people—and not simply the medical needs of individual community residents. In so doing, the CHNA requirement is part of a broader emphasis on public health and prevention in the ACA¹⁵ that, however modestly, moves the U.S. healthcare system and public health system toward integration.¹⁶

Will the CHNA requirement succeed in prompting meaningful hospital engagement with and response to communities' needs? For some hospitals, "community outreach" has been a euphemism for marketing hospital services to prospective patients.¹⁷ Expecting them to play a role in getting and keeping community members healthy—and out of the hospital—is truly asking something new of most hospitals. Some commentators celebrate the CHNA requirement as a golden opportunity to include hospitals in community partnerships seeking to address health needs ranging from improving access to screenings or prenatal care, to addressing social determinants of health and health disparities. Under this conception, the CHNA requirement thus becomes a key way to involve hospitals in prevention-oriented strategies for containing health spending nationally.¹⁸ Others are skeptical.¹⁹ As long as hospitals' own financial health depends on

15 While the ACA is best known for its steps to achieve near-universal insurance coverage for Americans, the mammoth health reform bill also included numerous provisions seeking to shift more public and private resources towards promoting wellness, rather than simply responding to illness. See *infra* text accompanying note 106. This shift in emphasis embodies the "Triple Aim" model of health policy, which includes "population health" as one of its three aims. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 764 (2008).

16 See Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health To Advance the Population's Wellbeing*, 159 U. PA. L. REV. 1777 (2011); see also Stephen M. Shortell, *Bridging the Divide Between Health and Health Care*, 309 JAMA 1121, 1121 (2013) ("[C]onsensus is developing that truly controlling health care costs and improving the overall health of the American people will require a much closer partnership, permeable boundaries, and increased interdependence among the health care delivery system, the public health sector, and the community development and social service sectors."); cf. David A. Asch & Kevin G. Volpp, *What Business Are We in? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012) ("Whereas doctors and hospitals focus on producing health care, what people really want is health.").

17 See *infra* note 194 and accompanying text.

18 See *infra* Section IV.B.

19 See Zachary J. Buxton, *Community Benefit 501(R)edux: An Analysis of the Patient Protection and Affordable Care Act's Limitations Under Community Benefit Reform*, 7 ST.

treating patients *in* the hospital, they reason, rarely enforced tax-exemption standards will produce little meaningful change in hospitals' behavior.

This Article proceeds from the premise that increasing hospitals' participation in collaborative efforts to improve community health could help address the persistent health issues and disparities plaguing many communities.²⁰ Increasingly, leaders in both medicine and public health are recognizing the importance of connecting clinical care providers to population health approaches as a strategy for controlling costs while improving health outcomes.²¹ Whether the new CHNA requirement will cause hospitals to engage meaningfully in community health projects will depend on many factors, including how reimbursement reforms and other non-tax-related incentives shape hospital behavior,²² as well as how the IRS interprets, implements, and enforces the ACA's requirement. This Article examines how the IRS could use its regulatory authority to encourage hospitals to play significant roles in community health transformation efforts, thus aligning their vision and energy with that of community partners.

One thing is certain: the CHNA requirement has captured hospitals' attention. Some hospitals have tapped into expertise from consultants and public health academics for help in conducting their first CHNA, while others have muddled through the requirements on their own. Public health researchers are studying all those efforts and considering how hospitals' community health assessments and partnerships might be made more efficient and effective.²³ The IRS has a rich opportunity, while hospitals are on this learning curve and before they develop entrenched practices, to develop guidance establishing clear but flexible expectations for how hospitals should assess and address community needs.

LOUIS. U. J. HEALTH L. & POL'Y 449, 450 (2014) (characterizing the ACA's new requirements for tax-exempt hospitals as "nothing more than superficial misdirection from community benefit's existing issues" and the CHNA requirement as "wholly unworkable in practice"); *see also infra* Section IV.C (addressing potential barriers to hospital and public health collaborations).

20 This premise currently lacks solid empirical evidence and thus is debatable, but on balance it seems sensible. *See infra* Section IV.B (discussing the value of hospitals' participation in community health improvement projects).

21 *See, e.g.,* Thomas D. Sequist & Elsie M. Taveras, *Clinic-Community Linkages for High-Value Care*, 371 NEW ENG. J. MED. 2148, 2148 (2014) ("One essential strategy for improving population health is linking the delivery system, the community, and the patient in an integrated effort.").

22 For example, hospitals that are required to provide a certain quantity of charity care as a condition of state and local tax exemption may be disinclined to make significant additional investments in community health initiatives.

23 *See infra* text accompanying notes 167-171.

This Article urges the IRS to seize that opportunity by refining its regulatory framework for the CHNA requirement in order to more robustly promote transparency, accountability, community engagement, and collaboration,²⁴ while simultaneously leaving hospitals some degree of flexibility. The IRS must push hospitals to expand their sense of responsibility to their communities, without unduly burdening them. Hospitals can make distinctive contributions to community health initiatives even as their core activity remains caring for patients. Spurring hospitals' active participation in community health improvement via regulatory guidance will not be simple, but the prize for success may be significant. In addition to advancing the health of communities, independent value may lie in getting hospitals "on board" as members of the team tackling community health problems. Accomplishing this would be a significant step toward a convergence of the healthcare and public health systems, seen by a growing number of policymakers and academics as a key to improving health outcomes in the United States.²⁵

Part I briefly describes the historical evolution of standards for hospital tax exemption, while examining growing dissatisfaction with the community benefit standard and the ACA's inclusion of new requirements for tax-exempt hospitals. Part II describes the final IRS regulations issued in December 2014 and assesses how they measure up in terms of promoting transparency, accountability, community engagement, and collaboration. Part III shows how the CHNA requirement presents an opening to boost hospital participation in collaborative community health initiatives and describes how some hospitals are already shifting their attention to community health needs and pursuing innovative approaches to address those needs. Part IV discusses how the IRS could encourage hospitals to reorient their community benefit investments and participate in collaborative efforts to effect community health improvement. By using its regulatory authority to promote alignment between hospitals' regulatory compliance activities and coinciding community health improvement initiatives, the IRS could itself play a meaningful role in the broader effort to reorient our system towards promoting health and not simply treating illness.

24 Other commentators have identified similar lists of values for guiding hospitals' involvement in community health efforts. See, e.g., Sara Rosenbaum, *Principles To Consider for the Implementation of a Community Health Needs Assessment Process*, GEO. WASH. U. SCH. PUB. HEALTH & HEALTH SERVS. (2013), http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf; Stephen M. Shortell et al., *The Contribution of Hospitals and Health Care Systems to Community Health*, 30 ANN. REV. PUB. HEALTH 373, 380-81 (2009).

25 See Thomas R. Friedan, *The Future of Public Health*, 373 NEW ENG. J. MED. 1748, 1753 (2015) (stating, as Director of the Centers for Disease Control and Prevention, that "[b]y working more closely together, clinical medicine and public health can help each other improve health maximally"); Gostin et al., *supra* note 16, at 1791-93.

I. HOSPITAL TAX EXEMPTION AND COMMUNITY OBLIGATION

The ACA's requirement that tax-exempt hospitals conduct CHNAs, while novel for most hospitals, supplements the longstanding community benefit standard. Consequently, this Article's discussion of hospitals' new responsibilities requires a basic understanding of how the community benefit standard has evolved.

I.R.C. § 501(c)(3) enables organizations that are "organized and operated exclusively for religious, charitable, scientific . . . or educational purposes" to achieve exemption from federal income tax obligations.²⁶ A substantial majority of U.S. hospitals are tax-exempt under § 501(c)(3),²⁷ and the financial value of tax exemption (in the form of forgone tax payments, the value of tax-exempt bond financing, and the deductibility of contributions) is enormous. The Congressional Budget Office (CBO) estimated that in 2002 the annual value of the federal tax exemption for nonprofit hospitals was \$6.1 billion.²⁸ A more recent estimate, replicating the CBO's methodology, placed the figure at \$13.0 billion.²⁹ Including the value of state and local exemptions as well increases the estimate to \$24.6 billion.³⁰

The question of how hospitals—which typically charge patients (or their insurers) for the care provided and often compete fiercely with their rivals—are understood as having a "charitable" purpose under federal law has evolved over time. Policymakers and scholars have advanced various rationales, including the views that nonprofit hospitals surpass for-profit hospitals in providing collective goods (for example, providing unprofitable services)³¹ and that, by providing charity care, hospitals relieve government of a burden it would otherwise bear.³²

26 26 U.S.C. § 501(c)(3) (2012).

27 U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-880, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 8 (2008) [hereinafter GAO REPORT]. Beyond the exemption from paying corporate income taxes, this status also permits hospitals to accept charitable contributions that are tax deductible by the donor and may qualify them to issue tax-exempt bonds to finance capital projects. *Id.* at 12.

28 See CBO REPORT, *supra* note 3.

29 See Rosenbaum et al., *supra* note 4, at 1227.

30 *Id.* at 1228.

31 CBO REPORT, *supra* note 3, at 4 (suggesting that providing uncompensated care to indigent individuals might also be viewed as a collective good because it may satisfy community members' "compassionate impulses" and prevent the spread of disease); see Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1347 (2003).

32 GAO REPORT, *supra* note 27, at 10 ("This exemption is based on the principle that the government's loss of tax revenue is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds.").

These rationales are often framed in terms of a *quid pro quo*: in exchange for substantial tax relief, hospitals supply something valuable to the government or their community.³³ Others, however, argue the exemption is unjustified, asserting that the government has not reliably extracted from nonprofit hospitals the benefits that could in theory justify exemption.³⁴ Empirical evidence of hospital behavior was for decades quite thin, making it difficult to evaluate the competing claims.

A. *The Hollow Community Benefit Standard*

Changes in the healthcare financing and delivery system since the middle of the twentieth century have shaped the evolution of the standard for hospital tax exemption. In 1956 the IRS announced that, to be considered “charitable,” a hospital must operate “to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.”³⁵ The IRS never quantified what level of charity care this “financial ability” standard demanded, however. The creation of Medicare and Medicaid in 1965 prompted concern that these programs would so diminish the need for charity care that hospitals would no longer be able to maintain their tax-exempt status.³⁶ As a result, in 1969 the IRS established the “community benefit” standard³⁷ to replace the “financial ability” standard. Even if a hospital did not provide significant charity care, the community benefit standard found a charitable purpose in the hospital’s provision of healthcare services that benefited the community generally. A Revenue Ruling setting out five factors³⁸ the IRS considered in granting tax exemption had been (with only minor adjustments³⁹)

33 See Lloyd H. Mayer, *The “Independent” Sector: Fee-for-Service Charity and the Limits of Autonomy*, 65 VAND. L. REV. 49, 64-69 (2012) (discussing and critiquing theories justifying exemption and identifying the important role of public benefit in explaining charities’ exempt status).

34 See M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 352-53 (1995); John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 51 (2005).

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

36 Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL. POL’Y & L. 251 (1991).

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

38 *Id.* These factors include operating an open emergency room, participating in public insurance programs, and having an independent governing board. The 1969 Revenue Ruling also indicates that the IRS will consider all the facts and circumstances regarding each hospital and that neither the absence of a listed factor or the presence of markers of community benefit will necessarily be dispositive.

39 In 1983, the IRS adjusted the standard to provide that the requirement of an open emergency room might not always apply. Rev. Rul. 83-157, 1983-2 C.B. 94.

the sole direction to hospitals regarding their obligations as tax-exempt entities. Practically speaking, the IRS typically did not scrutinize a tax-exempt hospital's ongoing operations to assess, much less quantify, what benefits its community actually received.

Thus, for four decades, the community benefit standard let hospitals enjoy the benefits of federal tax exemption without definite accountability. By the turn of the century, however, some members of Congress and federal regulators began arguing for more rigorous and quantifiable community benefit standards.⁴⁰ Reports from the CBO and the Government Accountability Office (GAO) highlighted the lack of consensus on how to define or measure community benefit⁴¹ and discretion was left to individual hospitals in these matters.⁴² Media exposés in the early 2000s that reported on decidedly uncharitable behavior by tax-exempt hospitals, including charging uninsured patients rates that far exceeded those charged to insured patients and employing heavy-handed debt collection practices against patients unable to pay the hospitals' charges, caught Congress's and the public's attention.⁴³

B. Schedule H: What Data Reveals About Community Benefit

The increased public scrutiny captured the hospital industry's attention. In 2006, the American Hospital Association (AHA) issued guidelines suggesting how hospitals might account for their community benefits by emphasizing the value of charity care and uncompensated care.⁴⁴ The same year, the IRS undertook its "Hospital Compliance Project," sending questionnaires to more than five hundred nonprofit hospitals to learn how they provided a community benefit.⁴⁵ Based on the results, in 2007 the IRS took its first step towards increased accountability and transparency, introducing a mandatory reporting

40 See, e.g., GAO REPORT, *supra* note 27, at 4 (describing Senator Grassley's request for "feedback on whether hospitals should be required to devote a minimum percentage of patient operating expenses or revenues (whichever is greater) to charity care in order to continue to qualify for federal tax exemption").

41 CBO REPORT, *supra* note 3, at 1.

42 GAO REPORT, *supra* note 27, at 7.

43 See Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules from Tax Status*, 53 U. LOUISVILLE L. REV. (forthcoming 2016) (manuscript at 19-20), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2451435 (describing "a flurry of hearings and inquiry in the early-mid 2000s" and "a wave of over sixty class action suits").

44 AHA *Guidance on Reporting of Community Benefit*, AM. HOSP. ASS'N (2006), www.aha.org/content/00-10/061113cbreporting.pdf.

45 IRS *Exempt Organizations Hospital Study Executive Summary of Final Report*, INTERNAL REVENUE SERV. (2009) [hereinafter *IRS Hospital Study*], http://www.irs.gov/pub/irs-tege/execsum_hospprojrept.pdf.

schedule specifically for hospitals (Schedule H) as part of the Form 990 annual informational return for all tax-exempt organizations.

Part I of Schedule H directed hospitals to detail their expenditures for “Financial Assistance and Certain Other Community Benefits” and indicated several categories of relevant expenditures. These categories included financial assistance, unreimbursed costs from means-tested government programs, health professions education, research, cash and in-kind contributions, as well as a category labeled “community health improvement services and community benefit activities.”⁴⁶ Part II directed hospitals to report separately their participation in “community building activities.” Several examples from Schedule H’s list of reportable “community building activities” include “physical improvements and housing,” “economic development,” and “community support.”⁴⁷ As discussed below, by creating separate reporting categories for “community health improvement services” and “community building activities” and designating only the former as a type of community benefit expenditures, the IRS may have sown confusion that now impedes hospitals’ embrace of activities addressing broad social determinants of health.⁴⁸

As the first decade of the twenty-first century drew to a close, the IRS appeared ready to impose some accountability on hospitals. Schedule H’s required accounting for community benefit expenditures supplied a novel opportunity to compare hospitals’ practices on an “apples to apples” basis. However, the first such major comparison published confirmed the conventional wisdom that hospitals sought to satisfy the community benefit standard primarily by providing care to indigent or uninsured patients who could not pay for their care.⁴⁹ A study published in the *New England Journal of Medicine* found that in

46 A worksheet fleshes out this category’s scope. Foreshadowing the ACA’s new requirement, the instructions indicate that these include activities associated with community health needs assessments and activities or programs justified by an established community need. See Schedule H, *supra* note 10, at Worksheet 4.

47 See *id.*

48 For a definition of social determinants of health, see *infra* note 79.

49 See Daniel B. Rubin et al., *Evaluating Hospitals’ Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption*, 103 AM. J. PUB. HEALTH 612, 613 (2013) (“[M]any nonprofit hospital leaders still consider community benefit to be largely synonymous with charity care”); cf. CBO REPORT, *supra* note 3, at 1 (adopting, for purpose of analysis comparing community benefits provided by for-profit and non-profit hospitals, a definition of community benefit that includes “the provision of uncompensated care, the provision of services to Medicaid patients, and the provision of certain specialized services that have been identified as generally unprofitable”); INTERNAL REVENUE SERV., IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT: FINAL REPORT 4 (2009), <https://www.irs.gov/pub/irs-tege/frepthospproj.pdf> (finding that “[u]ncompensated care was the largest reported community benefit expenditure overall and across all demographics” in a recent comprehensive survey).

fiscal year 2009, tax-exempt hospitals spent an average of 7.5% of their operating expenses on community benefits.⁵⁰ Of these expenditures, more than 85% were related to providing care to individual patients. More than half of that category (or 45.3% of hospitals' reported community benefit expenditures) reflected hospitals' costs for treating patients covered by means-tested government programs (mostly Medicaid) to the extent that those costs were not fully covered by government reimbursement. In comparison, charity care accounted for 25.3% of community benefit expenditures, and subsidized health services accounted for 14.7%.⁵¹ By contrast, a mere 5.3% of the hospitals' community benefit expenditures (or 0.4% of total hospital expenditures) went to direct community health improvement projects. An IRS report to Congress in 2015 contained similar breakdowns of the categories of spending, with 32% of community benefit spending in 2011 going to offset losses from government programs, 24% devoted to providing financial assistance to low-income patients, and 4% to community health improvement.⁵²

These figures lend heft to critiques of the effectiveness of the pre-ACA community benefit standard in producing meaningful benefits for communities. A common refrain of skeptics is that any benefits that tax-exempt hospitals provide to their communities and the people in them are small in comparison to the value that hospitals receive from tax exemption. As the types of expenditures that hospitals called "community benefit" expanded, the benefits actually flowing to the community as the *quid pro quo* for tax exemption shrank. For example, in 2013 the AHA published a study of hospital community benefit reporting that referred to both bad debt (uncollectible billings) and the amount by which a hospital's total allowable Medicare costs exceeds its Medicare revenues as community benefit expenditures, even though these expenses are simply costs of doing business for any hospital.⁵³ Recent revelations regarding the apparent

50 See Young et al., *supra* note 11, at 1519.

51 *Id.* at 1523 fig.1. It bears emphasizing that the study found "considerable variation" among hospitals in how much they spent on community benefit, with hospitals in the top spending decile reporting community benefit expenditures equaling 20.1%, on average, of their total expenditures, while hospitals in the bottom decile reported an average of 1.1%. *Id.* at 1522. A subsequent study analyzing data from the Schedule Hs filed by all tax-exempt hospitals in 2012 also found significant variation in the categorization of hospitals' reported expenditures. See Tahk, *supra* note 7. This study compared the expenditures that hospitals reported as "community benefits" on Schedule H with expenditures reported in the section of Schedule H for "community building" activities. It found that hospitals that devote more resources to community benefit as traditionally understood tend to be large hospitals in densely populated communities with many residents living just above the poverty line, while hospitals that spend more on community building tend to be located in communities whose residents are more likely to be privately insured. *Id.* at 36.

52 See Rosenbaum et al., *supra* note 4, at 1226 (describing the IRS's 2015 report).

53 See Sara Rosenbaum, *Hospital Community Benefit Expenditures: Looking Behind the*

arbitrariness of inflated hospital charges⁵⁴ call into question the consistency and legitimacy of how hospitals calculate their Medicaid shortfall, which (unlike bad debt and Medicare shortfall) is a permitted category of community benefit spending on Schedule H. If we also take into account research indicating that the behavior of non-profit hospitals does not differ meaningfully from that of for-profit hospitals in terms of social benefit provided,⁵⁵ skepticism as to whether the community benefit standard for tax exemption has produced real, quantifiable benefits to communities seems well justified.

C. The ACA Changes Hospitals' Obligations

Against this backdrop of mounting criticism of the community benefit standard and more data about hospitals' community benefit accounting, the ACA's enactment in 2010 ushered in significant changes to hospital tax exemption by creating additional conditions for hospitals, codified in a new I.R.C. § 501(r).⁵⁶ This provision of the ACA was pushed by Senator Charles Grassley, a vocal critic of hospitals' lack of accountability for community benefits and the egregious ways some hospitals treated poor patients.⁵⁷ Responding to the latter concern, several new requirements address how hospitals interact with their patients around matters of financial assistance, charges for services, and debt collection.⁵⁸ However, these requirements stop short of requiring hospitals to provide any particular quantum of free care to patients unable to pay.⁵⁹ The ACA's other new requirement takes a different tack, establishing the CHNA requirement as part of the *quid pro quo* for relieving hospitals from their federal tax liability.

Numbers, HEALTH AFF. BLOG (June 11, 2013), <http://healthaffairs.org/blog/2013/06/11/hospital-community-benefit-expenditures-looking-behind-the-numbers>.

⁵⁴ See Steven Brill, *Bitter Pill: How Outrageous Pricing and Egregious Profits Are Destroying Our Health Care*, TIME, Mar. 4, 2013, at 16; Barry Meier et al., *Hospital Billing Varies Wildly, Government Data Shows*, N.Y. TIMES (May 8, 2013), <http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html>.

⁵⁵ See Colombo, *supra* note 34, at 46 ("In general, independent reviews of the existing literature on the behavioral differences of nonprofit and for-profit hospitals find the studies at best inconclusive regarding whether nonprofit hospitals provide more socially-beneficial behavior in the form of better care, cheaper-but-equally-as-good care, or more charity care.").

⁵⁶ 26 U.S.C. § 501(r) (2012).

⁵⁷ See Brown, *supra* note 43, at 20-21.

⁵⁸ See *id.* at 4 (summarizing the new requirements).

⁵⁹ See *id.* at 24 (noting that § 501(r) contains "no specific requirements for the substance of or criteria for financial assistance").

The statute specifies a series of steps for the CHNA requirement. First, a hospital must conduct a CHNA at least once every three years, taking into account “input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”⁶⁰ Once it has completed the CHNA, the hospital must make a report on it “widely available to the public.”⁶¹ The hospital must then adopt an “implementation strategy to meet the community health needs identified through such assessment.”⁶² By establishing this multi-step process, Congress sought to ensure that tax-exempt hospitals in fact take steps to respond to the health needs of their communities. Due to the spare statutory language, the task of filling the many gaps regarding what exactly hospitals must do to meet the new CHNA requirement fell to the Secretary of the Treasury and the IRS.⁶³

II. A REGULATORY FRAMEWORK FOR IMPROVING COMMUNITY HEALTH

Developing regulations to implement the CHNA requirement was a regulatory odyssey stretching over nearly five years. It culminated on December 31, 2014 with the publication of final regulations (the “Regulations”)⁶⁴ that answered, at least partially,⁶⁵ many of the questions regarding hospitals’

60 § 501(r)(3)(B)(i).

61 § 501(r)(3)(B)(ii).

62 § 501(r)(3)(A)(ii).

63 § 501(r)(7).

64 The final regulations followed the publication of proposed regulations regarding hospitals’ CHNA obligation in April 2013, 78 Fed. Reg. 20,523 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53), which followed a Preliminary Guidance issued in July 2011, *Internal Revenue Bulletin: 2011-30, Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals*, INTERNAL REVENUE SERV. (July 25, 2011), http://www.irs.gov/irb/2011-30_IRB/ar08.html. The IRS also separately published proposed regulations regarding § 501(r)’s other requirements regarding financial assistance, billing, and collection policies. *See* Additional Requirements for Charitable Hospitals, 77 Fed. Reg. 38,148 (proposed June 26, 2012) (to be codified at 26 C.F.R. pt. 1). The final Regulations address all of § 501(r)’s requirements for hospitals. *See* Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602).

65 Of particular note in those states that already had some kind of community health assessment requirements for hospitals prior to the ACA’s enactment, the Regulations are silent on one question: will the IRS deem hospitals’ compliance with analogous state law requirements to satisfy the CHNA requirements of the new § 501(r)? If not, those hospitals argue, the duplicative—or, even worse, conflicting—obligations of federal and state law will be unduly burdensome. *See* California Hospital Association, Comment Letter on Proposed Rule Regarding Community Health Needs Assessments for Charitable Hospitals 1 (July 3, 2013), <http://www.regulations.gov/contentStreamer?documentId=IRS-2013-0016-0038&attachmentNumber=1&disposition=attachment&contentType=pdf> (urging the IRS to consider “deemed status for states like California with existing state law”). Similarly, although

CHNA obligations left open by § 501(r). The Regulations address a broad range of questions, including who is subject to the CHNA requirements, deadlines for compliance, and penalties for noncompliance.⁶⁶ As a foundation for understanding the Regulations' implications for hospitals' meaningful participation in community health improvement initiatives, this Part describes how the Regulations address basic aspects of the CHNA requirement, including how hospitals should define the community whose needs are to be assessed and the kinds of needs to be catalogued. It then summarizes aspects of the Regulations relevant to expectations of transparency, accountability, community engagement, and collaboration as hospitals take on an expanded role regarding community health.

A. What "Community?"

Health services research often uses the term "catchment area" to describe a hospital's market area, or the geographic area from which it draws patients.⁶⁷ Because the ACA expects hospitals to enlarge their concern beyond their actual patients, however, defining the "community" whose health needs the hospital must assess is a critically important first step. The Regulations adopt a generally permissive stance on this question, providing that a hospital "may take into account all of the relevant facts and circumstances, including the geographic area served . . . , target population(s) served . . . , and principal functions (for example, focus on a particular specialty area or targeted disease)."⁶⁸ A stricter tone prevails regarding the possibility that a hospital might cherry-pick its community: "[A] hospital may not define its community to exclude medically underserved, low-income, or minority populations who live in geographic areas from which the hospital draws its patients."⁶⁹ The reference to "medically underserved populations" sweeps broadly, including "populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other

Schedule H to Form 990 calls for a hospital to identify any state with which it files a community benefit report, it does not inquire specifically about health needs assessments performed pursuant to state law. Schedule H, *supra* note 10.

66 See 26 C.F.R. § 1.501(r)-3(a), (d) (2015) (establishing the CHNA obligation and exceptions for certain hospital facilities); § 1.501(r)-3(a)(2) (establishing the deadline for adoption of an implementation strategy); § 1.501(r)-2 (establishing consequences for failures to satisfy § 501(r)).

67 See, e.g., Stuart John Gilmour, *Identification of Hospital Catchment Areas Using Clustering: An Example from the NHS*, 45 HEALTH SERV. RES. 497 (2010).

68 § 1.501(r)-3(b)(3).

69 *Id.*

barriers.”⁷⁰ Thus, hospitals enjoy significant flexibility in defining their communities, but cannot exclude the very populations most likely to have significant health needs.⁷¹

Another point on which the Regulations are clear is that the CHNA must be conducted at the individual hospital facility level, even for hospitals that are part of multi-hospital systems.⁷² By contrast, Schedule H requires an organization to consolidate its reporting of community benefit operations.⁷³ Although the Regulations permit multi-facility CHNAs for hospitals that serve the same community, the general requirement that each hospital define its own community (whose needs it must assess and address) may result in investments targeting more specific needs.⁷⁴

B. Which Needs?

Allaying hospitals' concerns that they might be expected to catalog exhaustively every health need existing in their communities, the Regulations clarify that hospitals must identify only the “significant health needs of the community.”⁷⁵ In doing so, a hospital can consider both the needs of its community as a whole and the needs of “particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).” Once a hospital has identified significant health needs, it must prioritize them and “identify resources . . . potentially available to address those health needs.”⁷⁶

But what counts as a “health need,” and what makes it “significant?” On the first question, the final Regulations lay the groundwork for having hospitals “think big” in seeking to address root causes of poor health in their communities.⁷⁷ In response to comments on the proposed regulations, the IRS

70 § 1.501(r)-3(b)(5)(i)(B).

71 *But cf. Supporting Alignment and Accountability in Community Health Improvement: The Development and Piloting of a Regional Data-Sharing System*, PUB. HEALTH INST. (2014) [hereinafter *Supporting Alignment and Accountability in Community Health Improvement*], <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf> (finding that hospitals failed to pay sufficient attention to disparities in their communities).

72 § 1.501(r)-3(a)(1) (establishing the CHNA for hospital facilities).

73 *See Instructions for Schedule H (Form 990)*, INTERNAL REVENUE SERV. (2014), <https://www.irs.gov/pub/irs-pdf/i990sh.pdf>.

74 Professor Sara Rosenbaum suggested this point to me.

75 § 1.501(r)-3(b)(4).

76 *Id.*

77 *See, e.g., Sara Rosenbaum, Additional Requirements for Charitable Hospitals: Final Rules on Community Health Needs Assessments and Financial Assistance*, HEALTH AFF. BLOG (Jan. 23, 2015), <http://www.healthaffairs.org/blog/2015/01/23/Additional-Requirements-For-charitable-Hospitals-Final-Rules-on-community-Health-Needs->

added language embracing a broad understanding of community health needs:

[T]he health needs of a community include requisites for the improvement or maintenance of health status. . . . These needs may include, for example, the need to address financial and other barriers to access care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in a community.⁷⁸

Thus, under the Regulations, social determinants of health—factors like the availability or absence of healthful foods, transportation options, living wages, and safe neighborhoods⁷⁹—are among the health needs that hospitals should consider in their CHNAs.

By contrast, the Regulations provide no guidance on a “significance” threshold, referring simply to “all of the facts and circumstances present in the community.”⁸⁰ In addition, rather than providing advice on how hospitals should prioritize the significant needs they identify, the Regulations only offer suggestions: a hospital “may use any criteria . . . including, but not limited to, the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.”⁸¹

The Regulations commendably embrace a broad understanding of “health needs” by encompassing social determinants of health. However, their extreme deference to a hospital’s judgment in determining significance and prioritization may undercut the population health value of that broad understanding. The Regulations require hospitals to solicit input from community members and public health officials and to report on their process and findings, and this input *should* influence hospitals’ determinations of significance and priorities. Nonetheless, the Regulations’ failure to establish meaningful standards for

Assessments-and-Financial-Assistance (stating that the broad definition is a “strong signal that the CHNA process is about community health”)

78 § 1.501(r)-3(b)(4).

79 See *Determinants of Health*, HEALTHY PEOPLE 2020, <http://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health> (last visited Dec. 2, 2015). The Centers for Disease Control and Prevention lists social environment and physical environment, along with biology and genetics, individual behavior, and health services as primary determinants of health. *Social Determinants of Health*, CTRS. DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html> (last visited Dec. 2, 2015). For scientific research regarding the impact of social determinants, see *SOCIAL DETERMINANTS OF HEALTH* (Michael Marmot & Richard G. Wilkinson eds., 1999).

80 § 1.501(r)-3(b)(4).

81 *Id.*

significance and priorities could permit a hospital to identify as “significant” and to prioritize a health need that, from a public health perspective on community health, may be relatively inconsequential.

C. *Whose Input?*

The Regulations are generally a model of indirection in telling hospitals what steps to take in conducting the assessment. One must infer from the Regulations’ listing of the required elements of a hospital’s CHNA documentation that hospitals should collect and analyze data and other information and have some process and criteria for identifying and prioritizing significant health needs.⁸² Because the CHNA is an established practice in public health and health planning, the IRS may have concluded that prescribing specific steps for the process would be unnecessary and overly constraining for hospitals.⁸³

By contrast, the Regulations’ directions to hospitals on who must have a voice in the process are clear. To further the statutory requirement of community input, the Regulations provide that a hospital must solicit and take into account input from:

- (i) At least one . . . governmental public health department . . . with knowledge, information, or expertise relevant to the health needs of that community;
- (ii) Members of medically underserved, low-income, and minority populations in the community served . . . or individuals or organizations serving or representing [their] interests . . . ; and
- (iii) Written comments received on the [hospital’s] most recently conducted CHNA and most recently adopted implementation strategy.⁸⁴

The hospital must consider this input in identifying and prioritizing the community’s needs, as well as in identifying resources potentially available to meet those needs.⁸⁵ As discussed below,⁸⁶ the expected extent of the

82 § 1.501(r)-3(b)(6).

83 American Hospital Association, Comment Letter on Proposed Rule Regarding Community Health Needs Assessments for Charitable Hospitals 2 (June 27, 2013) [hereinafter *AHA Comments*], <http://www.aha.org/advocacy-issues/letter/2013/130627-aha-cl-irs-treas-reg106499-12.pdf> (“Congress . . . had no need to prescribe how to do a ‘needs assessment’”).

84 § 1.501(r)-3(b)(5)(i).

85 *Id.* The Regulations go on to provide a laundry list of additional sources of input (e.g., consumer advocates, academic experts, and healthcare providers) that the hospital may consider in its assessment). § 1.501(r)-3 (b)(5)(ii).

86 See *infra* Section V.B.3.

community's voice is less clear.

1. Opportunities for Collaboration

Support for collaborative approaches to assessing and addressing community health needs pervades the Regulations. The requirement that a hospital solicit and take into account input received from members or representatives of “medically underserved, low-income, and minority populations” and from a governmental health department opens the lines of communication and thus may lay a foundation for partnerships. However, beyond requiring hospitals to ask for and listen to input, the Regulations do not mandate any collaboration.⁸⁷ They do indicate that when a hospital produces its “CHNA report”—documenting its assessment process and its prioritization of health needs—it should identify any parties it collaborated with in that process.⁸⁸

A hospital that works with others in performing its health needs assessment ordinarily must produce its own individual CHNA report for its governing board to adopt. That said, if a hospital collaborated in conducting its CHNA, some parts of its report may be “substantively identical” to parts of another organization’s report.⁸⁹ It cannot, however, simply cut and paste the CHNA report of another hospital or health department. Only when collaborating hospitals and other organizations (like health departments) define their community to be the same and have conducted a CHNA together can collaborators produce a joint CHNA report.⁹⁰

Developing and executing its “implementation strategy” (the written plan describing how a hospital plans to address the significant health needs its CHNA identified) present similar opportunities for collaboration.⁹¹ The Regulations provide that as part of its implementation strategy, a hospital should describe any plans it has to collaborate in addressing community health needs.⁹² Moreover, a hospital may work with other hospitals, governmental departments, and nonprofit

⁸⁷ Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954, 78,967 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602) (rejecting suggested requirement of collaboration).

⁸⁸ § 1.501(r)-3(b)(6)(ii).

⁸⁹ According to § 1.501(r)-3(b)(6)(iv), part of the report may be “substantively identical to portions of a CHNA report of a collaborating hospital facility or the other organization conducting a CHNA, if appropriate under the facts and circumstances.” The regulations supply two examples of when including language from another organization’s report could be appropriate.

⁹⁰ § 1.501(r)-3(b)(6)(v). The joint CHNA report must identify each hospital to which it applies. The Regulations also clarify that multiple hospitals involved in a single ACO can produce a joint CHNA report.

⁹¹ § 1.501(r)-3(c)(1).

⁹² § 1.501(r)-3(c)(2).

organizations to figure out what to include in its implementation strategy. Teaming up to develop an implementation strategy does not ordinarily excuse a hospital from producing its own separate written plan “tailored to the particular hospital . . . , taking into account its specific resources.”⁹³ But when a group of collaborators has produced a joint CHNA report, hospitals in the group may also adopt a joint implementation strategy, as long as it clearly identifies each hospital’s particular role and responsibilities in carrying out the strategy’s action plan.⁹⁴

In sum, the final Regulations strongly endorse hospitals’ ability to choose collaborative approaches to carrying out their new responsibility without requiring them to partner with others as they assess and address community health needs. Earlier versions did not explicitly endorse hospitals’ collaboration with other hospitals or other organizations like health departments.⁹⁵ The final Regulations thus reflect an important recognition of the value of collaboration and alignment in community health improvement efforts.

D. Transparency and Accountability

The ACA itself demonstrates commitment to transparency regarding the CHNA process, requiring hospitals to make their CHNA reports “widely available to the public.”⁹⁶ The Regulations implement this requirement by directing hospitals to post their CHNA reports on a website and making hard copies available for public inspection at the hospital itself.⁹⁷ Thus, anyone interested in learning about a hospital’s CHNA process and findings can go online to find the report, or those without access to Internet, can pick up a copy at the hospital. By contrast, transparency requirements for a hospital’s implementation strategy are much weaker. The Regulations permit a hospital either to make its implementation strategy available on a website *or* submit it as part of its annual Form 990 filing. Form 990 is also the locus for the hospital’s sole obligation to report what it is actually doing to address community needs.⁹⁸ Form 990 filings are publicly available by request to a hospital or the IRS, but neither is required to put those filings online. Although some organizations, like

93 § 1.501(r)-3(c)(4).

94 *Id.*

95 Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20,523, 20,532-33 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53).

96 26 U.S.C. § 501(r)(3)(B)(ii) (2012).

97 § 1.501(r)-3(b)(8).

98 A hospital must describe in Form 990 “the actions taken during the taxable year to address the significant health needs identified through its most recently conducted CHNA . . . or, if no actions were taken with respect to one or more of these health needs, the reason(s) why no actions were taken.” 26 C.F.R. § 1.6033-2(a)(2)(ii)(f)(3).

GuideStar, collect the 990 Forms submitted by tax-exempt organizations and make them available on the Internet, the lack of direct and easy access to hospital reports of their community health activities decreases transparency.

Increasing transparency would enhance hospitals' accountability for the substantial financial benefits they receive from tax exemption. But the Regulations' accountability measures are also limited. As noted, hospitals must report annually the actions they have taken to meet the needs identified in their CHNA, but it is unclear how closely the IRS will scrutinize those reports. Moreover, the critical question is not simply what the hospital is doing, but whether its activities make a difference in meeting the community needs identified through the CHNA process. The final Regulations eliminated a provision that would have required implementation strategies to include a plan for evaluating the impact of hospitals' community health activities, but they added a requirement that subsequent CHNA reports include an evaluation of that impact.⁹⁹ This requirement of some evaluation of impact — while limited and nonspecific — at least lays a foundation for meaningful hospital accountability.

E. A Lingering Question: Community Benefit and Community Health Needs

The IRS Regulations go a long way in putting flesh on the statutory bones of the hospital's CHNA requirement. While I will argue below that the IRS should further refine its guidance to promote greater transparency, accountability, community engagement and collaboration in hospitals' compliance, the Regulations do make some important strides in these directions. Regrettably, they fail to fully answer an important question: Will a hospital's pursuit of broad community health improvement goals be deemed to meet both its CHNA obligations under § 501(r) and the community benefit standard?

1. Does § 501(r) Compliance Fully Satisfy the Community Benefit Standard?

According to the IRS, the ACA's new requirements (which reside in § 501(r) of the I.R.C.) do not displace the existing "community benefit" standard for hospital tax-exemption under § 501(c)(3), but instead represent additional requirements for those hospitals.¹⁰⁰ Although the obligations to adopt certain billing and collection practices and to complete CHNAs are in addition to the requirement that a hospital be "charitable," the congressional objectives underlying § 501(r) appear to overlap significantly with the concept of community benefit as a marker of a hospital's charitable nature. Yet the

⁹⁹ § 1.501(r)-3(b)(6)(F).

¹⁰⁰ Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78,954, 78,956 (Dec. 31, 2014) (to be codified at 26 C.F.R. pts. 1, 53, 602).

Regulations fail to indicate to what extent a hospital's satisfaction of the new requirements may also serve to satisfy the preexisting requirement.¹⁰¹ In other words, if a hospital establishes a financial assistance policy, implements § 501(r)'s other protections for financially strapped patients,¹⁰² conducts its CHNA, and develops and pursues an implementation strategy on schedule, has that hospital provided sufficient "community benefit?" Or is it expected to do something more?

Logically, it would seem that a hospital that follows a sound process in assessing its community's health needs and then acts pursuant to an implementation strategy to respond to the significant health needs it has identified should be deemed to have provided a "community benefit." But does that hospital also need to continue providing some level of charity care, as it likely has in the past? The Regulations do not address that question. By the same token,¹⁰³ it is uncertain whether a hospital that jumps through the hoops of CHNA compliance, but fails to take meaningful steps to address its community's most pressing health needs, can satisfy the community benefit standard simply by continuing to treat some patients who are uninsured or covered by Medicaid. Whether satisfaction of the new § 501(r) requirements can function as a substitute or alternative for the "community benefit" factors that the IRS set out in 1969, or whether they impose an additional layer of compliance, is simply unclear.¹⁰⁴

Given the IRS's history of lax enforcement of the community benefit standard and the minimal accountability imposed regarding implementation strategies, that question may not trouble many hospitals initially. Nonetheless, the ambiguous interaction of the tax-exemption requirements becomes more salient for hospitals considering participation in broad collaborative efforts to address upstream causes of poor health. These efforts may redirect hospital resources away from activities—like providing charity care—traditionally seen as satisfying community benefit requirements. This ambiguity illuminates

101 See Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20,523, 20,523 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53) (describing the ACA's enactment of § 501(r) and stating, "The Affordable Care Act did not otherwise affect the substantive standards for tax exemption that charitable hospital organizations are required to meet under section 501(c)(3)").

102 See *supra* notes 57-59 and accompanying text.

103 See *infra* Section IV.B.2.

104 Cf. Michael A. Stoto & Colleen Ryan Smith, *Community Health Needs Assessments? Aligning the Interests of Public Health and the Health Care Delivery System To Improve Population Health*, INST. MED. 1 (2015), <http://nam.edu/perspectives-2015-community-health-needs-assessments-aligning-the-interests-of-public-health-and-the-health-care-delivery-system-to-improve-population-health> (describing the CHNA requirement as "[i]ntended to leverage the 'community benefits'" that hospitals are required to provide).

another dimension of the Regulations' opacity.

2. *When Will "Community Building Activities" Count as Community Benefit?*

Section II.B describes how Schedule H, which collects information on hospital community benefit expenditures, draws a distinction between community benefit expenditures and "community building activities."¹⁰⁵ By separating out spending on "community building activities" (which encompasses efforts to address some social determinants)¹⁰⁶ from "community benefit" spending, Schedule H displays an understanding of "community benefit" that is more limited than the Regulations' vision of "community health needs." The IRS's message—at least when it first created Schedule H—was that "community building activities" do not count as a "community benefit."¹⁰⁷ This distinction left some hospitals confused about whether they could report as community benefit expenditure their investments in programs designed to improve their community's health, but falling within the Schedule's description of community building activities. This perplexing state of affairs may have led hospital administrators to stick with the safer (from a tax-exemption standpoint) route of engaging in activities, like charity care, that would be clearly reportable on the "community benefit" part of Schedule H.

After the ACA's enactment, the IRS made an encouraging, if not terribly clarifying, revision to the instructions for Schedule H. In 2011, it added a short sentence: "Some community building activities may also meet the definition of community benefit." This addition signals the IRS's willingness—in *some* cases—to treat hospital activities targeting non-medical determinants of health as providing community benefit. Unfortunately, the instructions do not specify when the IRS will do so, but rather direct a hospital wishing to claim community building activities as part of its community benefit expenditures to describe how those "promote the health of the communities it serves." As a result, a hospital wishing to respond to a community health need identified in its CHNA by participating in an initiative to address a social determinant of health is left uncertain whether the IRS would view that participation as community benefit.¹⁰⁸

¹⁰⁵ See *supra* text accompanying notes 46-48.

¹⁰⁶ The examples include "physical improvements and housing," "economic development," and "community support." Schedule H, *supra* note 46.

¹⁰⁷ The original instructions for Schedule H stated that community benefit activities were not reportable as "community building activities." *Id.*

¹⁰⁸ See Sara Rosenbaum et al., *Encouraging Nonprofit Hospitals To Invest in Community Building: The Role of IRS 'Safe Harbors'*, HEALTH AFF. BLOG (Feb. 11, 2014), <http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community-building-the-role-of-irs-safe-harbors>; *Supporting Alignment and Accountability in*

III. HOSPITALS AND POPULATION HEALTH: EMBRACING CONVERGENCE?

A. Alignment with the ACA's Broad Goals

The new CHNA requirement—while situated as a discrete provision regarding tax exemption—aligns both with the ACA's broader purposes and with increasing attention within the hospital industry to population health. Specifically, the CHNA requirement relates to the ACA's goals of providing health insurance for most Americans and increasing attention to prevention and public health. The decline in the number of uninsured Americans resulting from the ACA should produce an attendant decrease in the need for charity care.¹⁰⁹ This decrease could call into question hospitals' reliance primarily on charity care to satisfy the community benefit standard. The CHNA requirement provides a different mechanism for hospitals to justify their tax exemption.

That new mechanism also connects directly with the ACA's preventive aim. The ACA incorporates measures increasing support for providing preventive care to individual patients and population-level health promotion.¹¹⁰ These measures range from requiring qualified health plans to cover preventive care without patient copayment obligations, to encouraging employer wellness programs, to commissioning a National Prevention Strategy, to increasing financial support for the public health workforce.¹¹¹ In directing tax-exempt hospitals to look beyond providing medical services to patients and to address the health needs of their communities, the CHNA requirement aligns with the ACA's other public health-

Community Health Improvement, *supra* note 71, at 79-80.

109 Janet Corrigan et al., *Hospital Community Benefit Programs: Increasing Benefits to Communities*, 313 JAMA 1211, 1211 (2015) (reporting HHS's estimate that uncompensated care provided by hospitals will fall by \$5.7 billion in 2014). *But see* Brown, *supra* note 43, at 4-5 (noting the continuing problem of underinsured patients' ability to pay hospital bills). In addition, uninsurance has declined less in states that have chosen not to expand Medicaid. *See* Assistant Sec'y for Planning & Evaluation, *Health Insurance Coverage and the Affordable Care Act*, U.S. DEP'T HEALTH & HUM. SERVS. 2 (2015), <http://aspe.hhs.gov/sites/default/files/pdf/111826/ACA%20health%20insurance%20coverage%20brief%2009212015.pdf>.

110 *See generally* Laura Anderko et al., *Promoting Prevention Through the Affordable Care Act: Workplace Wellness*, 9 PREV. CHRONIC DIS. E175 (2012) (describing how the ACA's workplace wellness provisions reflect a focus on prevention and wellness); Frederic E. Shaw et al., *The Patient Protection and Affordable Care Act: Opportunities for Prevention and Public Health*, 384 LANCET 75 (2014) (describing ACA measures that emphasize prevention and spurring healthcare and public health collaborations to improve community health). *But see* Micah Berman, *A Public Health Perspective on Health Care Reform*, 21 HEALTH MATRIX 353, 355 (2011) (arguing that the ACA's understanding of public health is too narrow and does not reflect how most public health experts understand the field).

111 Shaw et al., *supra* note 110, at 78-79.

oriented provisions. Explicitly signaling this shift in orientation, the statute itself directs hospitals conducting CHNAs to take into account input from “persons . . . with special knowledge of or expertise in public health.”¹¹²

B. Convergence and Alignment with Public Health Objectives

Despite the ACA’s provisions that support preventive care and health promotion, some scholars have argued that the health reform law does not go far enough to adopt a public health perspective and to integrate public health approaches into the healthcare system.¹¹³ They assert that the most effective and efficient way to improve health outcomes in the United States is not simply to increase access to healthcare services, but to integrate what are currently two systems with distinctive focuses.¹¹⁴ The healthcare system “is concerned with the individual’s care and treatment, while public health is concerned with the health and well-being of populations.”¹¹⁵ For directing hospitals (traditionally part of the healthcare system) to conduct community health needs assessments (traditionally a public health tool), the CHNA requirement is hailed as one example of convergence between healthcare and public health.¹¹⁶

Echoing this sentiment, public health professionals and scholars have noted eagerly the opportunity the CHNA requirement presents for aligning hospitals’ community benefit schemes with health departments’ community health improvement objectives. Public health agencies and professional organizations actively participated in the development of regulations. In particular, comments from the public health community commended the IRS’s recognition of the vital contribution that health departments can make to the CHNA process.¹¹⁷

Similarly, public health scholars and commentators have welcomed the new collaborative opportunities the CHNA requirement seems likely to create.¹¹⁸ One

112 26 U.S.C. § 501(r)(3)(B)(i) (2012).

113 See, e.g., Berman, *supra* note 110, at 355.

114 Gostin et al., *supra* note 16, at 1781.

115 *Id.* at 1783.

116 *Id.* at 1787.

117 In its comments on the IRS’s 2013 proposed regulations, the National Association of County & City Health Officials (NACCHO) concluded: “NACCHO believes that the CHNA requirements have great potential to promote new, mutually beneficial collaborations between non-profit hospitals and local health departments to improve the health of the communities each serves.” National Association of County & City Health Officials, Comment Letter on Proposed Rule Regarding Community Health Needs Assessments for Charitable Hospitals 5 (June 28, 2013), http://www.naccho.org/advocacy/action/upload/July-2013-NACCHO-Comments-to-IRS-CHNA-Proposed-Rule_FINAL.pdf.

118 See, e.g., *Partner with Nonprofit Hospitals To Maximize Community Benefit Programs’ Impact on Prevention*, TR. AM.’S HEALTH 2 (2013) <http://www.healthymamericans.org/assets/files/Partner%20with%20Nonprofit%20Hospitals04>.

hails the law as “creat[ing] a powerful platform for an implementation strategy that ultimately yields a national system of community health needs assessments and implementation strategies that in scope parallels the law’s broad concept of community health transformation.”¹¹⁹ Another predicts that the requirement will “provide[] incentive for the [non-profit] hospital to go in a direction in which the public health sector has been going for a number of years—to utilization of models of citizen participation and public-private partnerships.”¹²⁰ Scholars note the concrete benefits of collaboration among hospitals, health departments, and community organizations: avoiding duplication of effort and permitting hospitals to access public health expertise and skills relating to developing population health measures, interpreting data, and engaging community members.¹²¹

These rosy expectations of increased collaboration find support in the experience in California, which has had a community health assessment requirement for hospitals since 1994. Reporting to the California Legislature in 1998, California’s Office of Statewide Health Planning and Development observed:

An unforeseen dividend of SB 697 was a stimulus for community-wide, collaborative health planning on a scale that has not been witnessed for many years. Perhaps this should not have been too surprising, for this broader-gauged planning is the natural extension of individual hospitals conducting needs assessments and benefit planning together with other interested parties in the community.¹²²

pdf (asserting that the CHNA requirement provides “new opportunities for nonprofit hospitals to partner with state and local health departments, local employers and businesses and community groups to increase their understanding of the needs of the community”).

119 Sara Rosenbaum & Ross Margulies, *Tax Exempt Hospitals and the Patient Protection and Affordable Care Act*, 126 PUB. HEALTH REP. 283, 284 (2011); see also Michael A. Stoto, *Community Health Needs Assessments—An Opportunity To Bring Public Health and the Healthcare Delivery System Together To Improve Population Health*, IMPROVING PUB. HEALTH (Apr. 16, 2013), <http://www.improvingpopulationhealth.org/blog/2013/04/community-health-needs-assessments-an-opportunity-to-bring-public-health-and-the-healthcare-delivery.html> (describing the CHNA requirement as “the key” to managing shared responsibilities for improving community health).

120 Ann L. Abbott, *Community Benefits and Health Reform: Creating New Links for Public Health and Not-for-Profit Hospitals*, 17 J. PUB. HEALTH MGMT. & PRACTICE 524, 528 (2011).

121 Jean O’Connor et al., *Paying for Prevention: A Critical Opportunity for Public Health*, 2012 PUB. HEALTH L. CONF. 69, 70-71 (2013).

122 STATE OF CAL., OFFICE OF STATEWIDE HEALTH PLANNING & DEV., NOT-FOR-PROFIT HOSPITAL COMMUNITY BENEFIT LEGISLATION (SENATE BILL 687): REPORT TO THE

C. Barriers to Alignment

Not everyone has been sanguine about hospitals' embracing a new community orientation and collaborating with community partners. While noting potential benefits of collaboration, the Hilltop Institute adds a caution: "Collaborative approaches to CHNA ... may not be easy to achieve. Partnerships between hospitals and public health agencies may present challenges in achieving a common focus in the face of differing philosophies and priorities."¹²³ Writing before the ACA's enactment, Dr. Stephen Shortell described overlapping strategic, cultural, technical, and structural barriers to engaging hospitals in community health efforts. Hospitals' central strategic priority is providing high quality acute care and emergency services to its patients (strategic). Health professionals working in hospitals thus understand their roles as providing medical care to sick or injured patients, not as promoting health or engaging communities (cultural). Most hospitals lack staff with public health training, population-level health data to support a needs assessment for a specific geographic area, and internal policies promoting community outreach and engagement with public health agencies (technical and structural).¹²⁴

The foregoing barriers are largely internal to hospitals. But even hospitals that overcome these barriers and seek to partner with health departments to improve community health may face a different set of challenges. These challenges flow from system-level differences between the medical care and public health systems in culture, orientation, and priorities, and the resulting difficulty in communicating clearly and establishing trust.¹²⁵

Perhaps the most daunting impediments to hospitals devoting serious attention to community health improvement, though, lie in how hospitals are paid¹²⁶ and the competitive nature of the hospital market. Most existing

LEGISLATURE 31 (1998).

123 Donna C. Folkemer et al., *Hospital Community Benefits After the ACA: Building on State Experience*, HILLTOP INST. 6 (2011), <http://www.hilltopinstitute.org/publications/HospitalcommunityBenefitsAftertheACA-HCBPIssueBrief2-April2011.pdf>.

124 Shortell et al., *supra* note 24, at 379-80.

125 Cf. LAWRENCE PRYBIL ET AL., IMPROVING COMMUNITY HEALTH THROUGH HOSPITAL-PUBLIC HEALTH COLLABORATION: INSIGHTS AND LESSONS LEARNED FROM SUCCESSFUL PARTNERSHIPS 40 (2014), http://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1001&context=hsm_book (emphasizing the importance of trust among successful hospital-public health partnerships).

126 Cf. *Strategic Investment in Shared Outcomes: Transformative Partnerships Between Health Systems and Communities*, HEALTH SYS. LEARNING GROUP 23 (2013) [hereinafter Health Sys. Learning Group Monograph], <http://stakeholderhealth.org/wp-content/uploads/2013/09/HSLG-V11.pdf> (noting the "perverse incentives in the current

reimbursement systems pay hospitals for treating patients who are sick or injured.¹²⁷ By and large, hospitals receive no compensation for keeping community members healthy and out of the hospital. One need not be a cynic to question how vigorously hospitals will pursue efforts that—if successful—will diminish their revenue streams. Recent efforts to reorient reimbursement schemes to incentivize preventive care, disease management, community-based care, and health promotion,¹²⁸ while promising, may be unlikely in the near term to overcome the “fill the beds” incentives that still exist.¹²⁹ Similarly, hospitals’ efforts to edge ahead of other local hospitals in attracting physicians, patients, and payers – and the attendant revenue – are unlikely to lead them to emphasize services and programs for community members with the greatest need. Additionally, the hospitals located in the communities with the greatest need may be the least able financially to make investments in population health-oriented measures, even if they are motivated to do so.¹³⁰

D. Hospitals’ Reaction and Its Importance

While less jubilant than public health professionals about their new community-health-oriented obligations, hospitals have tended not to complain too loudly—perhaps out of relief at avoiding more onerous requirements.¹³¹ Even

system of fee-for-service financing”).

127 See O’Connor et al., *supra* note 121, at 71 (making this point more broadly with respect to the need for payment mechanisms for community-level prevention strategies).

128 A particularly intriguing experiment began recently in Maryland, where the State and its hospitals have agreed with CMS to shift most of the hospitals’ revenue into global budgets, thus moving away from the traditional fee-for-service model. See Ankit Patel et al., *Maryland’s Global Hospital Budgets—Preliminary Results from an All-Payer Model*, 373 NEW ENG. J. MED. 1899, 1899 (2015). For a brief discussion of some additional efforts, see *infra* Section IV.E.

129 Cf. Shortell et al., *supra* note 24, at 380 (asserting that the most important policy issue for encouraging greater hospital engagement in community health promotion is “changes in health care payment systems for hospitals that create incentives for broader-based community health investment” and suggesting some alternatives); Martha H. Somerville et al., *Hospitals, Collaboration, and Community Health Improvement*, 43 J.L. MED. & ETHICS 56, 58 (2015) (suggesting that new reimbursement methods “may inadequately address the higher costs associated with serving the most vulnerable and needy populations”).

130 See Somerville et al., *supra* note 129 (noting competitive pressures as a challenge to collaboration).

131 Steven Ross Johnson, *Obamacare Rule Has Hospitals Targeting Health Improvement*, MODERN HEALTHCARE (June 14, 2014), <http://www.modernhealthcare.com/article/20140614/MAGAZINE/306149803> (quoting a representative of the AHA). One might think that, given the value of tax exemption to hospitals, the risk of losing tax-exempt status would provide a countervailing financial

before the ACA's passage, hospitals' potentially important role in partnerships aimed at improving health at the population, rather than patient, level was increasingly recognized.¹³² Indeed, hospitals' assessing and attending to community health concerns were not entirely new, even if the legal requirement to do so was. Some hospitals and health systems assessed community health needs in order to target their services to particular needs and to raise community awareness and support.¹³³

The hospital industry played an active role in the development of the regulatory guidance on the CHNA requirement. Industry comments on proposed regulations stressed the desirability of "avoiding detailed or prescriptive requirements that create unnecessary burden and limit [hospitals'] appropriate flexibility."¹³⁴ Multiple hospital commenters urged the IRS not to require hospitals to take into account input from public health officials, expressing concern that demanding consultation with thinly staffed health departments could affect hospitals' ability to comply.¹³⁵ But hospital commenters generally did not object on principle to working with public health departments or consulting with community members; instead, they expressed openness to that engagement.¹³⁶

Despite the Regulations' long gestation and the attendant uncertainty as to the precise contours of the CHNA obligations, hospitals had no choice but to begin conducting assessments and developing implementation strategies in order to meet the ACA's deadline for the CHNA requirement.¹³⁷ In doing so, a good number of hospitals have gone beyond minimal compliance, embracing

incentive. In light of the history of lax IRS enforcement and the lack of meaningful accountability measures in the regulations, hospitals may be unlikely to perceive the potential loss of tax-exempt status as a real threat.

¹³² See Shortell et al., *supra* note 24, at 374.

¹³³ Michael Bilton, *Community Health Needs Assessment*, TRUSTEE, Oct. 2011, at 21, 24.

¹³⁴ AHA Comments, *supra* note 83, at 2.

¹³⁵ See, e.g., Matthew L. Anderson, *Proposed Rule in Community Health Needs Assessments for Charitable Hospitals*, MINN. HOSP. ASS'N (July 3, 2013), www.mnhospitals.org/policy-advocacy/comment-letters/articletype/articleview/articleid/193/proposed-rule-on-community-health-needs-assessments-for-charitable-hospitals (comment submitted electronically in response to REG-106499-12; Community Health Needs Assessments for Charitable Hospitals Proposed Rule by MHA's Vice President for Regulatory/Strategic Affairs).

¹³⁶ *Id.* ("[T]he CHNA requirement has already generated a more robust level of collaboration and communication between hospitals and local public health agencies.").

¹³⁷ Pub. L. No. 111-148, § 9007(f), 124 Stat. 119, 859 (2010) (codified at I.R.C. § 501 (2012)) (requiring hospitals to conduct a CHNA within the three-year period that commenced on the first day of the hospital's first tax year that began after March 23, 2010 and ended on the final day of its first tax year that began after March 23, 2012).

opportunities to engage closely with community members and other stakeholders in efforts to address vexing community health issues. This Article urges the IRS to encourage such efforts by providing clear guidance emphasizing the need for transparency, accountability, and community engagement and the value of collaboration. Realistically, though, the history of lax IRS enforcement of the community benefit standard and current reality of shrinking agency budgets suggest it is unlikely that the IRS will closely police hospitals' compliance with whatever guidance it provides. As a result, the effectiveness of any guidance in shaping hospital conduct will depend partly on how receptive hospitals are. Evidence presented below suggests that a significant number of hospitals, rather than resisting the shift of orientation that the CHNA requirement contemplates, may be open to guidance on how best to accomplish it.

Hospitals are extremely heterogeneous, varying widely in terms of size, location, mission, and other factors.¹³⁸ Thus, broad generalizations about their preexisting commitments to community health improvement, or about their likely reactions to additional regulatory guidance on the CHNA requirement are not possible. That said, this Article's thesis does not depend on showing that its recommended regulatory guidance would change the behavior of all, or even a large majority of tax-exempt hospitals. Instead, the IRS's opportunity is to help normalize community and public health orientations within the hospital industry.¹³⁹ It can do so by establishing official expectations regarding hospitals' evolving role in promoting population health. Fostering a norm of community orientation can shape what hospitals expect of themselves.

A shift in the right direction in many hospitals' engagement with their communities and interest in promoting population health is already underway.¹⁴⁰ This movement likely results from a combination of economic and political stimuli, including accelerating initiatives to tie hospital reimbursement to quality- and value-related factors, pressure to address health disparities, and a desire to redeem hospitals' reputation within their communities after widespread media criticism. This Section shows that—whatever the reasons—a meaningful number of hospitals are already engaging with their communities to promote community

138 Lindsey Dunn & Scott Becker, *50 Things To Know About the Hospital Industry*, BECKER'S HOSP. REV. (July 23, 2013), <http://www.beckershospitalreview.com/hospital-management-administration/50-things-to-know-about-the-hospital-industry.html> (categorizing hospitals as nonprofit, for profit, government entities, rural, safety net, and academic medical centers).

139 Cf. Susan Sturm, *Law's Role in Addressing Complex Discrimination*, in HANDBOOK OF EMPLOYMENT DISCRIMINATION RESEARCH 35 (Laura B. Nielsen & Robert L. Nelson eds., 2005) (describing how legal norms develop not only through liability determinations, but also through legally structured occasions for deliberating about the relationship between norms and practice).

140 See *infra* Section IV.E.

health, often as part of a collaboration, and that even more hospitals are thinking and talking about doing so. This Section thus supports an assertion that a meaningful segment of the hospital industry would be receptive and responsive to further guidance by the IRS.

E. Hospitals' Attention to Population Health

1. Advice from the American Hospital Association

Even before the new CHNA requirement went into effect, many hospitals were reconceiving their roles in improving health. A series of reports from the AHA (the “AHA Reports”) discuss the strategic importance to hospitals of prioritizing “population health” in response to changes in the healthcare and reimbursement environment.¹⁴¹ The AHA Reports sound a central theme: managing and improving “population health” entails adopting a broader frame of reference than hospitals are accustomed to. One report describes it as “the shift from managing individuals to managing populations.”¹⁴² Yet this expanded frame of reference still often targets the population of hospital patients.¹⁴³ This “patient population” frame of reference likely overlaps, but is not entirely congruent with, the community whose needs hospitals are supposed to assess under the ACA. The law’s reference to “community health needs” suggests a geographic basis for defining the population whose needs matter. It directs hospitals to consider the health needs of people living in their environs, even if those people have never set foot into the hospital itself.¹⁴⁴

The AHA Reports point to the new CHNA requirement as one impetus

141 See, e.g., *Managing Population Health: The Role of the Hospital*, AM. HOSP. ASS’N (2012) [hereinafter *Managing Population Health*], http://www.hpoe.org/Reports-HPOE/managing_population_health.pdf; *The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships*, AM. HOSP. ASS’N (2013) [hereinafter *Role of Small and Rural Hospitals*], http://www.hpoe.org/Reports-HPOE/The_Role_Small_Rural_Hospital_Effective_Population_Health_Partnership.pdf; *The Second Curve of Population Health*, AM. HOSP. ASS’N (2014), <http://www.hpoe.org/Reports-HPOE/SecondCurveToPopHealth2014.pdf>; *Trends in Hospital-Based Population Health Infrastructure: Results from an Association for Community Health Improvement and American Hospital Association Survey*, AM. HOSP. ASS’N (2013), http://www.hpoe.org/Reports-HPOE/ACHI_Survey_Report_December2013.pdf.

142 *Managing Population Health*, *supra* note 141, at 7.

143 See *id.* at 3 (asserting that hospitals should “examine how to manage the health of their patient populations to improve outcomes”).

144 PRYBIL ET AL., *supra* note 125, at 42 (noting the need for collaboration partners to share common understandings of “population health concepts, definitions, and principles”); cf. Rosenbaum, *supra* note 77 (“The final rules . . . underscore that the key issue is the community that *needs the care of the hospital*, not simply current patients.”) (emphasis added).

among several for increased attention to population health improvement. Other factors pushing hospitals in this direction are “external forces to simultaneously reduce cost, improve quality, and implement value-based payment programs.”¹⁴⁵ Also prompting the shift are other provisions of the ACA, such as denials of payment for hospital readmissions and the support of pilot or demonstration programs creating medical homes and accountable care organizations.¹⁴⁶ Woven through the AHA Reports is the message that the world hospitals have operated in for the past half century—a world dominated by reimbursements for discrete services for individual patients—is changing quickly, and hospitals need to adapt to the current environment and be ready for changes yet to come. Improving their ability to manage population health “will be essential for care delivery in the future value-based market.”¹⁴⁷

The AHA Reports advise hospitals on how to pursue this seemingly radical reorientation of their community commitments. At the core of this advice is the need for partnership: “[t]rue population health is not an outcome that hospitals and health systems will be able to achieve without collaboration and shared ownership of goals with other sectors.”¹⁴⁸ Partnering with other actors within the healthcare system (like physicians), with payers and employers, and with social services agencies, public health departments, and community organizations can help hospitals reach a broader swath of community members and permit the sharing of financial, personnel, and knowledge resources. Thus, for example, hospitals might partner with physicians to improve care coordination for high-cost patients, with hospitals providing data about clinical encounters to identify variations in care and show best practices and physicians supplying the ongoing patient interaction critical to behavioral change.¹⁴⁹ Alternatively, a hospital might collaborate with community cultural organizations to develop outreach mechanisms to encourage screenings, connect neighborhood residents to primary care providers, and supply culturally appropriate information about diet and healthy living.¹⁵⁰ As the AHA Reports emphasize, efforts to improve population health will look different across the range of hospitals, as hospitals’ missions and available resources vary.¹⁵¹ The AHA’s suggestions provide hospitals tools for beginning to develop their own population health strategies.¹⁵²

145 *Managing Population Health*, *supra* note 141, at 3.

146 *Id.* at 5.

147 *Id.* at 6.

148 *Id.* at 9.

149 *Id.* at 12.

150 *Id.* at 15 (providing examples).

151 *Id.* at 9; see also *Role of Small and Rural Hospitals*, *supra* note 141, at 7-8 (describing the particular challenges and opportunities that small and rural hospitals face in seeking to address population health).

152 Another resource for hospitals is the *ACHI Community Health Assessment Toolkit*,

2. Hospitals Pursuing Population Health: Some Examples

Indeed, finding examples of hospitals pursuing initiatives to address community health needs, whether alone or as part of a network, has become easy. While not attempting to survey hospital practices comprehensively, this Section illustrates the diversity of approaches that hospitals can take and demonstrates the plausibility¹⁵³ of hospitals' playing meaningful roles in such initiatives. In doing so, it also highlights potential models for informing the IRS's refinement of its guidance to hospitals. These examples embody the shift away from conceptualizing "community benefit" as entailing primarily uncompensated hospital care for individual patients. Instead, their expanded frames of reference encompass the hospitals' communities. They vary significantly in how broadly they understand community health needs and hospitals' roles in responding to them.

Contrasting examples appear in a 2014 article on the *Modern Healthcare* website describing two hospitals' responses to needs identified in their community needs assessments.¹⁵⁴ According to the article, Advocate Trinity Hospital learned from its assessment that its community on Chicago's South Side suffered high rates of stroke and that heart disease, and that cancer produced more than half the deaths in its service area. In response to this information, the hospital invested in a primary stroke center to shorten the distance that patients suffering stroke would have to travel and in a second heart catheterization lab and new radiology equipment.¹⁵⁵ Assessments conducted by the Henry Ford Health System, based in Detroit, revealed that heart disease, diabetes, and infant mortality were the most pressing issues for its community stakeholders. To address those issues, Henry Ford chose to partner with community organizations to tackle lack of prenatal care and low birth weight, both contributors to infant mortality. The hospital-community partnership trains navigators who work to identify at-risk women in their neighborhoods and to connect them to community

AM. HOSP. ASS'N (2007), <http://www.assesstoolkit.org>. The Association for Community Health Improvement is also affiliated with the AHA.

¹⁵³ Of course, the plausibility or viability of any particular hospital's effort to collaborate with community partners on broad initiatives depends on numerous factors, including the hospital's mission, leadership, competitive position within its market, financial situation, and the availability and interest of community partners. Another factor present in several states are laws imposing on nonprofit hospitals a minimum level of charity case expenditures as a condition of state tax exemption. *See, e.g.,* NEV. REV. STAT. § 439B.320 (2015). Hospitals in these states will have less flexibility to redirect community benefits investments towards community health initiatives.

¹⁵⁴ *See* Johnson, *supra* note 131.

¹⁵⁵ *Id.*

resources.¹⁵⁶

Both hospitals are responding to health needs that they would not have identified had they focused only on patients' individual health needs. They each assessed needs at the community level and asked what gaps they might fill in addressing the needs identified. But the natures of their responses differ notably. According to the article, Trinity Hospital's response to high rates of stroke and deaths from heart disease and cancer in its community was to beef up the medical services available to patients with those conditions. By contrast, Henry Ford responded by partnering with community-based organizations to establish a neighborhood presence designed to help prevent the health issues identified in the assessment from arising in the first place.

Drawing this distinction does not detract from the value of Trinity's response. By investing in the creation of a primary stroke center, it ameliorated a geographic barrier to stroke victims' accessing appropriate care, and geographic barriers may contribute to health disparities.¹⁵⁷ But when Henry Ford identified infant mortality as a big problem, it joined community partners to work in neighborhoods promoting the health of pregnant women—and ultimately their babies—by connecting them with a range of resources. It understood that the most effective response to some health needs lies not in more and better *medical* care, but in addressing aspects of community life that undermine health, or the *social determinants of health*. This latter, less conventional (for hospitals, anyway) approach to promoting community health is what I argue the IRS should more forcefully encourage and facilitate in its guidance to hospitals by focusing on the values described in Part V.B.

Some hospitals have begun working together to exchange information about innovative approaches to community health partnerships,¹⁵⁸ and a burgeoning

¹⁵⁶ *Id.*

¹⁵⁷ Cf. Renee Hsia & Yu-Chu Shen, *Possible Geographical Barriers to Trauma Center Access for Vulnerable Patients in the United States: An Analysis of Urban and Rural Communities*, 146 ARCHIVES SURGERY 46 (2011) (finding that certain vulnerable groups are at higher risk of poor access to trauma centers); Michelle L. Mayer, *Disparities in Geographic Access to Pediatric Subspecialty Care*, 12 MATERNAL & CHILD HEALTH J. 624 (2008) (identifying characteristics of populations at risk for poor geographic access).

¹⁵⁸ See Health Sys. Learning Group Monograph, *supra* note 126. The Health Systems Learning Group (HSLG) included thirty-six non-profit health systems seeking, in response to the ACA's passage, "to identify and activate a menu of proven community health practices and partnerships that work from the top of the mission statement to the bottom line. . . . [to identify] new pathways to transform unmanaged charity care into strategic, sustainable community health improvement." *Id.* at 10. These hospitals also recognize that community partnerships engaging a broad range of community stakeholders are needed to address many community health needs and that a hospital's role in supporting community health transformation will often be that of supporting partner, rather than lead actor. *Id.* at 14 ("In many cases, the hospital may not take the lead, but will provide strategic support in a defined

literature¹⁵⁹ describes hospitals' engagement in a wide range of activities to address community health needs.¹⁶⁰ Examples include a Memphis hospital's partnership with five hundred congregations to create a Congregational Health Network, which hired congregational navigators to connect with volunteer liaisons in each congregation and work as community care coordinators arranging post-discharge services;¹⁶¹ the participation of Camden hospitals in the Camden Coalition, which created a "hot spotting" approach to identifying heavy users of medical care and meeting their needs in the community, thus decreasing avoidable emergency room visits;¹⁶² and Advocate Christ Medical Center's partnership with the community organization CeaseFire to develop the Chicago region's first hospital-based program focused on preventing gun violence by employing trained "violence interrupters" as well as community-based outreach workers.¹⁶³ Other hospitals are participating in medical-legal partnerships, which add lawyers to the team providing patient care to help address legal or social issues underlying patients' poor health.¹⁶⁴ Initiatives are not limited to urban

area."). In July 2013 the group changed its name to Stakeholder Health. See STAKEHOLDER HEALTH, <http://stakeholderhealth.org> (last visited Jan. 4, 2016).

159 See, e.g., Martha Hostetter & Sarah Klein, *Improving Population Health Through Communitywide Partnerships*, QUALITY MATTERS NEWSL. (Feb. 23, 2012), <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/february-march/in-focus>; Martha H. Somerville et al., *Hospital Community Benefits After the ACA: Partnerships for Community Health Improvement*, HILLTOP INST. 1 (2012), <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief3-February2012.pdf> (describing "partnerships among public health agencies, nonprofit hospitals, and the communities they serve"); Health Sys. Learning Group Monograph, *supra* note 126.

160 Some of these hospital activities followed the completion of an ACA-mandated CHNA, while other initiatives preceded the ACA requirement or were prompted by other concerns. This Section simply provides examples of the diverse activities hospitals are engaged in, without asserting that the stimulus for a particular hospital's community-focused effort was the new CHNA requirement. Similarly, it is difficult to discern from the literature how many of these initiatives are likely to be sustained for long enough to have a significant impact on community health.

161 Health Sys. Learning Group Monograph, *supra* note 125, at 33 (describing efforts of Methodist Le Bonheur Hospital).

162 See *About the Camden Coalition*, CAMDEN COALITION HEALTHCARE PROVIDERS, <http://www.camdenhealth.org/about/about-the-coalition/history> (last visited Jan. 4, 2016) (describing the history of the Coalition); Atul Gawande, *The Hot Spotters*, NEW YORKER (Jan. 24, 2011), <http://www.newyorker.com/magazine/2011/01/24/the-hot-spotters>.

163 See Health Sys. Learning Group Monograph, *supra* note 126, at 71.

164 See generally Ellen M. Lawton & Megan Sandel, *Medical-Legal Partnerships Collaborating To Transform Healthcare for Vulnerable Patients, A Symposium Introduction and Overview*, 35 J. LEG. MED. 1, 3-4 (2014) (describing the structure and expansion of the medical-legal partnership model and its potential to address legal contributions to the social

hospitals. Hospitals in sixteen mountainous and mostly rural North Carolina counties have partnered with local health departments to establish Western North Carolina Healthy Impact, which coordinates a collaborative CHNA, and the hospitals have aligned their individual implementation strategies with the broader, community-wide health improvement plan.¹⁶⁵ These examples just begin to describe the diverse ways hospitals can engage in community-centered strategies to address community health needs.¹⁶⁶

These examples—and others like them—also provide the data for nascent research into how hospitals are actually engaging with their communities and the development of best practices¹⁶⁷ for community health improvement initiatives. A project undertaken by the Public Health Institute to develop a set of online tools for comparing the assessment, planning, and implementation processes that hospitals are using in carrying out their CHNA obligations¹⁶⁸ is an example of this research.¹⁶⁹ This project's purpose is to assist hospitals and other entities seeking to pursue community health improvement, and particularly to support the alignment of resources in communities with significant health disparities. The results of this pilot study of CHNA reports from a random sample of forty-four hospitals reflect, according to the authors, "a practical reality that there are considerable opportunities for enhancement in most communities."¹⁷⁰ To be

determinants of health).

165 See Martha H. Somerville et al., *Hospital Community Benefits After the ACA: Present Posture, Future Challenges*, HILLTOP INST. 10-11 (2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf408710.

166 For other examples, see Christine Fry et al., *Health Reform, Healthy Cities: Using Law and Policy To Reduce Obesity Rates in Underserved Communities*, 40 FORDHAM URB. L.J. 1256, 1288-89 (2013) (describing obesity-prevention initiatives of Cedar Sinai Hospital in Los Angeles and New York Presbyterian Hospital in New York City).

167 See, e.g., Kevin Barnett, *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential*, PUB. HEALTH INST. (2012), <http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvue24oqqvn5z6qaciw2u4.pdf>.

168 See *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71. This project is being funded by Centers for Disease Control and Prevention through a cooperative agreement with the National Network of Public Health Institutes.

169 Other examples include Karen Wade & Gene W. Matthews, *Review of North Carolina Hospitals' Community Health Needs Assessments and Implementation Strategies*, NETWORK FOR PUB. HEALTH L. (2014), https://www.networkforphl.org/_asset/r1gg6w/Network-NC-CHNA-Report.pdf; *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71; and Tahk, *supra* note 7, at 59-64 (analyzing data from 2012 tax returns for all tax-exempt hospitals in the United States).

170 Wade & Matthews, *supra* note 169, at 6.

blunt: there is a lot of room for improvement. In particular, the findings suggest the need for clarification and assistance relating to how a hospital defines its community; the role and extent of community input; how health needs are prioritized; how interventions are targeted geographically to address health disparities; and how hospitals develop tools to evaluate their community health activities.¹⁷¹

In summary, this Part demonstrates that the hospital industry recognizes the need for increased attention to population health, that numerous hospitals and health systems already are engaged in efforts to improve their communities' health, and that initial research into hospitals' CHNA compliance activities finds ample room for improvement in connecting compliance to community health advances. Together, these findings suggest the importance of further guidance from the IRS to help harness and direct the substantial investment hospitals are making in the CHNA enterprise. The broad goals of such guidance should be to maximize the prospect of those investments' "moving the needle" both in addressing community health needs and in producing meaningful knowledge about how to do so. Thus, they set the stage for this Article's final Part.

IV. THE OPPORTUNITY GOING FORWARD

This Article posits that targeted regulatory guidance on hospitals' new CHNA obligation is critically important to maximizing the potential for community health improvement. Having described the existing regulatory framework and approaches already percolating in the hospital community, the final step is to consider how the IRS's regulatory approach could be more effective. To that end, this Part will first note some broad considerations regarding the IRS's role in making health-related policy. Then it will examine in greater depth the four substantive values the IRS should promote going forward, explaining their importance and suggesting ways to advance each of them. It will close with a few ideas on mechanisms the IRS might consider for promoting those values.

A. The IRS as Health Policy Maker

Questioning the desirability of the IRS's central role in formulating health policy through its administration of tax-exemption standards is not novel.¹⁷² Thus, before a discussion describing *what* the IRS should do to refine its CHNA guidance going forward, pausing briefly to address *why* this Article focuses on the IRS's role at all is in order. As described above, the IRS did not historically

¹⁷¹ *Id.* at 5-6.

¹⁷² See, e.g., Fox & Schaffer, *supra* note 36, at 266-67.

(at least until the last decade) pay much attention to hospital tax exemption.¹⁷³ Its long-term track record does not augur well for its paying close and creative attention to enforcing the CHNA requirement. Moreover, as an agency whose primary focus is collecting revenue, its staff cannot be expected to bring a deep level of expertise or understanding to the project of refining the CHNA guidance to help accomplish community health goals.¹⁷⁴

Notwithstanding these legitimate questions, asking the IRS to play an important role now and in the coming years is justified. The agency's recent Schedule H initiative to collect community benefit information from hospitals and its engagement with diverse stakeholders in the promulgation of the Regulations demonstrate a commitment to closer oversight of tax-exempt hospitals. In addition, using the Tax Code to accomplish health policy goals accords with the IRS's growing role in administering social welfare policy more broadly.¹⁷⁵ The agency's "to do" list from the ACA alone is long and complex,¹⁷⁶ suggesting that it will develop increasing expertise in health matters. Indeed, given the broad demands of ACA implementation and a shrinking agency budget,¹⁷⁷ the pertinent question may be whether the IRS will have the resources to pay more than cursory attention to the CHNA requirement now that it has issued the Regulations.

Yet investing resources in the further refinement of the CHNA guidance could bear valuable fruit. As discussed in Part III.E, forces are pushing hospitals to increase their focus on population health. The IRS has an opportunity to leverage these forces so that hospitals' investments in population health are channeled in socially optimal directions, rather than being driven solely by hospitals' economic interests. The resources at stake are enormous. As Chris Kabel has pointed out, if tax-exempt hospitals were to invest in primary preventive care just twenty percent of their current community benefit expenditures on uncompensated and discounted care, the investment would be about \$2.2 billion annually. This amount exceeds Congress's annual allocation to

173 See *supra* Section II.A.

174 See *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (making a similar observation in deciding not to grant *Chevron* deference to IRS regulations relating to the availability of tax subsidies for health insurance purchases under the ACA: "[i]t is especially unlikely that Congress would have delegated this decision to the IRS, which has no expertise in crafting health insurance policy of this sort.") (emphasis in original).

175 See generally Susannah Camic Tahk, *The Tax War on Poverty*, 56 ARIZ. L. REV. 791 (2014) (describing increasing reliance on IRS to administer poverty-reducing programs).

176 I INTERNAL REVENUE SERV., 2014 ANNUAL REPORT TO CONGRESS 67, 77 (2014), <http://www.taxpayeradvocate.irs.gov/Media/Default/Documents/2014-Annual-Report/HEALTH-CARE-IMPLEMENTATION-Implementation-of-the-Affordable-Care-Act-May-Unnecessarily-Burden-Taxpayers.pdf>.

177 *Id.* at 68.

the Prevention and Public Health Fund, the federal government's largest commitment to prevention.¹⁷⁸

Hospital involvement in promoting community health will doubtless evolve over time. But if the IRS fails now, at the beginning, to play a leading role in promoting transparency, accountability, community engagement, and collaboration in hospitals' compliance activities, other narratives may take hold and produce less desirable patterns of hospital behavior. Once patterns are established, influencing how hospitals conduct their CHNAs will be far more difficult.¹⁷⁹ For that reason, it is important that the IRS not take its eye off the ball just because it has issued the CHNA Regulations.

Admittedly, hospitals are unlikely to welcome any proposal that the IRS enhance its oversight of the CHNA requirement. For hospitals conducting a CHNA for the first time, the process undoubtedly demanded significant energy and resources. Enhancing the IRS's regulatory guidance as suggested in this Part, however, need not increase the compliance burden on hospitals and may even, to the extent that hospitals collaborate to assess and address community health needs, decrease it. Further guidance can simultaneously establish clear expectations for hospitals and, recognizing the diversity of hospitals' situations, permit significant flexibility in how those expectations are met. Combining clear expectations regarding transparency, accountability, and community engagement with significant flexibility will encourage collaboration and facilitate hospitals' meaningful efforts to address community health issues.

In developing the Regulations, the IRS sought to strike this balance, including elements of both flexibility and standards. The Regulations tilt towards unconstrained decision making by hospitals, however, in the areas of identifying and prioritizing needs. In granting hospitals unfettered discretion to decide which health needs are significant and then to prioritize them, the Regulations make it too easy for hospitals to "think small" and thus decrease hospitals' incentive to partner with others in broader or more challenging community health projects. This Article proposes an antidote that emphasizes process-oriented values rather than substantive prescriptions in order to accommodate hospital diversity while encouraging the institutions to "think big" about their potential contributions to community health.¹⁸⁰

178 Chris Kabel, *What Is the Future of Hospital Community Benefit Programs?*, STAN. SOC. INNOVATION REV. (June 5, 2013), http://ssir.org/articles/entry/what_is_the_future_of_hospital_community_benefit_programs.

179 Cf. *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71 (noting that established community benefit activities may constrain hospital choices in implementing CHNAs).

180 Cf. *IRS Hospital Study*, *supra* note 45, at 4 (noting the difficulty of having a more precise standard than community benefit that applies to diverse set of hospitals currently

B. Four Values To Promote

1. Transparency

Transparency and accountability are cardinal virtues for the IRS to promote in further CHNA guidance to hospitals. Beyond the world of hospitals, these values are of central concern in the broader nonprofit sector. The National Council on Nonprofits advises its constituents on practices for “Cultivating a Culture of Accountability and Transparency.”¹⁸¹ The two values are connected (and are also related to community engagement and collaboration), but addressing each separately permits a more careful teasing out of its distinctive value.

In the context of hospitals’ CHNA obligation, transparency entails openness with respect to both the process by which the CHNA report and implementation strategy are created and the end products. This transparency offers benefits on several levels.¹⁸² A hospital’s openness in sharing information about how it assessed its community’s health needs and decided on strategies to respond to those needs helps community members understand how they might engage with the hospital’s efforts or tap into health improvement resources. Mandating transparency regarding a hospital’s response to community health needs may prompt hospitals to devote greater attention and resources to those needs¹⁸³ in order to enhance their reputation in the community and generate greater patient affinity.¹⁸⁴ Recent research suggests that the transparency associated with targeted disclosure laws may empower hospital staff to carry out their responsibilities more effectively.¹⁸⁵ In addition, information about hospitals’ CHNA processes and conclusions may serve as useful data for health

doing different things).

181 See *Financial Transparency*, NAT’L COUNCIL NONPROFITS, <http://www.councilofnonprofits.org/tools-resources-categories/financial-transparency> (last visited Jan. 4, 2016).

182 Accord Rosenbaum, *supra* note 24, at 6 (listing the benefits of transparency).

183 See, e.g., Timothy D. Lytton et al., *There Is More to Transparency than Meets the Eye: The Impact of Mandatory Disclosure Laws Aimed at Promoting Breastfeeding*, 40 AM. J.L. & MED. 393 (2014) (describing how mandatory disclosure laws designed to increase breastfeeding encouraged nurse managers within hospitals to advocate for changes to hospital policies and implement performance standards).

184 Cf. David Grande et al., *Perceived Community Commitment of Hospitals: An Exploratory Analysis of Its Potential Influence on Hospital Choice and Health Care System Distrust*, 50 INQUIRY 312 (2013) (reporting results of a survey finding that patients with favorable views of their local hospital’s community commitment were more likely to choose the hospital for surgery).

185 See Lytton et al., *supra* note 183.

departments engaged in health improvement efforts.¹⁸⁶

Transparency is also a precondition for a hospital's accountability, whether to regulators or community members. On the most obvious level, the IRS's ability to determine a hospital's compliance with the CHNA requirement depends on receiving sufficient information from the hospital. More broadly, transparency regarding hospitals' community health-oriented activities provides some accountability to the public and the hospital's particular community on how the hospital is actually using the financial benefit it receives from tax exemption. In that sense, requiring greater transparency regarding a hospital's community health-oriented efforts is analogous to the transparency mandated by the Federal Funding Accountability and Transparency Act (FFATA).¹⁸⁷ That law provides for online information about federal expenditures (e.g., grants, loans, and contracts) so that the public can know how tax dollars are being spent and hold the government accountable for spending decisions.¹⁸⁸ Because the forgone revenue from hospital tax exemption is akin to a tax expenditure,¹⁸⁹ similar value lies in the public availability of information about hospital expenditures.

In addition, transparency regarding a hospital's community health assessment and improvement activities facilitates the formation and effective functioning of partnerships. A hospital's openness about its prioritization of community needs and plans to address those needs permits other organizations to

186 For example, the Pennsylvania Department of Health has considered the community health priorities identified by Pennsylvania hospitals in their first round of CHNAs as part of the state health department's identification of health needs. I learned about the Pennsylvania Department of Health's approach from a conversation with faculty members at the University of Pittsburgh's Graduate School of Public Health regarding uses of the data collected in hospital CHNAs.

187 Pub. L. No. 109-282, 120 Stat. 1186 (2006) (codified as amended at 31 U.S.C. § 6101 (2012)).

188 See *About FSRS*, FED. FUNDING ACCOUNTABILITY & TRANSPARENCY ACT SUBAWARD REPORTING SYS., <http://www.fsr.gov> (last visited Jan. 4, 2016) ("The intent [of the FFATA] is to empower every American with the ability to hold the government accountable for each spending decision. . . . [T]he legislation requires information on federal awards (federal financial assistance and expenditures) be made available to the public via a single, searchable website . . .").

189 In recent years, the federal government increasingly has sought to measure the extent and effectiveness of tax expenditures, which it defines as revenue losses resulting from special tax code provisions that reduce taxpayers' income tax liabilities, JOINT COMM. ON TAXATION, JCS-97-14, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2014-2018, at 2 (2014). According to the Joint Committee on Taxation, "The tax exemption for charities is not treated as a tax expenditure even if taxable analogues may exist. For example, the tax exemption for hospitals and universities is not treated as a tax expenditure notwithstanding the existence of taxable hospitals and universities." *Id.* at 9 n.19. Although the revenue forgone as a result of a hospital's tax exemption thus does not meet the federal government's definition of tax expenditure, the value of transparency that supports accountability still pertains.

identify areas of shared concern, paving the way for possible partnerships. Community health collaborations require open communication among partners to ensure alignment and coordination of efforts, and transparency is particularly vital in multi-sector, sustained collaborations seeking to produce “collective impact” on a complex problem.¹⁹⁰

Finally, transparency regarding hospitals’ experiences as they engage in community health improvement activities—whether those experiences are encouraging or disappointing—lays the foundation for collective learning and the development of best practices. For example, the hospitals and health systems in the Health Systems Learning Group committed to sharing information to permit learning from one another’s experiences.¹⁹¹ More broadly, the availability of sufficiently granular information regarding hospitals’ experiences in implementing the CHNA requirement provides researchers with the data needed for developing process improvements and evaluating the impact of the legislative requirement.¹⁹²

Of course, transparency is not cost free. In the simplest terms, hospitals’ collecting, recording, and sharing of information demand resources in the form of staff training and time and technology support. Hospitals’ concerns about the level of detailed transparency required were evident in comments on early versions of the IRS CHNA guidance, where hospitals voiced worries about having to identify every community member providing any input during the CHNA process.¹⁹³

Beyond the financial cost, asking hospitals to share information about their CHNA process may uncover reservations relating to reputational or competitive concerns. In the years when hospitals’ tax-exempt status was defined only in terms of “community benefit,” many hospitals relied on their marketing departments to gather and publicize information about their community benefit

190 John Kania & Mark Kramer, *Collective Impact*, STAN. SOC. INNOVATION REV., Winter 2011, at 36, 36.

191 See Health Sys. Learning Group Monograph, *supra* note 126, at 5.

192 Cf. Kristin Madison et al., *Using Reporting Requirements To Improve Employer Wellness Incentives and Their Regulation*, 39 J. HEALTH POL. POL’Y & L. 1013 (2014) (making a similar point with respect to employer wellness programs and proposing reporting requirements); *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 88 (noting the value of increased transparency regarding the roles and contributions of various stakeholders as providing “a practical means of disseminating innovative approaches to comprehensive community health improvement”).

193 See Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20523, 20531 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pt. 1) (“[The] CHNA report may summarize, in general terms, how and over what time period input was provided, and need not provide a detailed description of each instance of feedback.”).

activities.¹⁹⁴ From a business perspective, hospitals' incentive was to craft a community benefits approach that enhanced their image within their community and satisfied the IRS, while minimizing the actual resources deployed. Striking this balance offered a hospital a competitive edge, along with an incentive to treat its community benefit operations as entailing proprietary information, but this view of community benefit is opposed to a high level of transparency.

Although some hospitals have shown a commitment to transparency regarding their CHNA processes, the pilot study of the first round of CHNA reports found transparency lacking in a number of areas. Because of the importance of transparency and countervailing concerns that may lead some hospitals to hang back from sharing information, ongoing guidance by the IRS should promote greater transparency.

The IRS already made an important commitment to transparency by interpreting the ACA's requirement that CHNA reports be "widely available to the public" as requiring the hospital to post its CHNA report online, in addition to making a paper copy available for public inspection at the hospital.¹⁹⁵ These are steps in the right direction, but making the CHNA report, which describes the assessment process and its results, easily accessible to community members does not fully meet the need for transparency. Information about the hospital's plans and the activities underway to address high priority needs should also be readily available to community stakeholders, potential partners, and researchers.

Currently, the Regulations require a hospital to file annually with the IRS (1) either a copy of its current implementation strategy or a link to the website where it has posted the implementation strategy along with its CHNA report, and (2) a description of its activities during the past year to address the significant health needs identified in its CHNA or an explanation of why no action was taken with respect to one or more needs.¹⁹⁶ Thus, the IRS already requires hospitals to collect and report this information, and the IRS filings are a matter of public record, although they may not be easily accessible to community members.¹⁹⁷ To heighten the transparency of hospitals' community health

194 See *Community Benefit Contributions and Reporting: Emerging Standards Present an Opportunity for the U.S. Nonprofit Hospital Sector To Articulate Benefits Clearly and with a Unified Voice*, CHARTIS GROUP 4 (2009), <http://www.chartis.com/files/pdfs/chartis-community-benefit-contributions-reporting-health-care-management.pdf>; *A Marketer's Guide to Community Benefit Reporting and IRS Form 990*, PATSY METHENY, LLC, at xvi (2009), healthleadersmedia.com/supplemental/7757_browse.pdf ("The responsibility rests with hospital and health system marketers to put all the pieces of community benefit together to create a consistent, ongoing message that demonstrates the organizations' commitment to improving the community's health status.").

195 Treas. Reg. § 1.501(r)-3(b)(7) (2015).

196 Treas. Reg. § 1.6033-2(a)(2)(ii)(I)(2), (3).

197 See *supra* note 98 and accompanying text.

activities and undercut the view that those activities constitute proprietary information, the IRS should require hospitals to post their implementation strategies online alongside their CHNA reports and to provide annual online updates of community health activities underway. Requiring this additional level of transparency should not burden hospitals, who must already collect and report this information to the IRS, and it would go a long way towards promoting a continuing flow of communication between hospitals and their communities.

In addition, the IRS should encourage greater transparency by further clarifying its expectations for the processes and standards hospitals should employ when conducting and reporting on their needs assessments and strategies. Initial reviews of the first round of CHNA reports note the challenge of determining how hospitals defined their communities, the nature and extent of input received from community representatives, and the process used for prioritizing significant health needs.¹⁹⁸ The lack of detail is not surprising. For most hospitals, preparing a CHNA report pursuant to the ACA was their maiden voyage into new and unfamiliar waters, and the IRS's preliminary guidance left open many questions about what hospitals had to do and report. As the process becomes more familiar, the IRS should communicate its expectations that hospitals describe their processes, decisions, rationales, and findings with greater granularity. Sufficient detail is critical not only for demonstrating hospital accountability to local communities and the federal fisc, but also for providing data to enable assessment of whether establishing community health obligations for tax-exempt hospitals contributes to improvements in community health.¹⁹⁹

2. Accountability

In contrast to increasing emphasis on transparency, a stronger commitment to accountability would hold hospitals more clearly responsible for meeting the legal expectations established by the ACA²⁰⁰ and, on some level, for contributing to community health improvement. If transparency is about openness and availability of information, accountability is about holding decision makers answerable for their actions. At the most basic level, accountability would ensure that hospitals benefiting from federal tax exemption in fact do what the law

198 See *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 85-89; Wade & Matthews, *supra* note 169, at 2.

199 Cf. Jessica Berg, *Putting the Community Back into the "Community Benefit" Standard*, 44 GA. L. REV. 375, 412-15 (2010) (noting difficulty of measuring public health benefits).

200 These include the steps required for compliance with the CHNA requirement, as well as the requirements relating to financial assistance policies, hospital charges, and collection practices. For a discussion of the latter requirements, see *supra* note 43 and accompanying text.

directs them to do. More exacting accountability would ask whether an individual hospital's actions measurably improved a health need in its community. Finally, we may also consider the government's accountability: Does imposing a CHNA obligation on hospitals as a condition of tax exemption produce an aggregate public good? Thus, the IRS should consider several levels of accountability.

Accountability requires at a bare minimum some mechanism for ensuring that tax-exempt hospitals have completed the CHNA-related steps required by § 501(r) and the Regulations. Currently, basic accountability attaches to the requirement that hospitals make their CHNA report available online and Schedule H's inclusion of questions about whether and how a hospital conducted a CHNA and addressed the needs identified. The information requested from hospitals remains fairly minimal, particularly when it comes to carrying out their plans to address a community health need. Schedule H asks hospitals to indicate how they have addressed needs identified in their CHNAs, but a hospital can respond simply by checking a box for "Execution of the implementation strategy." The instructions direct hospitals to check that box "if the hospital facility has begun, continued, or completed execution of its implementation strategy." This check-the-box approach provides little in the way of transparency and signals little appetite on the IRS's part for holding hospitals accountable.

At the very least, the IRS should ask hospitals for more detailed descriptions of what they are actually doing. In addition to advancing transparency, the anticipation of being required to report on activities in some detail should prompt hospitals to be deliberate in performing and tracking their community health activities. Because the Regulations permit a range of consequences for hospitals that fail to comply with § 501(r),²⁰¹ the IRS can calibrate its response to those hospitals²⁰² and thus may be willing to impose accountability measures.

Another layer of accountability involves trying to determine whether a hospital's community health-oriented activities have an actual impact on the community health needs the hospital seeks to address. One scholar writing about accountability for nonprofit organizations contrasts an organization's accountability "upwards" toward its funders (here, the federal government) with its accountability "downwards" towards groups that use its services or, more

201 The possible consequences range from the revocation of §501(c)(3) status for an organization, to the imposition of a \$50,000 excise tax, to the IRS's ignoring minor omissions and errors that are either inadvertent or due to reasonable cause. If a hospital organization operates multiple hospitals and one of them fails to comply, the income from the noncompliant hospital facility will be subject to taxation. *See* 26 C.F.R. §1.501(r)-2 (2015); 26 C.F.R. §53.4959-1 (2015).

202 *See* Berg, *supra* note 199, at 406 (suggesting the possible value of intermediate sanctions).

broadly, to the communities its programs indirectly affect.²⁰³ Assessing a hospital's "downwards" accountability by measuring the impact of its community health-oriented activities presents a daunting challenge.²⁰⁴ Public health interventions targeting upstream determinants of health are hard to evaluate because of the slow pace at which the root causes of poor health typically change and the difficulty of teasing out the contributions of the various factors affecting health.²⁰⁵ Moreover, improving key indicators of population health will typically require shared responsibility among hospitals, public health agencies, and other community organizations, so that no single organization can be held accountable for outcomes.²⁰⁶

Even when an intervention targets a discrete health behavior or outcome for improvement, hospitals typically are not well equipped — in terms of either staff expertise or health information and data tracking technologies — to develop and implement metrics and strategies for monitoring progress.²⁰⁷ Perhaps most importantly, because hospitals are "learning by doing" as they begin conducting assessments and devising health improvement strategies, it seems unwise at this point to hold them accountable (in the sense of subjecting them to bad consequences) for failing to make measurable progress in improving community health. If anything, hospitals should be encouraged to be ambitious, rather than play it safe, as they consider the impact they might have on their community's health.²⁰⁸

Reservations about the feasibility of expecting individual hospitals to rigorously evaluate the impact of their community health activities, however, do not justify abandoning or watering down a commitment to accountability. Peter Drucker's saying—"what gets measured gets managed"—applies here, and points to the importance of requiring hospitals to engage in some form of monitoring and reporting changes in the community health needs they seek to address.²⁰⁹ A hospital that is part of a collaborative health improvement initiative

203 See Alnoor Ebrahim, *The Many Faces of Nonprofit Accountability*, in JOSSEY-BASS HANDBOOK ON NONPROFIT LEADERSHIP & MGMT. 101, 103 (David O. Renz ed., 2010).

204 See Rubin et al., *supra* note 49, at 614.

205 Cf. Berg, *supra* note 199, at 413.

206 See Stoto & Ryan, *supra* note 104, at 8.

207 *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 80-81; cf. Jessica G. Burke et al., *What Can Be Learned from the Types of Community Benefit Programs That Hospitals Already Have in Place?*, 25 J. HEALTH CARE POOR & UNDERSERVED 165, 178 (2014) (finding that few community benefit programs are evaluated rigorously and suggesting that hospitals partner with public health professionals to carry out and evaluate their programs).

208 See Nelson et al., *supra* note 14, at 9 (cautioning that "an outcome-based approach could raise concerns regarding whether nonprofit hospitals might become risk-averse, perhaps leading to a smaller number of creative, innovative strategies and activities").

209 Cf. Corrigan et al., *supra* note 109, at 1211 (characterizing the regulatory structure as

could be required to report on its performance of its agreed-on contribution to the collaboration.²¹⁰ In addition, in developing their strategies, hospitals and their partners can rely on a growing body of evidence documenting interventions that produce community health improvements.²¹¹

The July 2013 proposed regulations would have required hospitals to include a plan for measuring impact as part of their implementation strategy, but they contained no requirement for reporting the results of those measurements. By contrast, the final Regulations no longer require the implementation strategy to include an evaluation plan, but instead call for CHNA reports to include an evaluation of the impact made by the hospital's activities responding to health needs identified in the hospital's *preceding* CHNA report. Ideally, a hospital's strategy for addressing a community health need should include, from the beginning, an articulation of how the hospital expects its strategy will affect its prioritized health needs and a plan for measuring impact.²¹² Without that, engaging in activities with no reasoned basis for expecting them to have an impact is too easy for hospitals. Imposing the discipline of identifying a basis in evidence or logic for believing that activities will have an impact seems likely to improve the quality of hospitals' strategies, as well as to enhance the chance of actual impact.

Hospitals may object to the imposition of both a front-end requirement of a plan for evaluation and a back-end requirement of reporting evaluation results as more burdensome than the Regulations' more limited approach. Such a requirement should not only enhance the effectiveness of individual hospitals' strategies, but also encourage hospitals to participate in community health collective impact efforts²¹³ and better equip researchers and policy makers to assess whether the CHNA requirement produces measurable community benefit.²¹⁴ Thus, efforts by individual hospitals to monitor, measure, and report

providing hospitals "a substantial amount of flexibility while requiring little accountability or evidence of effect on population health").

210 See Stoto & Ryan, *supra* note 104, at 11.

211 See Rosenbaum et al., *supra* note 108 (citing government and nonprofit reports).

212 Cf. Simone R. Singh, *Community Benefit in Exchange for Non-Profit Hospital Tax Exemption: Current Trends and Future Outlook*, 39 J. HEALTH CARE FIN. 32, 39 (2013) (suggesting that "the performance measures that hospitals specify in their improvement plans may serve as the basis for an evaluation of the health outcomes").

213 See Kania & Kramer, *supra* note 190, at 40 (noting that one of the five conditions needed for a successful collective impact effort is a shared measurement system for collecting data and measuring results consistently).

214 See Rosenbaum, *supra* note 24, at 6 ("[I]nnovative promising practices can be coupled with thorough evaluation to help improve health and further build the evidence base for community interventions.").

the impact of their community health activities are an essential building block for evaluating the impact of the ACA's CHNA requirement.

This point leads to the third dimension of accountability that the IRS should advance in providing guidance to hospitals: the accountability of policy makers to assess whether policies are achieving their desired ends. Over time, researchers—if good data are available—should be able to evaluate whether requiring tax-exempt hospitals to complete the CHNA-related requirements of § 501(r) leads to improvements in the community health problems targeted, to more efficient collaborative approaches to community health problems, or to whatever policy goal might be assessed. If the CHNA requirement is shown to lead to measurable improvements in the effectiveness or efficiency of community health improvement efforts, then the ACA's innovation may be judged a success. If it is not, then the whole CHNA requirement appears as an empty exercise that imposes burdens on hospitals to no good end. If data about what hospitals do and how health measures change are unavailable or spotty, then we can only scratch our heads and wonder whether the CHNA policy has accomplished anything.

Because most hospitals are beginners when it comes to developing evaluation strategies for community health interventions and tracking data regarding community health measures,²¹⁵ the IRS may justify the Regulations' limited approach to accountability by referring to the need to learn to crawl before walking or running. Over time, however, accountability mechanisms should be refined. While an enforcement approach emphasizing efforts over outcomes seems a wise way for the IRS to begin, it should explore ways to maximize the collection and evaluation of data as soon as possible. Developing an evidentiary basis for assessing which community-focused hospital initiatives actually work must be addressed if the goal is truly community health improvement on a large scale.

3. *Community Engagement*

Community engagement is a third value that the IRS should promote in ongoing guidance. A core tenet of public health practice recognizes community engagement as critical to effective community health improvement initiatives.²¹⁶

215 See Barilla et al., *supra* note 126, at 11 (describing the need for hospitals to develop models for evaluating “the complex interaction of factors that contribute to changes in utilization, improved health outcomes, and improvised conditions in the broader community,” which the Report calls “social returns on investment”).

216 See generally NAT'L INSTS. HEALTH, NO. 11-7782, PRINCIPLES OF COMMUNITY ENGAGEMENT, at xv (2d ed. 2011), http://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf (providing guidance and tools for community engagement efforts and describing the science base supporting community engagement).

Community engagement is important both for identifying and understanding a community's health problems and for maximizing the effectiveness of interventions. Therefore, if the CHNA requirement seeks for hospitals to play a meaningful role in improving the health of their communities, closely involving those communities in the process is essential. As discussed above, emphasizing transparency and accountability will facilitate community engagement. As discussed below, this community engagement will enhance a hospital's ability to form effective partnerships.

Ideally, a hospital would continually interact with groups and individuals in its community.²¹⁷ Highlighting two particular points in the community health improvement cycle, though, may be helpful: (1) soliciting and considering community input in identifying and prioritizing health needs, and (2) developing and implementing strategies that involve community members on an ongoing basis. These are both points where the IRS could facilitate or require greater community engagement by hospitals.²¹⁸

To the first point, the Regulations provide that satisfying the statutory requirement of taking into account input from persons representing the broad interests of the community requires hospitals to "solicit and take into account input from "[m]embers of medically underserved, low-income, and minority populations . . . or individuals or organizations serving or representing the interests of such populations."²¹⁹ The final Regulations clarify that hospitals should consider community input in both identifying and prioritizing significant health needs,²²⁰ as well as in identifying resources that might be tapped to address those needs. They also indicate that a hospital can demonstrate its compliance by summarizing the input received, "how and over what time period it was provided," what organizations provided input, and what "medically underserved, low-income, or minority populations" were represented.²²¹

Expanding hospitals' obligation to consider community input not only in identifying needs, but also in prioritizing these needs and identifying potentially helpful resources, represents the IRS's validation of community engagement. An examination of the first round of CHNA reports reveals that few hospitals indicated that community members participated in setting priorities. More

217 See Rosenbaum, *supra* note 24, at 5 ("Successful models indicate that community engagement is essential at each stage of the community health improvement process . . .").

218 In addition, the Regulations require that, in conducting CHNAs after their initial one, hospitals must take into account written comments received on its most recent CHNA and implementation strategy. 26 C.F.R. § 1.501(r)-3(b)(5)(C) (2015).

219 § 1.501(r)-3(b)(5)(B).

220 *Id.* The proposed regulations referred only to hospitals' consideration of input in "assessing health needs." Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20,523, 20,541 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pt. 1).

221 26 C.F.R. § 1.501(r)-3(b)(6)(iii).

generally, researchers could not determine whether hospitals' solicitation of input created meaningful opportunities to engage community members or simply represented the hospitals' jumping through regulatory hoops.²²² Similarly, these researchers distinguished community consultation from community engagement.²²³ Simply seeking information or opinions from community members and stakeholders, without drawing them into dialogue about their views, experiences, and ideas, will not produce the full benefits of community engagement. Such inquiry without true engagement may help explain why many hospitals used criteria for prioritizing health needs that focused more on the hospital's situation than on the community and its needs.²²⁴

Hospitals' limited vision of community engagement (likely combined, in many cases, with a desire to control and circumscribe their eventual commitments) likewise affects the strategies hospitals adopt for addressing community needs. One of the few studies to date of the initial round of CHNA reports and implementation strategies found that hospitals' strategies emphasized clinical care initiatives over addressing health behaviors or social, economic or environmental factors.²²⁵ Carrying out strategies of the latter ilk more likely entails ongoing community engagement, but may be "messier," requiring the hospital to cede some control.

Because the optimal level of community engagement depends on the widely varying situations of both hospitals and their communities, rejecting any prescribed formula for community engagement is appropriate. That said, the IRS should pursue steps to increase hospitals' robust engagement of their communities. Without mandating any particular form of engagement, it could require greater specificity from hospitals in reporting how they solicit and take into account input from community representatives, which groups participated in the CHNA and implementation strategy processes, and how community input translated into priorities and strategies. With that information readily available, community members can see either that their input has an impact on what the hospital does (which could motivate them to become further involved) or that the hospital disregards their input (which could motivate them to demand greater consideration).²²⁶

Moreover, making more granular information about individual hospitals'

222 *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 77-78.

223 *Id.* at 84.

224 *Id.* at 78.

225 Wade & Matthews, *supra* note 169, at 2.

226 *Cf. Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 77 (noting that it was unclear from review of CHNA reports how meaningful community engagement was and whether it had any influence).

interactions with their communities available would permit researchers to draw comparisons among hospitals' performances in terms of community engagement and to describe best practices available to assist hospitals seeking to connect more effectively with their communities. The IRS may not have the resources or inclination to scrutinize closely the seriousness of hospital efforts at community engagement, but researchers do, if only the data were available. Finally, clarifying that community-focused collaborative activities addressing social determinants of health will "count" in satisfying a hospital's community benefit obligation could remove a lingering disincentive for some hospitals to invest in community engagement. Uncertainty on that point may make hospitals reluctant to move beyond more conventional community benefit activities.²²⁷

4. Collaboration: Where It All Comes Together

Several aspects of the Regulations lay the foundation for hospitals' collaboration with one another and other community stakeholders during the process of assessing and addressing community health needs. By requiring hospitals to solicit and take into account input from health departments and members or representatives of minority, underserved and low-income groups, the Regulations require some level of dialogue, an obvious precondition to collaboration. They also reinforce the centrality of a population health perspective. In addition, the Regulations not only endorse partnering in assessment processes and sharing information, they also permit some hospitals to submit joint CHNA reports and implementation strategies, as long as hospitals do not use "collaboration" as a mask for free-riding on others' efforts and commitments.

Going forward, the IRS should recognize factors that may make collaboration attractive to hospitals, as well as concerns that may undercut collaborative efforts. Its ongoing guidance to hospitals should seek to reinforce the former and counteract the latter. Leaders in the hospital industry recognize partnerships as an essential element of hospitals' playing meaningful roles in improving population health,²²⁸ as do public health scholars.²²⁹ By being attuned to forces at play in hospitals' world, the IRS can encourage hospital participation in collaborative projects to improve community health—including broad collective impact initiatives—without mandating any particular collaboration.

The Regulations require hospitals to seek and take into account health department input. The PHI Report, however, found that many hospital CHNA reports left unclear the level and form of engagement that actually occurred

²²⁷ See *id.*

²²⁸ See *Managing Population Health*, *supra* note 141, at 3-5.

²²⁹ See Rosenbaum, *supra* note 24, at 3.

between the hospital and health department and suggested that many hospitals simply may have relied on the health department for help with a particular element of the assessment (for example, providing data or conducting a focus group). Beyond this minimal cooperation, the PHI Report stresses the value of actual alignment between the community health activities of hospitals and health departments, so that limited resources can be leveraged and used efficiently. The IRS can encourage closer hospital/health department collaborations without mandating them by, for example, providing more guidance on what the “take into account input received” requirement actually means.²³⁰ Ideally, that guidance would identify both the minimum level of consultation that is expected and exemplary practices that are encouraged. Given obstacles to alignment of hospital and health department efforts, joint efforts may not occur immediately. But by clarifying its expectations regarding input, the IRS could make sustained dialogue regarding community needs more likely and thus pave the way for alignment.²³¹

Collaborating with other hospitals and health departments may be of particular value. For one, multi-hospital/health department collaborations can defuse the concern that local health departments may not have the capacity to provide the mandated input to numerous local hospitals conducting CHNAs separately and simultaneously.²³² In addition, working with a health department and other hospitals to devise and carry out community health improvement strategies could be attractive for hospitals new to the CHNA process. However, several practical factors may make it less likely that hospitals will participate in collaborative projects without clearer regulatory encouragement.

First, as discussed above, historically some hospitals have viewed aspects of their community benefit programs as proprietary information. A competitive mindset and unwillingness to share information would prevent effective collaboration among hospitals. While hospitals do not compete with health departments, a general reticence to share information deemed proprietary diminishes the likelihood hospitals will participate in a joint strategy for addressing community health needs. From this perspective, the importance of transparency as a means of undercutting a view of community benefits approaches as proprietary information becomes evident.

The Regulations’ relative weakness on accountability may also lower the

230 Cf. *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 77 (noting difficulty in determining exactly how a hospital took community input into account and whether opportunities for input were meaningful).

231 Cf. *id.* at 81-82 (noting obstacles to alignment, but stating: “Where dialogue has been established, there is a growing recognition of the overlap between roles and target populations, and the opportunities to leverage limited resources.”).

232 See *supra* note 133 and accompanying text.

chances of robust collaborations. As discussed above, the Regulations require a hospital to describe the anticipated impact of its planned actions, report annually on actions taken to address significant health needs, and include in its next CHNA report an evaluation of those actions' impact. These requirements create some accountability for hospitals, but not enough to maximize opportunities for real changes in community health. Recalling the historical lack of clear IRS guidance on what the community benefit standard demands, hospitals may read the absence of guidance on monitoring and measuring impacts as a signal that simply "going through the motions" of evaluating impact will suffice. That approach would be antithetical to public health's growing commitment to evidence-based measurement of impact and could be a barrier to effective partnerships with health departments.

A lack of regulatory enthusiasm for hospitals' collection and sharing of data and measuring impact may be particularly problematic when it comes to encouraging some hospitals to "think big" and be willing to participate in multi-sector collective impact initiatives to address community health issues.²³³ The AHA Reports identify physicians, payers, employers, social services providers, and community organizations²³⁴ as having potential roles to play in improving community health, particularly when the target for improvement is a social determinant of health. For hospitals to play a meaningful role in addressing non-medical factors contributing to poor health, they almost certainly will need to collaborate with other stakeholders. Encouraging hospitals to participate in ambitious health-oriented collective impact initiatives, however, requires adjustment of an additional aspect of the IRS's existing guidance.

Specifically, the IRS should revise its instructions to hospitals completing Schedule H to clarify that it will deem a hospital's participation in a community health-oriented collaboration to be a community benefit. Because the ACA's creation of the CHNA requirement supplements, rather than replaces, the preexisting community benefit standard, it is theoretically possible that a hospital could satisfy the CHNA requirement but not the community benefit standard. Moreover, while the final Regulations' broad definition of "community health need" should reassure hospitals that the category includes social determinants of health, Schedule H's instructions are less clear that "community building activities" count as community benefit.²³⁵ This lack of clarity may sap a

233 See Kania & Kramer, *supra* note 190, at 40 (identifying a shared measurement system by which participants collect data and measure results consistently using a short list of indicators as one of the five conditions needed for a successful collective impact effort).

234 See *Managing Population Health*, *supra* note 141, at 3 fig.1.

235 As discussed above, recent revisions to those instructions state that some community building activities "may also meet the definition of community benefit," without clarifying which community building activities will meet that definition. See *supra* Section II.E.2.

hospital's enthusiasm for participating in a collective impact initiative where the hospital's contribution would not be a traditional form of community benefit. By clarifying that community benefit encompasses efforts to address a social determinant the hospital has identified as a community health need, even if the hospital is not the leader of the partnership,²³⁶ the IRS could eliminate legal concerns for hospitals willing to think broadly about their roles in their communities.²³⁷

Going forward, the IRS should provide guidance on these points in order to facilitate and encourage hospitals' partnering with health departments²³⁸ and other community stakeholders, whether in discrete interventions or in broad-reaching collective impact collaboratives. Despite the clear value of hospitals' joining with others to address community health needs,²³⁹ it would be unwise for

Community building activities are generally understood as strengthening a community's capacity to promote its residents' well being, but the Catholic Health Association has recommended that hospitals use public health literature to demonstrate how a particular community building activity in fact improves the health of individuals and populations in the hospital's community, so that it should count as a community benefit. *See Community Benefit and Community Building*, CATHOLIC HEALTH ASS'N (2013) (on file with author).

236 *See* Martha Hostetter & Sarah Klein, *Improving Population Health Through Communitywide Partnerships*, QUALITY MATTERS (2012), <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/february-march/in-focus> (noting that community-wide partnerships that do not rely primarily on hospital leadership may be more effective and sustainable).

237 The IRS could remedy this situation either by treating all community building activities as forms of community benefit or by clarifying that any community building activities that address a significant health need identified in a hospital's CHNA report can be counted as community benefit. *See Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 75 (suggesting that the IRS eliminate Part II of Schedule H as a separate part of the form and fully integrate the community building category into Part I, where hospitals report community benefit expenditures).

238 Another unanswered question regarding the viability of hospital-health department collaborations in conducting assessments lies in the conflicting timelines that the ACA establishes for hospitals and the Public Health Accreditation Board (PHAB) has created for health departments. *See Standards & Measures Version 1.5*, PUB. HEALTH ACCREDITATION BD. 13 (2013), <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf> (noting that Standard 1.1 requires health departments to "participate in or lead a collaborative process resulting in a comprehensive community health assessment" at least every five years). Because the three-year CHNA cycle originates in the statute itself, the IRS has no ability to substitute a different time frame, but dialogue between the federal government and the PHAB over possible approaches to coordination could produce a solution.

239 Hospitals themselves recognize this. *See, e.g., Role of Small and Rural Hospitals*, *supra* note 141, at 10 (recommending that small and rural hospitals perform their CHNAs in conjunction with their local health departments).

the IRS to go further and *require* that hospitals either engage in particular types of partnerships or attempt to address social determinants of health, at least for now. The broad diversity in hospitals' resources, community needs, and potential partners counsels the importance of simultaneously facilitating partnerships, while maintaining significant hospital flexibility. In addition, implementing the previously suggested measures relating to transparency, accountability, and community engagement should help pave the way for successful partnerships. Finally, the IRS can help hospitals learn about the importance of social determinants to community health and the emerging literature regarding best practices for CHNAs and models for collaboration, either by incorporating them in its own guidance or by directing hospitals to the growing resources provided by the nonprofit world and other government departments.²⁴⁰

C. From What to How

This Article urges the IRS to promote the values of transparency, accountability, community engagement, and collaboration in implementing the CHNA requirement for hospitals. Just *how* the IRS might go about promoting these values is a necessary correlate of the “what?” question that occupies the previous section. Fully exploring the “how” question is beyond the scope of this Article, but this section highlights several potentially useful ideas other scholars have advanced. These range from proposals that the IRS use its traditional tools for providing guidance to suggestions that it partner with other agencies to draw upon their expertise and resources.

Now that the IRS has finally completed a multi-year process of notice-and-comment rulemaking, it seems unlikely that it would be eager to plunge once again into the rule-making fray.²⁴¹ That said, the agency has many other tools it regularly uses for providing guidance, including revenue rulings, private letter rulings, and technical advice memoranda.²⁴² Although these informal means of guidance do not carry the force of law, they are nonetheless official mechanisms

240 Cf. *Supporting Alignment and Accountability in Community Health Improvement*, *supra* note 71, at 79-80 (noting the importance of hospital education).

241 One way for pursuing further rulemaking without going through the full notice-and-comment process would be for the IRS to engage in negotiated rulemaking. See Ehren K. Wade, Comment, *Just What the Doctor Ordered?: Health Care Reform, the IRS, and Negotiated Rulemaking*, 66 ADMIN. L. REV. 199, 231 (2014) (suggesting the use of negotiated rulemaking by the IRS in developing regulations implementing § 501(r)).

242 See generally Donald L. Korb, *The Four R's Revisited: Regulations, Rulings, Reliance, and Retroactivity in the 21st Century: A View from Within*, 46 DUQ. L. REV. 323, 324 (2008) (describing the kinds of guidance the Internal Revenue Service issues to the public and explaining the reliance the public can place on each type of guidance).

for communicating agency interpretations of the law and agency enforcement approaches. Indeed, the community benefit standard originated in a revenue ruling.²⁴³

A straightforward way for the IRS to implement at least some of this Article's suggestions would be by revising Schedule H. Revisions might change the information hospitals are asked to supply, thereby advancing transparency and accountability. For example, some commentators have suggested that the IRS revise Schedule H to require a detailed report from hospitals on the population health outcomes of their activities.²⁴⁴ Alternatively, the IRS could more directly promote changes in hospitals' conduct—for example, encouraging sustained community engagement and collaboration—by changing how Schedule H categorizes certain types of activities. Specifically, the IRS should eliminate the ambiguity in its message about when hospitals' participation in "community building" activities will qualify as community benefits. It could do so broadly, perhaps by instructing hospitals that *any* community building activities undertaken as part of an implementation strategy responding to an identified community health need will count as community benefit. Or, as suggested by Professor Sara Rosenbaum, the agency could describe "certain evidence-based [community] investments" as falling with a "safe harbor" that will automatically qualify as community benefit expenditures.²⁴⁵

Of course, any refinements to the IRS's guidance to hospitals to encourage participation in collaborative efforts addressing determinants of health should be informed by expertise as to the types of engagement and collaboration likely to produce community health improvement. The IRS could adapt its staffing and organizational structure to house such expertise internally,²⁴⁶ but that approach seems improbable given the agency's shrinking budget. Alternatively, the IRS could consult or partner with other agencies having substantive expertise in public health,²⁴⁷ much as it sought input from the Centers for Disease Control in developing the existing Regulations.

Piggybacking is another possible approach to leveraging expertise from a sister agency, specifically the Centers for Medicare and Medicaid Services (CMS), and encouraging the collection of data for evaluation and accountability purposes. As the federal government seeks new approaches to promoting health, containing costs, and improving quality, CMS is the ringmaster for much innovation, and it increasingly emphasizes public health approaches. One of the

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

244 Rubin et al., *supra* note 49, at 614.

245 Rosenbaum et al., *supra* note 108.

246 Cf. Takh, *supra* note 175, at 841-42 (suggesting modification of IRS structure to take into account its growing level of responsibility for anti-poverty programs).

247 *Id.* at 841.

goals of CMS's 2013 Quality Strategy was "Prevention and Public Health."²⁴⁸ Describing its role as the driver and enabler of change in these areas, CMS supports change by healthcare providers like hospitals in diverse ways, from establishing the parameters for new risk-based provider collaborations like accountable care organizations (ACOs) to supporting demonstration projects through the Centers for Medicare and Medicaid Innovation. Building on the concept of safe harbors, the IRS could facilitate hospitals' engagement in collaborative initiatives that are somehow under CMS's auspices by assuring hospitals that such participation will count towards their community benefit obligation.²⁴⁹ CMS has committed to supporting provider learning and to "improving the use of data for monitoring and continuous improvement . . . by aligning population health programs and metrics."²⁵⁰ Blessing hospitals' participation in CMS projects could enhance accountability and make sure that hospitals' activities would feed into a critically important learning loop. It would also promote alignment between CMS's population-health focused efforts and hospitals' compliance activities.

The mechanisms by which the IRS might further refine its guidance to hospitals complying with the CHNA requirement to encourage meaningful contribution to community health improvement merit further exploration. Piggybacking on CMS initiatives seems a particularly promising route, but others doubtless exist as well. The key will be to identify ways to push hospitals towards greater transparency, accountability, community engagement, and collaboration, while eschewing a one-size-fits-all approach that ignores hospital diversity and unduly limits flexibility.

CONCLUSION

The IRS has issued regulations instructing hospitals how to satisfy the ACA's CHNA requirement for tax exemption, but hospitals remain on a steep learning curve as they adjust to this new expectation. This learning must occur while hospitals also face challenges in adapting to evolving reimbursement methods and competitive landscapes. All the while, a growing chorus of voices proclaims that improving health outcomes in the U.S. while controlling costs

248 Ctrs. for Medicare & Medicaid Servs., *CMS Quality Strategy 2013—Beyond*, U.S. DEP'T HEALTH & HUM. SERVS. 1 (2013), <http://www.ahrq.gov/workingforquality/agencyplans/cms-quality-strategy.pdf>.

249 See Corrigan et al., *supra* note 109 (suggesting that CMMI demonstration projects should encourage hospitals to participate in region-wide CHNAs); Shortell, *supra* note 16, at 1122 (suggesting that CMS offer "a risk-adjusted community population-wide health budget to local consortia of health care, public health, and community and social service organizations").

250 Ctrs. for Medicare & Medicaid Servs., *supra* note 248, at 18.

demands greater integration of public health and healthcare delivery. These circumstances present an opportunity for the IRS to facilitate hospitals' development of CHNA-related approaches that hold real promise for contributing to community health improvement. The IRS has an important role to play in "moving the needle" in community health by focusing its ongoing CHNA guidance to hospitals in order to promote transparency, accountability, community engagement, and collaboration. In the long run, encouraging hospitals to develop a more expansive vision of their role and equipping them to make meaningful contributions to improving the health of their communities may be the greatest "community benefit" of all.

The Antidotes to the Double Standard: Protecting the Healthcare Rights of Mentally Ill Inmates by Blurring the Line Between *Estelle* and *Youngberg*

Rose Carmen Goldberg*

Abstract:

This Note is an examination of mentally ill inmates' constitutional right to treatment. It has significant doctrinal and practical implications. In terms of doctrine, the Supreme Court has created distinct standards for the minimum levels of care for inmates (*Estelle*) and the civilly committed mentally ill (*Youngberg*). Under this framework mentally ill inmates are constitutionally equivalent to inmates generally, but are entitled to less care than the civilly committed even if they suffer the same illness. This Note explores this gap through the lens of equal protection and argues that mentally ill inmates are similarly situated to the civilly committed. It further contends that inmates constitute a "discrete and insular minority" and thus the standard establishing their right to care should be subject to strict scrutiny. This Note finds that *Estelle* fails this test.

Practically, this Note brings visibility to a consequential area of the law neglected by scholarship. Over half of inmates are mentally ill and yet treatment in prisons is inadequate. The literature at the intersection of health, criminal justice, and constitutional rights has not constructively considered how doctrine should be changed to protect the wellbeing of this vulnerable population. Scholars have also provided little oversight of the judicial administration of justice in this field; there are few reviews of how judges actually apply treatment rights standards. This Note lessens this blind spot by exposing how courts fail to properly distinguish between different standards.

This Note proposes that the most promising antidote to the *Estelle*-

* J.D., Yale Law School, 2015; M.P.A., Columbia University, 2008. This Note is dedicated to Professor Robert Burt: his inspiration, support, and friendship are sorely missed. Many thanks also to Devon Porter for her insights, to the *Yale Journal of Health Policy, Law & Ethics* for excellent editorial support, and to the *Yale Law Journal* and Oscar M. Ruebhausen Fund for financial sustenance. Finally, much gratitude to Sol Wachtler for the spirited reminder of *semper avanti*.

Youngberg double standard, counterintuitively, is not the creation of a uniform standard. A standard that puts mentally ill inmates on equal footing with the civilly committed would solve the doctrinal puzzle, but would be subject to *Youngberg*'s inherent flaws and the judicial malpractice in this area. Recognizing the deficiencies of a purely judicial remedy, this Note recommends a solution relying both on courts and Congress. It concludes by highlighting the importance of targeting the primary causes of society's neglect of mentally ill inmates—the stigmatization of mental illness and incarceration—as a necessary step in spurring these institutions to action. Vindication of mentally ill inmates' right to treatment requires that society first overcome its prejudice against this vulnerable population.

TABLE OF CONTENTS

INTRODUCTION.....	114
I. BACKGROUND: THE CRISIS IN INMATE MENTAL HEALTHCARE	117
II. THE DOUBLE STANDARD: <i>ESTELLE</i> 'S INFERIORITY TO <i>YOUNGBERG</i>	119
A. GAMBLE'S <i>ESTELLE</i>	119
B. ATTACKING <i>ESTELLE</i>	120
1. IMPERMISSIBLY VAGUE	120
2. ELUSIVE INTENT	121
3. LIMITED PRACTICAL BITE	123
C. ADVOCATING FOR ROMEO'S <i>YOUNGBERG</i>	124
III. BLURRING THE LINE: THE IMPLICATIONS OF EQUAL PROTECTION	125
A. SIMILARLY ILL AND CONFINED	126
B. FUNDAMENTAL RIGHT TO HEALTHCARE.....	128
C. INMATES AS DISCRETE AND INSULAR.....	129
D. FATAL IN FACT.....	132
IV: JUDICIAL MALPRACTICE: ROMEO'S INCARCERATION	133
A. <i>YOUNGBERG</i> BEHIND BARS	134
B. CONFLATING ROMEO AND GAMBLE	134
V. <i>YOUNGBERG</i> 'S DEMISE: THE WRONG PRESCRIPTION.....	135
VI. RESUSCITATING GAMBLE: THE DOUBLE-DOSE REMEDY.....	137
A. LEGISLATING EQUALITY.....	137
B. A UNIFORM STANDARD AS ONE PIECE OF THE PUZZLE	139
C. RESISTANCE TO REFORM	140
1. FAIRNESS	140
2. PRACTICABILITY	141
3. EFFECTIVENESS.....	142
4. ADVERSE OUTCOMES	143
CONCLUSION: THE ANTIDOTES	144

INTRODUCTION

A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.

—U.S. Supreme Court Justice Anthony Kennedy¹

A few decades ago, two individuals under state custody turned to the justice system to substantiate their rights to healthcare. Their respective claims climbed all the way to the Supreme Court of the United States, where each story prompted judicial recognition of a constitutional right to treatment. In many respects, these individuals' cases were mirror images. Both individuals had been involuntarily committed to state custody because of socially undesirable behavior. While in custody, each was at the mercy of the state for healthcare and their claims were based on the state's failure to provide basic care. While confined, each suffered illness and injury. Instead of providing treatment, the state moved these two ailing individuals into isolation.

Both repeatedly sought redress within their institutions of confinement before seeking justice in the court system. They turned to the courts asserting rights to additional and alternative forms of treatment, grounding their claims in the Eighth Amendment's prohibition against cruel and unusual punishment. The Court implicitly recognized a dimension of equality between these two individuals' constitutional rights by using the same concept to define their right to treatment—adequacy.² It based this finding on the fact that confinement had put both individuals at the institutions' mercy for basic care.³

Despite the parallelism between the two individuals' claims and the Court's recognition of an element of equality, the Court ultimately fixated on what it considered to be an essential difference: One individual's confinement was based on criminal conviction; the other was civilly committed. Gamble, the criminal,

1 *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

2 *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982) (“[R]espondent is entitled to minimally *adequate* training.”) (emphasis added); *Estelle v. Gamble*, 429 U.S. 97, 105 (1976) (“[A] claim by a prisoner that he has not received *adequate* medical treatment [can] state[] a violation of the Eighth Amendment.”) (emphasis added).

3 See *Youngberg*, 457 U.S. at 320 n.27 (“[T]he purpose of respondent's commitment was to provide reasonable care and safety, conditions not available to him outside of an institution.”); *Estelle*, 429 U.S. at 104 (“[I]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.”) (citation omitted).

sought care for a back injury he suffered while working on a prison plantation.⁴ He received pain medication without a full assessment or treatment, and was placed in solitary confinement.⁵ He asked the Court to protect his right to basic care. Romeo, the civilly committed individual, was thirty-three but purportedly had the capacity of an eighteen-month-old child. His mother's claim on his behalf demanded habilitation and freedom from shackling.⁶

The Court held that the different purposes of Gamble and Romeo's confinements dictate unequal treatment standards, with inmates entitled to less care than the civilly committed because the purpose of their confinement is punishment.⁷ This finding resulted in the two constitutional standards that courts use today. Inmates' rights are assessed under the minimalist *Estelle* standard developed in Gamble's case and the civilly committed are protected by the more robust *Youngberg* standard from Romeo's case.

In building this constitutional divide, the Court in effect shaped healthcare into a penal weapon; its limitation is a valid form of punishment.⁸ This Note rejects this premise, arguing that "denial of medical care is surely not part of the punishment which civilized nations may impose for crime."⁹ It focuses on this double standard's implications of for mentally ill inmates. Under the current constitutional regime, mentally ill inmates are entitled to less care¹⁰ than the civilly committed even if they suffer the same symptomology. To illustrate the practical ramifications of this gap, Part I of this Note provides an overview of the current crisis in inmate mental health. Part II examines the legal framework underlying this discrepancy by analyzing the *Estelle* and *Youngberg* standards in juxtaposition.

4 This Note uses the term "prison" as shorthand for all institutions of criminal confinement, including jails.

5 *Estelle*, 429 U.S. at 109 ("Gamble was placed in solitary confinement for prolonged periods as punishment for refusing to perform assigned work which he was physically unable to perform.").

6 *Youngberg*, 457 U.S. at 309.

7 *Id.* at 321-22 ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.").

8 See *Estelle*, 429 U.S. at 105-06 ("[I]nadvertent failure to provide adequate medical care cannot be said to constitute 'an unnecessary and wanton infliction of pain' or to be 'repugnant to the conscience of mankind.'").

9 *Id.* at 116 n.13 (Stevens, J., dissenting).

10 The two constitutional standards under discussion in this Note apply to mental and physical healthcare. See *Youngberg*, 457 U.S. at 321-22 (noting that the civilly committed are entitled to at least as much care as inmates, which under *Estelle* includes physical and mental health treatment); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (finding that under *Estelle* there is "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart").

Part III is the crux of this Note. It undertakes an equal protection review of *Estelle* relative to *Youngberg* and finds that *Estelle* fails this test. Parts IV and V take this Note's equal protection review conclusion in a counterintuitive direction by arguing against a uniform standard on par with *Youngberg*. Specifically, Part IV raises doubts about the potential of a judicial solution by discussing trends of judicial malpractice in the application of *Youngberg*. Part V reveals further serious weaknesses in the *Youngberg* standard, in theory and in application, that counsel against its use for inmates. In Part VI, this Note responds to the deficiencies of a purely judicial remedy by proposing a solution that relies on both the courts and Congress.

This project's scope is limited in two notable ways. First, this Note does not discuss the implications of the Prison Litigation Reform Act (PLRA) on inmates' ability to bring suits related to mental health. The PLRA bars lawsuits by inmates for monetary damages for mental injury unless physical harm is present.¹¹ This impediment to litigation is outside this Note's focus on judicial doctrine and extra-judicial remedy. Second, this Note does not investigate the weight that costs might have in the constitutional balance. Scholars have debated what effect, if any, prison resource limitations should have on application of *Estelle* without reaching a consensus; this Note only touches on this debate tangentially.¹² Full engagement in this strain of controversy would lead this Note astray from its equality inquiry because prisons¹³ and civil institutions¹⁴ are both

11 Prison Litigation Reform Act of 1995, Pub. L. No. 104-134, § 803, 110 Stat. 1321, 1321-72 (1996) (codified as amended at 42 U.S.C. § 1997e(e) (2012) (prior to 2013 amendment)).

12 Compare Marc J. Posner, *The Estelle Medical Professional Judgment Standard: The Right of Those in State Custody To Receive High-Cost Medical Treatments*, 18 AM. J.L. & MED. 347, 353 (1992) (“[C]ost concerns cannot be considered in determining prisoners’ medical care rights.”), with Carrie S. Frank, *Must Inmates Be Provided Free Organ Transplants?: Revisiting the Deliberate Indifference Standard*, 15 GEO. MASON U. C.R. L.J. 341, 356 (2005) (“[T]here appears to remain a fair amount of confusion as to whether cost can ever be a legitimate consideration that precludes a finding of deliberate indifference.”), and Barbara Kritchewsky, *Is There a Cost Defense? Budgetary Constraints as a Defense in Civil Rights Litigation*, 35 RUTGERS L.J. 483, 497 (2004) (“Constitutional standards that incorporate a subjective state-of-mind analysis [including *Estelle*] allow budgetary limitations to enter the analysis.”).

13 See, e.g., NATHAN JAMES, CONG. RESEARCH SERV., R42937, THE FEDERAL PRISON POPULATION BUILDUP: OVERVIEW, POLICY CHANGES, ISSUES, AND OPTIONS 10 (2014) (explaining that the federal prison system is struggling with “the increasing cost” of its operations).

14 Nicole Fisher, *Mental Health Loses Funding As Government Continues Shutdown*, FORBES (Oct. 10, 2013, 12:06 PM), <http://www.forbes.com/sites/theapothecary/2013/10/10/mental-health-loses-funding-as-government-continues-shutdown> (“[A]s federal and state governments look to cut budgets at every turn, mental and behavioral health services are often on the chopping block first.”).

cash-strapped and these severe resource limitations call for an inquiry all its own.

I. BACKGROUND: THE CRISIS IN INMATE MENTAL HEALTHCARE

In the decades since the Court drew a constitutional line between healthcare in prisons and civil institutions, the Gambles of the world have started to look even more like Romeos. Not only are both dependent on the state for care; the care they need is nearly equivalent. The deinstitutionalization movement in the 1970s resulted in widespread closure of civil commitment institutions and an influx of mentally ill individuals into the criminal justice system.¹⁵ Today, prisons are de facto mental hospitals.¹⁶ They confine an estimated 1,264,300 mentally ill individuals,¹⁷ 356,268 of whom suffer from severe mental illness.¹⁸ This is ten times more than hospitals house.¹⁹

Mentally ill inmates now out-number their non-ill counterparts—over half of inmates are mentally ill.²⁰ Evidence suggests they suffer primarily from one of two illnesses: major depression and anxiety disorder.²¹ Inmates are also reported to have high rates of bipolar disorder (36.3%), severe depression (22.5%), and psychosis or schizophrenia (18.6%).²²

Despite these serious conditions, mentally ill inmates are routinely deprived of care.²³ At least forty percent of this population receives no form of treatment

Financial cuts . . . mean that those who need services most are often those left without proper care.”).

15 Danielle Drissel, *Massachusetts Prison Mental Health Services: History, Policy and Recommendations*, 87 MASS. L. REV. 106, 106 (2003).

16 E.g., Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 657 (2003) (“[J]ails and prisons have become the new mental hospitals.”).

17 Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. DEP’T JUSTICE 1 (2006), <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

18 *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, TREATMENT ADVOCACY CTR. & NAT’L SHERIFFS’ ASS’N 6 (2014) [hereinafter TREATMENT ADVOCACY CTR., *State Survey*], <http://tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>.

19 *Id.*

20 James & Glaze, *supra* note 17, at 3.

21 *The Health Status of Soon-To-Be-Released Inmates: A Report to Congress*, NAT’L COMM’N ON CORR. HEALTH CARE 24 tbl.3-3 (2002), <https://www.ncjrs.gov/pdffiles1/nij/grants/189735.pdf>.

22 Eladio D. Castillo & Leanne F. Alarid, *Factors Associated with Recidivism Among Offenders with Mental Illness*, 55 INT’L L.J. OFFENDER THERAPY & COMP. CRIMINOLOGY 98, 105 (2011).

23 See, e.g., *Ramos v. Lamm*, 485 F. Supp. 122, 144 (D. Colo. 1979), *aff’d in part, set aside in part*, 639 F.2d 559 (10th Cir. 1980) (“Mental health needs are shunned and ignored as if they were an ugly stepchild of corrections.”) (citation omitted).

to address their mental health needs while incarcerated.²⁴ This lack of treatment often leads to decompensation,²⁵ one consequence of which is increasing difficulty complying with prison rules. This, in turn, contributes to mentally ill inmates' high placement rates in solitary confinement, which further bleakens their prognosis.²⁶ Multiple interrelated failings in the prison system set the stage for this human tragedy, including severe understaffing of mental health professionals, limited efforts to identify and monitor the mentally ill, and overreliance on medication to temporarily dull symptoms.²⁷

Scholars have spoken out against this injustice. Some have provided nuanced critiques of *Estelle*²⁸ and a lesser number have looked beyond the bench, emphasizing the importance of the politics that surround application of *Estelle*.²⁹ One work on *Estelle* turns to *Youngberg* as a potential remedy in recognition of the similarities between Gamble and Romeo, but does not underpin its proposal with legal argument.³⁰ It also does not focus on mental health. The literature on *Youngberg* leaves the prison context virtually untouched, perhaps because in

24 Paula M. Ditton, Bureau of Justice Statistics, *Mental Health and Treatment of Inmates and Probationers*, U.S. DEP'T JUST. 9 (1999), <http://www.bjs.gov/content/pub/pdf/mhtip.pdf>.

25 TREATMENT ADVOCACY CTR. *State Survey*, *supra* note 18, at 15. Decompensation is defined as "loss of physiological compensation or psychological balance." *Decompensation*, MERRIAM-WEBSTER (2015), <http://www.merriam-webster.com/medlineplus/decompensation>.

26 *Human Rights at Home: Mental Illness in U.S. Prisons and Jails: Hearing Before the Subcomm. on Human Rights & the Law of the S. Comm. on the Judiciary*, 111th Cong. 1 (2009) [hereinafter *Human Rights at Home*] (statement of Sen. Dick Durbin, Chairman).

27 *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, HUM. RTS. WATCH 4 (2003) [hereinafter *Ill-Equipped*], <http://www.hrw.org/sites/default/files/reports/usa1003.pdf>.

28 See, e.g., Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 946 (1992) (arguing that *Estelle* is "an inappropriate measure of the constitutionality of prison health care provision" in part because of its subjective intent requirement); Philip M. Genty, *Confusing Punishment with Custodial Care: The Troublesome Legacy of Estelle v. Gamble*, 21 VT. L. REV. 379, 380-81 (1996) (claiming that the use of a subjective standard is misguided because asking courts to consider only prisons' intent creates a safe harbor when the impact of unintentional actions is egregious).

29 See, e.g., Margo Schlanger, *Plata v. Brown and Realignment: Jails, Prisons, Courts, and Politics*, 48 HARV. C.R.-C.L. L. REV. 165, 169 (2013) (explaining that the article "lighten[s] scholarly emphasis on judges in favor of closer examination of the multi-player politics"); Margo Schlanger, *Beyond the Hero Judge: Institutional Reform Litigation as Litigation*, 97 MICH. L. REV. 1994, 1999 (1999) (faulting an *Estelle* article for its exclusive concern with "the judiciary, and even more narrowly, the judicial activity of doctrine creation"); see also Fred Cohen, *The Limits of Judicial Reform of Prisons: What Works; What Does Not*, 40 CRIM. L. BULL. 421, 465 (2004) ("Ultimately, overall community sentiment and penal philosophy will dictate the larger picture and litigation will, in effect, keep the place clean.").

30 Posner, *supra* note 12, at 355.

crafting *Youngberg* the Court barred its application to inmates.³¹ This Note fills this gap in the literature by directly analyzing the disparity between Gamble and Romeo's legal rights.

II. THE DOUBLE STANDARD: *ESTELLE*'S INFERIORITY TO *YOUNGBERG*

A. Gamble's Estelle

The Court's adjudication of Gamble's case in *Estelle v. Gamble* established inmates' constitutional right to healthcare.³² It defined this right indirectly, by interdicting "*deliberate indifference* to serious medical needs . . . that can offend 'evolving standards of decency' in violation of the Eighth Amendment."³³ Post-*Estelle* courts have added texture by dividing the standard into objective and subjective elements.³⁴ The objective prong requires that "the deprivation [is] sufficiently *serious*,"³⁵ limiting the type of harm that qualifies.³⁶ One court, for instance, found that the interruption of HIV medication was not "serious" because the delay did not result in injury.³⁷ Courts agree that mental illness is a serious condition that warrants constitutional protection.³⁸

31 *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982) ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.").

32 *Helling v. McKinney*, 509 U.S. 25, 40 (1993) ("[I]t was not until 1976, in *Estelle v. Gamble* . . . that this Court first [applied the Eighth Amendment to prison deprivations].") (Thomas, J., dissenting).

33 *Estelle v. Gamble*, 429 U.S. 97, 106 (1976) (emphasis added).

34 See, e.g., *Wilson v. Seiter*, 501 U.S. 296, 298 (1991); *Gill v. Mooney*, 824 F.2d 192, 174 (2d Cir. 1987); *Toombs v. Bell*, 798 F.2d 297, 298 (8th Cir. 1986); *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

35 *Wilson*, 501 U.S. at 299 (emphasis added).

36 *Smith v. Carpenter*, 316 F.3d 178, 184 (2d Cir. 2003) ("[N]ot every lapse in prison medical care will rise to the level of a constitutional violation.") (citations omitted); *Capps v. Atiyeh*, 559 F. Supp. 894, 901 (D. Or. 1982) ("To the extent prison conditions are restrictive and even harsh, they are part of the penalty criminals must pay for their offenses against society.") (citations omitted).

37 *Smith*, 316 F.3d at 188 ("Although [the inmate] suffered from an admittedly serious underlying condition, he presented no evidence that the two alleged episodes of missed medication resulted in permanent or on-going harm to his health."); see *Board v. Farnham*, 394 F.3d 469, 481 (7th Cir. 2005) ("[W]e hold [that the inmate] had an established constitutional right to toothpaste . . .").

38 See, e.g., *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996) ("[P]sychiatric needs can constitute serious medical needs."); *Seifullah v. Toombs*, 940 F.2d 662, 662 (6th Cir. 1991) ("The eighth amendment requirement of adequate medical care for a prisoner applies equally to psychiatric care."); *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) ("This circuit has recognized that deliberate indifference to an inmate's serious mental health needs violates the eighth amendment."); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983)

The subjective component shifts the inquiry to mens rea. The *Estelle* Court specifies that mere “accident[al]”³⁹ behavior does not qualify and subsequent courts have maintained the ineligibility of unintentional harm.⁴⁰ They situate blameworthiness “somewhere between the poles of negligence at one end and purpose or knowledge at the other.”⁴¹ In effect, they equate it with recklessness.⁴²

B. Attacking *Estelle*

1. Impermissibly Vague

Courts have directed strong salvos at *Estelle*’s basis in the Eighth Amendment’s prohibition against “cruel and unusual punishment.” Judges have accused the *Estelle* Court of inadequately explaining, and perhaps considering, why the Eighth Amendment should apply to inmates’ health rights; the relevance of punishment to healthcare is not self-evident.⁴³ This lack of rationale, in conjunction with the vagueness of the Eighth Amendment itself, have left courts feeling unmoored in their implementations of *Estelle*.⁴⁴

(“Treatment of the mental disorders of mentally disturbed inmates is a ‘serious medical need.’”) (citation omitted); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982) (“[Deliberate indifference] requirements apply to . . . mental health.”); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980) (“[The Constitution requires] treatment for inmates’ . . . psychological or psychiatric [needs].”); *Inmates of Allegheny Cty. Jail v. Peirce*, 612 F.2d 754, 763 (3d Cir. 1979) (“[T]he ‘deliberate indifference’ standard of *Estelle v. Gamble* is applicable in evaluating the constitutional adequacy of psychological or psychiatric care provided at a jail or prison.”); *Bowring*, 551 F.2d at 47-48.

39 *Estelle v. Gamble*, 429 U.S. 97, 105 (1976) (“An accident, although it may produce added anguish, is not on that basis alone to be characterized as wanton infliction of unnecessary pain.”).

40 See, e.g., *Farmer v. Brennan*, 511 U.S. 825, 835 (1994) (“[D]eliberate indifference describes a state of mind more blameworthy than negligence.”); *Whitley v. Albers*, 475 U.S. 312, 319 (1986) (“It is obduracy and wantonness, not inadvertence or error in good faith, that characterize the conduct prohibited by the Cruel and Unusual Punishments Clause.”).

41 *Farmer*, 511 U.S. at 836.

42 See, e.g., *id.* at 838 (“[A]n official’s failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.”); *LaMarca v. Turner*, 995 F.2d 1526, 1535 (11th Cir. 1993) (“To be deliberately indifferent, a prison official must knowingly or recklessly disregard an inmate’s basic needs so that knowledge can be inferred.”).

43 See, e.g., *Helling v. McKinney*, 509 U.S. 25, 40 (1993) (“In essence, however, this extension of the Eighth Amendment to prison conditions rested on little more than an *ipse dixit*.”).

44 See, e.g., *Wells v. Franzen*, 777 F.2d 1258, 1264 (7th Cir. 1985) (“Because the eighth amendment draws its meaning from the evolving standards of decency in a maturing society, there is no fixed standard to determine whether conditions are cruel and unusual.”) (citations

The objective prong aggravates *Estelle*'s vagueness.⁴⁵ Post-*Estelle* courts have specified that a serious need "is one that has been *diagnosed by a physician* as mandating treatment or one that is so obvious that even a *lay person would easily recognize* the necessity for a doctor's attention,"⁴⁶ but this elaboration is of little avail. Inmates have limited access to physicians—the Iowa prison system, for instance, houses 2000 mentally ill inmates and has three psychiatrists.⁴⁷ The deference to lay persons is also problematic. Prison staff receive little to no mental health training and are ill-equipped to recognize what warrants treatment.⁴⁸ Arguably, only exceedingly severe conditions will be detected and covered by *Estelle*.⁴⁹ This leaves a lot of suffering unprotected.

In struggling to define the objective prong in the context of the grim realities of prison healthcare, some courts have turned it into a balancing test.⁵⁰ They weigh cost against medical severity. In contrast, some scholars argue that medical need is dispositive; situational factors, however relevant to treatment feasibility, do not belong in the constitutional inquiry.⁵¹ The divergence between these approaches, with courts and scholars on both sides,⁵² is further evidence of the *Estelle* standard's inadequacy. In permitting such disparate interpretations, *Estelle* creates room for inconsistent outcomes.⁵³

2. Elusive Intent

Estelle's subjective component creates an unreasonably high evidentiary

omitted); *Langley v. Coughlin*, 715 F. Supp. 522, 535 (S.D.N.Y. 1989) ("[T]his standard is not one that can be applied with geometric precision."); see also Frank, *supra* note 12, at 346. ("[T]he *Estelle* opinion offers only limited guidance as to what types of conduct constitute deliberate indifference.").

45 *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); see also Frank, *supra* note 12, at 347 ("In *Estelle*, the Supreme Court provided little guidance to define what constitutes a serious medical need.").

46 *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980) (citations omitted) (emphases added).

47 *Ill-Equipped*, *supra* note 27, at 95.

48 TREATMENT ADVOCACY CTR., *State Survey*, *supra* note 18, at 11.

49 Susan W. Brenner & David M. Galanti, *Prisoners' Rights to Psychiatric Care*, 21 IDAHO L. REV. 1, 29 (1985) ("In the psychological context . . . only those prisoners who demonstrate blatant, abnormal behavior will be entitled to treatment.").

50 *Woodall v. Foti*, 648 F.2d 268, 272 (5th Cir. Unit A June 1981) ("[T]he court should consider the availability and expense of providing psychiatric treatment.").

51 See, e.g., Posner, *supra* note 12, at 353 ("[C]ost concerns cannot be considered in determining prisoners' medical care rights.").

52 Frank, *supra* note 12, at 356 ("[T]here appears to remain a fair amount of confusion as to whether cost can ever be a legitimate consideration that precludes a finding of deliberate indifference.").

53 *Id.* at 348 ("[A] rule without reason simply will not do.").

burden.⁵⁴ Proving the mens rea of recklessness requires strong evidence that speaks to prison administrators' internal state of mind.⁵⁵ Courts' deference to prison administration and inmates' limited resources hamper inmates' ability to meet this standard.⁵⁶ Indeed, many *Estelle* cases are lost for failure to satisfy the subjective prong,⁵⁷ and these denials include legitimate claimants.⁵⁸ Mentally ill inmates are particularly disadvantaged because awareness of nuanced mental disorders is especially hard to prove.⁵⁹

Some courts have attempted to remedy this flaw by shifting towards a negligence-based standard.⁶⁰ These efforts are unlikely to save *Estelle* because they are vulnerable to the charge that they constitutionalize medical

54 *E.g.*, Drissel, *supra* note 15, at 108 (“[T]he threshold for stating a constitutional claim for violation of the right to mental health treatment under the Eighth Amendment is very high.”).

55 *See, e.g.*, Duckworth v. Franzen, 780 F.2d 645, 652 (7th Cir. 1985) (“The infliction of punishment is a *deliberate act intended to chastise or deter*. This is what the word means today; it is what it meant in the eighteenth century.”) (emphasis added), *overruled by* Farmer v. Brennan, 511 U.S. 825, 843 (1994).

56 *See, e.g.*, DesRosiers v. Moran, 949 F.2d 15, 18 (1st Cir. 1991) (“Medical evidence about the cause of the infection was inconclusive. Documentary proof was scant; in point of fact, the evidence was scattershot as to whether, and if so, to what extent, the prison's medical staff was required to document the delivery of routine services.”).

57 *See, e.g.*, Farmer, 511 U.S. at 847 (“[W]e reject petitioner's arguments and hold that a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement *only if he knows* that inmates face a substantial risk of serious harm.”) (emphasis added); Inmates of Allegheny Cty. Jail v. Peirce, 612 F.2d 754, 760 (3d Cir. 1979) (“On this record, we perceive no ‘deliberate indifference’ to the inmates’ serious medical needs in disregard of the standard enunciated in [*Estelle*].”).

58 *See, e.g.*, Brenner & Galanti, *supra* note 49, at 29 (“In the psychological context, [*Estelle*'s subjective intent requirement] means that only those prisoners who demonstrate blatant, abnormal behavior will be entitled to treatment.”); Friedman, *supra* note 28, at 946 (arguing that *Estelle* is “an inappropriate measure of the constitutionality of prison health care provision” because of its subjective intent requirement); Genty, *supra* note 28, at 380-81 (claiming that the use of a subjective standard is misguided).

59 Lori A. Marschke, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U. L. REV. 487, 490 (2004) (“Given the complexities of mental illness and prison guards’ general lack of awareness of mental health needs, the mentally ill face a tougher burden in proving actual knowledge than their physically ill counterparts.”)

60 *See, e.g.*, Doe v. N.Y.C. Dep’t of Soc. Servs., 649 F.2d 134, 143 (2d Cir. 1981) (“[G]ross negligent conduct creates a strong presumption of deliberate indifference.”); Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977) (“[R]epeated examples of such treatment bespeak a deliberate indifference by prison authorities.”); Langley v. Coughlin, 715 F. Supp. 522, 536 (S.D.N.Y. 1989) (“[T]he inference of such indifference may be based upon proof of a series of individual failures by the prison to provide adequate medical care even if each such failure—viewed in isolation—might amount only to simple negligence.”).

malpractice.⁶¹ Others object to the relevance of the prison's "state of mind" altogether, arguing that the severity of the harm should determine culpability.⁶² Justice Stevens raised this very point in his *Estelle* dissent:

I believe the Court improperly attaches significance to the subjective motivation of the defendant as a criterion for determining whether cruel and unusual punishment has been inflicted. Subjective motivation may well determine what, if any, remedy is appropriate against a particular defendant. However, whether the constitutional standard has been violated should turn on the character of the punishment.⁶³

This more radical rejection of *Estelle* is persuasive. *Estelle*'s motivating purpose is to protect inmates from harmful conditions, and thus it makes sense that the standard should focus on the nature of the injury, not prisons' intent.

3. *Limited Practical Bite*

Even when inmates' claims successfully navigate the uncertainty of *Estelle*'s objective and subjective prongs, judicial findings of culpability can have little practical effect. An infamous California case initiated in 1990 and decided as *Brown v. Plata*⁶⁴ in 2011 illustrates this phenomenon. Although the Court strongly condemned the treatment of mentally ill inmates as violative of *Estelle*,⁶⁵ this decades-long saga is still not resolved. Victory in court under *Estelle* has done little to ameliorate the horrendous conditions mentally ill inmates in California face.⁶⁶ The California correctional system was largely unmoved by the Court's poignant but lofty constitutional pronouncements, and it does not stand alone in this recalcitrance. This shows that the *Estelle* standard requires drastic

61 *Langley*, 715 F. Supp. at 536 ("[T]he Eighth Amendment does not constitutionalize the law of medical malpractice."); see also Fred Cohen, *Captives' Legal Right to Mental Health Care*, 17 L. & PSYCHOL. REV. 1, 22 (1993) ("[A] complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.") (emphasis added).

62 See, e.g., Genty, *supra* note 28, at 380-81 (1996) (claiming that the use of a subjective standard is misguided because asking courts to consider prisons' intent creates a safe harbor when the impact of unintentional actions is egregious).

63 *Estelle v. Gamble*, 429 U.S. 97, 116 (1976) (Stevens, J., dissenting).

64 131 S. Ct. 1910 (2011).

65 *Id.* at 1923 ("For years the medical and mental health care provided by California's prisons has fallen short of minimum constitutional requirements and has failed to meet prisoners' basic health needs. Needless suffering and death have been the well-documented result.").

66 *Id.* at 1924 ("Because of a shortage of treatment beds, suicidal inmates may be held for prolonged periods in telephone-booth sized cages without toilets.").

modification, if not wholesale substitution, to fulfill the purpose with which the Court originally conceived it.⁶⁷

C. *Advocating for Romeo's Youngberg*

In *Youngberg*, the Court found *Estelle* inadequate for the civilly committed.⁶⁸ It rejected the component of Romeo's claim based on the Eighth Amendment, ruling that unlike an inmate's claim, Romeo's was properly assessed under the Fourteenth Amendment.⁶⁹ It grounded this bifurcation in an assertion that the involuntarily committed are "entitled to more considerate treatment . . . than criminals"⁷⁰ because the purpose of their confinement is treatment, not punishment. To provide more robust protection, the *Youngberg* Court created a new standard—"professional judgment"—that instructs courts to defer to professionals in determining whether treatment is constitutionally adequate.⁷¹

In sharp contrast to *Estelle*, *Youngberg* imposes affirmative obligations. To satisfy *Youngberg*, the state must provide "training" that preserves individuals' ability to care for themselves when not confined;⁷² *Estelle* completely rejects rehabilitative rights.⁷³ Moreover, in directly asserting a protective right to care, *Youngberg* sidesteps *Estelle*'s hypocrisy. *Youngberg*, unlike *Estelle*, does not attempt to reconcile its positive purpose and a negative "no deliberate indifference" framework. For this reason, *Youngberg* is a better judicial lodestar. It rightly focuses on the central issue of treatment instead of the secondary question of intent.⁷⁴

Youngberg also trumps *Estelle* because it more adequately guards against judicial interference with medical expertise. Under *Youngberg*, a treatment decision is presumptively valid unless it "is such a substantial departure from accepted professional judgment . . . as to demonstrate that the person responsible

67 *Helling v. McKinney*, 509 U.S. 25, 42 (1993) ("Were the issue squarely presented, therefore, I might vote to overrule *Estelle* . . . I seriously doubt that *Estelle* was correctly decided . . .") (Thomas, J., dissenting).

68 Although the claim in *Youngberg* was brought by an institutionalized mentally disabled individual, the Court's holding is broadly applicable to committed individuals, including the mentally ill. *Youngberg v. Romeo*, 457 U.S. 307, 319 n.25 (1982).

69 *Id.* at 324.

70 *Id.* at 322.

71 *Id.* at 323.

72 *Id.* at 327.

73 *See, e.g., Grubbs v. Bradley*, 552 F. Supp. 1054, 1124 (M.D. Tenn. 1982) (finding that a lack of rehabilitative programs does not violate the Eighth Amendment).

74 Brenner & Galanti, *supra* note 49, at 31 ("A better approach would be to begin with the presumption that all prisoners have a constitutional right to psychiatric care.").

actually did not base the decision on such a judgment.”⁷⁵ *Youngberg* further retreats from the realm of medicine by emphasizing that a court’s inquiry does not properly involve a comparative assessment of the potentially numerous treatment options available in a given case.⁷⁶ It leaves this to the medical professionals. *Estelle*, in contrast, instructs courts to conjecture about what qualifies as a medically “unnecessary and wanton infliction of pain.”⁷⁷

III. BLURRING THE LINE: THE IMPLICATIONS OF EQUAL PROTECTION

Estelle and *Youngberg*’s inequality is by design. Indeed, the *Youngberg* Court’s discriminatory intent is made plain through its explicit positioning of inmates’ rights below the rights of the committed.⁷⁸ Although this straightforward reading of *Youngberg* invites equal protection review of the *Estelle-Youngberg* double standard, this constitutional territory is uncharted. Most of the inmate equal protection literature and cases compares inmates to inmates.⁷⁹ The few that view inmates’ rights in juxtaposition to non-inmates⁸⁰ do not examine the treatment rights double standard.⁸¹ This Part of the Note

⁷⁵ *Youngberg*, 457 U.S. at 323.

⁷⁶ *Id.* at 321 (“[T]he Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made.”).

⁷⁷ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (citing *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

⁷⁸ *Youngberg*, 457 U.S. at 321-22 (“Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals . . .”).

⁷⁹ See, e.g., Rachel C. Grunberger, *Johnson v. California: Setting a Constitutional Trap for Prison Officials*, 65 MD. L. REV. 271, 294 (2006) (discussing the appropriate level of equal protection review for racial segregation of inmates); James F. Horner, Jr., *Constitutional Issues Surrounding the Mass Testing and Segregation of HIV-Infected Inmates*, 23 MEM. ST. U. L. REV. 369 (1993) (claiming that courts will likely never find compelled HIV testing of inmates and status-based segregation violative of equal protection); Michelle Masotto, “*Death Is Different*”: *Limiting Health Care for Death Row Inmates*, 24 HEALTH MATRIX 317 (2014) (arguing that death row inmates are not entitled to the same healthcare as other inmates under equal protection); Joanna E. Saul, *This Game Is Rigged: The Unequal Protection of Our Mentally-Ill Incarcerated Women*, 5 MOD. AM. 42 (asserting that male and female inmates are similarly situated with respect to mental health treatment due to equal dependence on the state for care).

⁸⁰ See, e.g., *Baxstrom v. Herold*, 383 U.S. 107, 110 (1966) (finding that equal protection entitles inmates to the same civil commitment procedures as non-inmates); see also Sharona Hoffman, *Beneficial and Unusual Punishment: An Argument in Support of Prisoner Participation in Clinical Trials*, 33 IND. L. REV. 475 (2000) (arguing that laws barring inmates from clinical trials violate equal protection).

⁸¹ Part I of this Note mentions the one article that is an exception and explains that its limitations, namely, its lack of legal analysis and distance from mental health, leave this Note to occupy this field. Posner, *supra* note 12, at 347.

responds to this invitation to subject *Estelle* to a new form of equal protection review. And it finds that in relegating individuals like Gamble to second-class health, the double standard violates equal protection.

A. Similarly Ill and Confined

Inmates and the civilly committed are similarly situated with respect to their reliance on the state for treatment. Generally, to qualify as similarly situated under the Constitution, groups only need to share characteristics that relate to the claimed service.⁸² In this context, the claimed service is mental healthcare and an inmate suffering from the same illness as a committed individual has a need that warrants similar treatment. Because of the high prevalence of mental illness in prisons, this line of reasoning applies to inmates on a wide scale.

Some courts have employed a less claimant-friendly definition of “similarly situated” to inmates. In *Klinger v. Department of Corrections*, for instance, the Eighth Circuit considered a range of factors, including security level and inmate numerosity, in comparing inmates across genders.⁸³ It denied the gender-based equal protection claim because of differences in these other traits between genders.⁸⁴ If this same analysis were applied to mentally ill inmates, they might not look so similar to the civilly committed. These groups vary in several dimensions, including security and numerosity.⁸⁵ Yet the wide-ranging *Klinger* analysis is on shaky ground. It includes factors that are irrelevant to the equal protection inquiry, which should focus exclusively on traits related to the challenged state action.⁸⁶ In the context of the *Estelle-Youngberg* double standard, the challenged action is differentiated treatment rights, so only

82 See, e.g., *Betts v. McCaughtry*, 827 F. Supp. 1400, 1405 (W.D. Wis. 1993), *aff'd*, 19 F.3d 21 (7th Cir. 1994) (“To be ‘similarly situated,’ groups need not be identical in makeup, they need only share commonalities that merit similar treatment.”); *Kerrigan v. Comm’r of Pub. Health*, 957 A.2d 407, 422 (Conn. 2008) (“[T]he question is ‘not whether persons are similarly situated for all purposes, but whether they are similarly situated for purposes of the law challenged.’”) (citation omitted).

83 31 F.3d 727, 731-32 (8th Cir. 1994).

84 *Id.* at 727.

85 TREATMENT ADVOCACY CTR., *State Survey*, *supra* note 18, at 15 (finding that there are ten times more seriously mentally ill individuals in prisons than in civil institutions).

86 See, e.g., Angie Baker, *Leapfrogging over Equal Protection Analysis: The Eighth Circuit Sanctions Separate and Unequal Prison Facilities for Males and Females in Klinger v. Department of Corrections*, 31 F.3d 727 (8th Cir. 1994), 76 NEB. L. REV. 371, 386 (1997) (“In determining that women inmates were not ‘similarly situated’ to male inmates, the appeals court considered variables that, even taken together, failed to sustain its findings.”); Brenda V. Smith, *Watching You, Watching Me*, 15 YALE J.L. & FEMINISM 225, 275 (2003) (“Although these propositions are true, the analysis tends toward circular logic because [they are used to avoid comparing the trait that is actually relevant to the challenged action].”).

treatment factors should enter the fray.

Indeed, a number of courts have specifically rebuked *Klinger*'s logic in the context of inmates' mental health rights.⁸⁷ In *Baxstrom v. Herold*, for instance, the Court found that equal protection entitles inmates to the same civil commitment procedures as everyone else.⁸⁸ It reasoned that the use of different standards for inmates and non-inmates is "arbitrary,"⁸⁹ rejecting the claim that criminality warrants differentiation.⁹⁰ In explanation, the Court asserted that equal protection requires that "a distinction made have some relevance to the purpose for which the classification is made"⁹¹ and criminality is not germane to mental illness. This logic applies neatly to the *Estelle-Youngberg* controversy. The purpose of the classifications in this context is to determine treatment rights—both *Estelle* and *Youngberg* were crafted for this reason. Under *Baxstrom*, criminality is an unwelcome trespasser in this health-focused area of government action.

Baxstrom's relevance could be challenged on the ground that it involved an inmate "nearing the expiration point of a prison term"⁹²—in other words, an individual bordering on being a non-inmate. In this light, *Baxstrom*'s rejection of the relevance of criminality could be viewed as a result of the fact that it was essentially comparing non-inmates to non-inmates. Yet this overlooks the fact that today's Gambles also sit at the border between inmates and non-inmates. Mentally ill inmates tend to rapidly cycle in and out of prison⁹³ so for significant portions of their stays, they could be characterized as near the end of their terms. Moreover, this objection ignores the *Baxstrom* Court's broad, unequivocal

87 See, e.g., *Souder v. McGuire*, 516 F.2d 820, 821-22 (3d Cir. 1975) (finding that a mental health law that allows officials to use less rigorous commitment procedures for inmates than non-inmates raises "serious equal protection" issues); *U.S. ex rel. Schuster v. Herold*, 410 F.2d 1071, 1073 (2d Cir. 1969) ("[W]e believe that before a prisoner may be transferred to a state institution for insane criminals, he must be afforded substantially the same procedural safeguards as are provided in civil commitment proceedings."); *Evans v. Paderick*, 443 F. Supp. 583, 585 (E.D. Va. 1977) (refusing to construe a civil commitment statute to exempt inmates from protection because of their criminal status).

88 383 U.S. 107, 110 (1966) ("We hold that petitioner was denied equal protection of the laws by the statutory procedure under which a person may be civilly committed at the expiration of his penal sentence without the jury review available to all other persons civilly committed.").

89 *Id.* at 111.

90 *Id.* ("The director contends that the State has created a reasonable classification differentiating the civilly insane from the 'criminally insane.'").

91 *Id.* (citing *Walters v. City of St. Louis*, 347 U.S. 231, 237 (1954)).

92 *Id.* at 114.

93 TREATMENT ADVOCACY CTR., *State Survey*, *supra* note 18, at 9 ("In the Los Angeles County Jail, 90 percent of mentally ill inmates are repeat offenders, with 31 percent having been incarcerated ten or more times.").

language disclaiming the relevance of criminality to mental health treatment.

Alternatively, one could argue that *Baxstrom*, a case about the right not to be civilly committed, is inapposite because it involves the right to *avoid* treatment. According to this line of attack, *Baxstrom* disclaims the relevance of criminality because it has no bearing on the right to refuse treatment—even inmates retain this right.⁹⁴ A proponent of this argument could claim that the double standard, in contrast, properly accounts for criminality because it is relevant to positive treatment rights. Society's obligation to care for inmates is related to criminality because crime is the basis of their confinement and reliance on the state. This objection fails because it overlooks the fact that *Estelle* and *Youngberg*, like *Baxstrom*, also protect the right to refuse treatment. Overtreatment can constitute deliberate indifference⁹⁵ or departure from professional judgment.⁹⁶ Thus, *Baxstrom* is not distinguishable on this point. It requires that courts drop criminality from their *Estelle* analysis, and find Gamble and Romeo similarly situated.⁹⁷

B. Fundamental Right to Healthcare

That mentally ill inmates and the committed mentally ill are similarly situated does not end the equal protection inquiry. Similarly situated groups can be treated differently if there is a valid reason, which depends on the nature of the right and level of constitutional scrutiny.⁹⁸ Mentally ill inmates' claims are entitled to the most demanding level of review, strict scrutiny, because they seek protection of a fundamental right.⁹⁹

Estelle established treatment as a fundamental right for inmates when it found this entitlement in the Eighth Amendment to the U.S. Constitution.¹⁰⁰ It

94 See, e.g., *Washington v. Harper*, 494 U.S. 210 (1990).

95 See, e.g., *Ruiz v. Estelle*, 503 F. Supp. 1265, 1336 (S.D. Tex. 1980), *aff'd in part*, 688 F.2d 266 (5th Cir. 1982).

96 *Youngberg v. Romeo*, 457 U.S. 307, 310 (1982).

97 For a discussion of why inmates are similarly situated to non-inmates with respect to healthcare rights of another sort, see Sharona Hoffman, *Beneficial and Unusual Punishment: An Argument in Support of Prisoner Participation in Clinical Trials*, 33 IND. L. REV. 475, 505 (2000) (arguing that laws barring inmates from clinical trials violates their right to equal protection with non-inmates).

98 See, e.g., *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (“[A] reasonable and sensitive judgment must [recognize] that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment.”).

99 See Richard B. Saphire, *Equal Protection, Rational Basis Review, and the Impact of Cleburne Living Center, Inc.*, 88 KY. L.J. 591, 601 (2000) (“[T]he Court has extended strict scrutiny to classifications that implicate so-called ‘fundamental interests.’”).

100 See Michele Westhoff, *An Examination of Prisoners’ Constitutional Right to Healthcare: Theory and Practice*, HEALTH LAWYER, Aug. 2008, at 1, 5 (“This historic

explained its holding in terms strongly reminiscent of fundamental rights generally, which are “deeply rooted in this Nation’s history and tradition.”¹⁰¹ The *Estelle* Court pointed to America’s long tradition of prohibiting cruel and unusual punishment as consistent with the constitutional drafters’ intentions.¹⁰² It specified that these historical beliefs not only proscribe outright torture, but also the suffering that can result from the denial of medical care. This conclusion, according to the *Estelle* Court, is based on “elementary principles”¹⁰³ with deep roots in common law.¹⁰⁴ In other words, the right to healthcare is fundamental.

Although there are few grounds for convincingly arguing against this interpretation of *Estelle* since its holding is explicitly rooted in the Eighth Amendment’s fundamental protections, one could object that relying on *Estelle* while attacking it is unsound. Yet this Note does not argue against *Estelle* in its entirety. It supports *Estelle*’s assertion of a fundamental right to healthcare but views *Estelle*’s implementation of this premise as self-defeating.

C. Inmates as Discrete and Insular

Mentally ill inmates’ claims for care are also entitled to strict scrutiny, which subjects prisons’ actions to the most stringent form of review, on the basis that inmates constitute a discrete and insular minority. Courts have tended to place inmates at the bottom of the constitutional classificatory totem pole, only entitling their claims to rational basis review, which almost always upholds the challenged government conduct.¹⁰⁵ Yet a growing contingent of courts is bucking

decision [*Estelle*] marked the first time in history that the Supreme Court had recognized a *fundamental* right to healthcare for any group of Americans.”) (emphasis added).

101 *Moore v. City of E. Cleveland*, 431 U.S. 494, 503 (1977).

102 *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (“[T]he primary concern of the drafters was to proscribe ‘torture(s)’ and other ‘barbar(ous)’ methods of punishment.”).

103 *Id.* at 103.

104 *Id.* at 103-04 (“The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common-law view that ‘(i)t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.’”) (citation omitted).

105 *See, e.g., Turner v. Safley*, 482 U.S. 78, 89 (1987) (“[T]here must be a ‘valid, rational connection’ between the prison regulation and the legitimate governmental interest put forward to justify it.”) (citation omitted); *Bell v. Wolfish*, 441 U.S. 520, 561 (1979) (“[T]he determination whether these restrictions and practices constitute punishment in the constitutional sense depends on whether they are rationally related to a legitimate nonpunitive governmental purpose.”); *Boivin v. Black*, 225 F.3d 36, 42 (1st Cir. 2000); *Nicholas v. Tucker*, 114 F.3d 17, 20 (2d Cir. 1997); *Carson v. Johnson*, 112 F.3d 818, 821-22 (5th Cir. 1997); *Roller v. Gunn*, 107 F.3d 227, 233 (4th Cir. 1997); *Hampton v. Hobbs*, 106 F.3d 1281, 1286 (6th Cir. 1997); *United States v. King*, 62 F.3d 891, 895 (7th Cir. 1995).

this trend¹⁰⁶ and prominent scholars are supportive. They assert that inmates are entitled to strict scrutiny because they fit squarely within *United States v. Carolene Products*¹⁰⁷ footnote four's definition of a discrete and insular minority.¹⁰⁸

In its famous footnote four, the *Carolene Products* Court called for a "more searching judicial inquiry" when discrimination is alleged against "discrete and insular minorities."¹⁰⁹ In the same breath, it mentioned racial, religious, and ethnic minorities, but with no hint of exclusivity. Mentally ill inmates also qualify as discrete and insular because societal prejudice against them likewise "tends seriously to curtail the operation of those political processes ordinarily to be relied upon."¹¹⁰ Widespread voting right bans,¹¹¹ poverty,¹¹² and stigma¹¹³ limit their ability to influence politics and legislation. This is precisely the type of disempowerment *Carolene Products*' footnote four identifies as cause for courts

106 See, e.g., *Cutter v. Wilkinson*, 544 U.S. 709, 716-17 (2005) ("To secure redress for inmates who encountered undue barriers to their religious observances, Congress carried over from RFRA the 'compelling governmental interest'/'least restrictive means' standard."); *Johnson v. California*, 543 U.S. 499 (2005) (finding that strict scrutiny should apply to the prison case at hand since it involved racial discrimination); see also *Hudson v. Palmer*, 468 U.S. 517, 557 (1984) (Stevens, J., dissenting) ("Prisoners are truly the outcasts of society. Disenfranchised, scorned and feared . . . prisoners are surely a 'discrete and insular minority.'") (emphasis added).

107 *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938) (establishing, in a landmark case, that courts' standards of review should vary according to the nature of the given constitutional claim).

108 See, e.g., Erwin Chemerinsky, *The Constitution in Authoritarian Institutions*, 32 SUFFOLK U. L. REV. 441, 449-60 (1999) ("[Inmates] are [a] classic example[] of [a] discrete and insular minorit[y], who have little political power."); Pamela S. Karlan, *Bringing Compassion into the Province of Judging: Justice Blackmun and the Outsiders*, 71 N. DAK. L. REV. 173, 176 (1995) ("Prison inmates may be the least sympathetic group of 'outsiders' in our constitutional jurisprudence."); James E. Robertson, *Psychological Injury and the Prison Litigation Reform Act: A "Not Exactly," Equal Protection Analysis*, 37 HARV. J. ON LEGIS. 105, 157 (2000) ("*Carolene Products* supports classifying inmates [as a discrete and insular minority] because modern prisoners are, in many relevant ways, similar to *Carolene*-era blacks.").

109 *Carolene Prods. Co.*, 304 U.S. at 152 n.4.

110 *Id.*

111 George P. Fletcher, *Disenfranchisement As Punishment: Reflections on the Racial Uses of Infamia*, 46 UCLA L. REV. 1895, 1898 (1999).

112 James E. Robertson, *The Jurisprudence of the PLRA: Inmates As "Outsiders" and the Countermajoritarian Difficulty*, 92 J. CRIM. L. & CRIMINOLOGY 187, 209 n.85 (2002) ("About one-half of inmates free for a year or more before their arrest reported incomes under \$10,000; nineteen percent reported incomes less than \$3,000.").

113 Jason Schnittker, *The Psychological Dimensions and the Social Consequences of Incarceration*, 651 ANNALS AM. ACAD. POL. & SOC. SCI. 122 (2014) (discussing "the stigma of a criminal record").

to heighten their protection through strengthened review of government conduct.

Post-*Carolene* courts have offered little additional guidance as to what constitutes a “discrete and insular minority.”¹¹⁴ The appellation was first applied to racial minorities but the cases did not elaborate the constitutional characteristic.¹¹⁵ Aliens were next and were even called a “prime example,” but again, with little by way of explanation.¹¹⁶ Courts’ findings about who does *not* belong are more instructive. For instance, old people were denied this classification under the rationale that everyone (life circumstances permitting) becomes old.¹¹⁷ Inmates survive this test. Unlike old age, incarceration is not inevitable.

Scholars have helped fill the definitional void left by courts. An elucidation proposed by Bruce Ackerman,¹¹⁸ characterized as the “most widely accepted,”¹¹⁹ explains that a “discrete” minority’s “members are marked out in ways that make it relatively easy for others to identify them.”¹²⁰ As an example, he notes that African American women qualify as “discrete” because they cannot plausibly hide their traits.¹²¹ Arguably, inmates are even more “discrete” under Ackerman’s definition. African American women could, no doubt with a lot of trouble, hide or minimize their race and gender traits through aesthetic choices. Inmates, on the other hand, can do nothing to minimize their confinement; by definition it marks their status against their will.

Ackerman’s refinement of the term “insular” is also supportive. He defines insularity as “the tendency of group members to interact with great frequency in

114 See Harvie Wilkinson, *The Supreme Court, the Equal Protection Clause, and the Three Faces of Constitutional Equality*, 61 VA. L. REV. 945, 981 (1975) (“A court’s act of designating groups as ‘discrete and insular’ has so far been more a matter of feel on the part of the court than of any rationally justifiable process. The label is more emotive than analytical.”).

115 See, e.g., *Regents of Univ. of California v. Bakke*, 438 U.S. 265, 290 (1978) (casting doubt on the importance of “discreteness and insularity” in determining the standard of review).

116 *Graham v. Richardson*, 403 U.S. 365, 372 (1971).

117 *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313-14 (1976) (“[O]ld age does not define a ‘discrete and insular’ group . . . in need of ‘extraordinary protection from the majoritarian political process.’ Instead, it marks a stage that each of us will reach if we live out our normal span.”).

118 Bruce A. Ackerman, *Beyond Carolene Products*, 98 HARV. L. REV. 713 (1985). Although Ackerman’s central thesis is that footnote four is flawed, his critique does not lessen the doctrine’s applicability to inmates. Ackerman contends that discreteness and insularity may in fact be indicative of political power, and not disenfranchisement. As this Note discusses, inmates have essentially no political power.

119 Marcy Strauss, *Reevaluating Suspect Classifications*, 35 SEATTLE U. L. REV. 135, 149 (2011).

120 Ackerman, *supra* note 118, at 729.

121 *Id.*

a variety of social contexts.”¹²² Inmates interact with one another in *every* social context; their confinement limits them to each other’s company. Moreover, their interactions are frequent before and after incarceration. Inmates predominantly belong to certain socioeconomic groups,¹²³ and these groups tend to cohere outside prison walls as well.¹²⁴

D. Fatal in Fact

The application of strict scrutiny to the double standard is bound to be fatal, regardless of whether this standard of review is triggered by the fundamental nature of inmates’ right to treatment¹²⁵ or their status as a discrete and insular minority.¹²⁶ Strict scrutiny instructs courts to determine whether the challenged action serves a “compelling interest” and is “narrowly tailored” to further this interest.¹²⁷ Since the state usually fails at least one of these tests, strict scrutiny is considered a death knell for challenged government actions.¹²⁸

In the prison context, the government interest most often raised as compelling is safety.¹²⁹ Although courts usually defer to prisons on safety matters,¹³⁰ strict scrutiny demands a more searching inquiry.¹³¹ By instructing

¹²² *Id.* at 726.

¹²³ Robertson, *supra* note 112, at 209 n.85 (“About one-half of inmates free for a year or more before their arrest reported incomes under \$10,000; nineteen percent reported incomes less than \$3,000.”).

¹²⁴ Douglas S. Massey et al., *The Changing Bases of Segregation in the United States*, 626 ANNALS AM. ACAD. POL. & SOC. SCI. 74, 74 (2009) (“During the last third of the twentieth century, the United States moved toward a new regime of residential segregation characterized by moderating racial-ethnic segregation and rising class segregation.”).

¹²⁵ *Reno v. Flores*, 507 U.S. 292, 302 (1993) (“[The government cannot] infringe certain ‘fundamental’ liberty interests *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.”).

¹²⁶ *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938).

¹²⁷ *Grutter v. Bollinger*, 539 U.S. 306, 326 (2003) (“[S]uch classifications are constitutional only if they are narrowly tailored to further compelling governmental interests.”).

¹²⁸ See, e.g., Gerald Gunther, *Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972) (referring to strict scrutiny review as “the aggressive ‘new’ equal protection, with scrutiny that was ‘strict’ in theory and fatal in fact”).

¹²⁹ See, e.g., *Johnson v. California*, 543 U.S. 499, 512 (2005) (finding that prison safety is “a compelling government interest”); *Lee v. Washington*, 390 U.S. 333, 334 (1968) (entertaining “the necessities of prison security and discipline” as compelling interests).

¹³⁰ See, e.g., *Turner v. Safley*, 482 U.S. 78, 79 (1987) (finding a prison rule “entitled to deference on the basis of the significant impact of prison correspondence on the liberty and safety of other prisoners and prison personnel”).

courts to assess whether the government action is “narrowly tailored” to achieve the compelling interest, this level of review requires courts to abandon any presumption of relevancy. Indeed, how the double standard contributes to safety is far from clear. Evidence suggests that instead of improving safety, the double standard undermines it. Without *Youngberg*’s more robust treatment rights, mentally ill inmates are more likely to be victims of prison violence,¹³² to inflict harm,¹³³ and to drain management resources that could otherwise be expended on safety measures.¹³⁴ *Estelle* therefore falls flat under equal protection review.

IV: JUDICIAL MALPRACTICE: ROMEO’S INCARCERATION

Although no court has explicitly recognized the equal protection implications of the double standard, a number have applied *Youngberg* in prisons.¹³⁵ This could be evidence of an appreciation of the strength of mentally ill inmates’ equal protection claims. Yet the confused nature of some of these applications¹³⁶ suggests that many judges are struggling to administer *Estelle* and

131 *Gutter*, 539 U.S. at 308 (“[S]trict scrutiny is designed to provide a framework for carefully examining the importance and the sincerity of the government’s reasons for using [a given trait] in a particular context.”) (emphasis added).

132 See *Ill-Equipped*, *supra* note 27, at 101 (“Compared to other prisoners, moreover, prisoners with mental illness also are more likely to be exploited and victimized by other inmates.”).

133 See Brandi Grissom, *A Tie to Mental Illness in Violence Behind Bars*, N.Y. TIMES (Sept. 21, 2013), <http://www.nytimes.com/2013/09/22/health/a-tie-to-mental-illness-in-the-violence-behind-bars.html> (“It is not surprising that prisons with a greater proportion of mentally ill inmates would have more violence than others.”).

134 TREATMENT ADVOCACY CTR., *State Survey*, *supra* note 18, at 10 (“Because of their impaired thinking, many inmates with serious mental illnesses are major management problems.”).

135 *Langley v. Coughlin*, 715 F. Supp. 522, 538 (S.D.N.Y. 1989) (“[S]ince *Youngberg* was decided, a number of courts have invoked its standards to adjudicate claims of denial of medical care by convicted prisoners.”); see also Susan Stefan, *Leaving Civil Rights to the “Experts”: From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 717 (1992) (“As the professional judgment standard has been expanded beyond the mental health system, claims such as those against prisons and jails for not providing adequate treatment or screening for suicidal or mentally disabled prisoners and pretrial detainees also fall into this category.”).

136 This Note does not aim to provide a comprehensive presentation of the myriad ways that courts cross-apply and confuse *Estelle* and *Youngberg*. Rather, it illustrates courts’ tendencies with select cases. For additional examples of judges applying *Youngberg* in prisons in health-related contexts, see *Davidson v. Cannon*, 474 U.S. 344 (1986); *Santana v. Collazo*, 793 F.2d 41 (1st Cir. 1986); *Wells v. Franzen*, 777 F.2d 1258 (7th Cir. 1985); *Harding v. Kuhlmann*, 588 F. Supp. 1315 (S.D.N.Y. 1984), *aff’d mem.*, 762 F.2d 990 (2d Cir.1985); and *Newby v. Serviss*, 590 F. Supp. 591 (W.D. Mich. 1984).

Youngberg properly, blurring the standards in an unprincipled way. It follows, then, that replacing *Estelle* with *Youngberg* is no panacea since the contours of the standards tend to fall apart in application.

A. *Youngberg Behind Bars*

Some courts that apply *Youngberg* in prisons provide forthright explanations. Their reasoning tends to focus on one critical point—inmates and the civilly committed are *equally* dependent on the state because of their confinement. *Langley v. Coughlin*, a case brought in the Southern District of New York challenging a prison's failure to address the mental health needs of inmates in solitary confinement, is a prime example.¹³⁷ In applying *Youngberg*, the *Langley* court explained that inmates and committed individuals' right to care "rests in significant measure upon the same rationale."¹³⁸ Namely, that the state has limited each individual's "freedom to act on his own behalf."¹³⁹ The district court concludes that this "unitary theory" requires equivalent standards, regardless of the purpose of confinement.¹⁴⁰

The logic in cases like *Langley*¹⁴¹ supports the substance of this Note's equal protection argument even though it does not raise equal protection explicitly. Like this Note, these courts consider the similarity between inmates and committed individuals' needs to be dispositive, and they reject the relevance of the purpose of confinement. This line of precedent also suggests that this Note's initial proposal that *Youngberg* supplant *Estelle* is not beyond the realm of possibility—that some judges have already made this change reflects receptiveness.

B. *Conflating Romeo and Gamble*

Other larger¹⁴² pockets of *Estelle-Youngberg* case law, with more limited expositions of the reasons behind application of a given standard, provide less cause for optimism. They reveal that a significant cohort of judges confuse *Estelle* and *Youngberg* such that the standard they purport to apply does not in fact determine the outcomes of their cases. Collectively, these misapplications

¹³⁷ *Langley*, 715 F. Supp. at 531.

¹³⁸ *Id.* at 535 (emphasis added).

¹³⁹ *Id.* at 539.

¹⁴⁰ *Id.*

¹⁴¹ For another illustrative example, see *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990), in which the court held, "Just as it does for mental patients, the State must provide . . . treatment for inmates."

¹⁴² See Stefan, *supra* note 135, at 705 ("[C]ourts rarely undertake to explain the logic behind their extension of the professional judgment standard to this very different scenario.").

suggest that judicial malpractice in this arena is widespread, and relying solely on judicial reform would therefore be unwise.

Some courts recognize *Estelle*'s relevance but the standard they apply reads nothing like *Estelle*. One court, for instance, purports to apply *Estelle* but the language it lays out closely approximates *Youngberg*: "The [E]ighth [A]mendment protects inmates from an environment in which *degeneration* is probable and *self improvement* unlikely."¹⁴³ In fact, it is *Youngberg* that protects specifically against "deteriorati[on]"¹⁴⁴ and supports self-improvement by requiring "training."¹⁴⁵ *Estelle*, in contrast, does not protect rehabilitation.¹⁴⁶ The court only mentions *Youngberg* to disclaim its applicability,¹⁴⁷ which suggests that it is unaware that the standard it is applying is, in effect, *Youngberg*.

One could argue that judges who opine in this manner¹⁴⁸ are not confused; they are sneaky. They agree with the judges who openly proclaim *Youngberg*'s applicability but choose not to name *Youngberg* to guard their opinions against being overturned for applying the "wrong" standard. This Note does not pretend to discern judges' unstated intentions, but it still finds this explanation unpersuasive. The case law this Note reviewed contained no evidence of such sleight of hand and there are indications that judges are prone to such malpractice in other contexts.¹⁴⁹

V. *YOUNGBERG*'S DEMISE: THE WRONG PRESCRIPTION

Youngberg's desirability as a substitute for *Estelle* is questionable on more than as applied grounds. *Youngberg* has flaws that counsel against its use

143 *Capps v. Atiyeh*, 559 F. Supp. 894, 901 (D. Or. 1982) (emphases added).

144 *Youngberg v. Romeo*, 457 U.S. 307, 327 (1982).

145 *Id.* at 322 ("[R]espondent is entitled to minimally adequate *training*."). (emphasis added).

146 *See, e.g., Grubbs v. Bradley*, 552 F. Supp. 1052, 1124 (M.D. Tenn. 1982) (finding that a lack of rehabilitative programs does not violate the Eighth Amendment).

147 *Capps*, 559 F. Supp. at 917 (D. Or. 1982) (referring to *Youngberg* as a standard applicable in "another context").

148 For other examples, see *Danese v. Asman*, 875 F.2d 1239 (6th Cir. 1989); *Zwalesky v. Manistee County*, 749 F. Supp. 815 (W.D. Mich. 1990); *McCloud v. Delaney*, 677 F. Supp. 230 (S.D.N.Y. 1988); and *Willis v. Barksdale*, 625 F. Supp. 411 (W.D. Tenn. 1985). For examples of how the malpractice runs in both directions—courts also bungle *Youngberg* in ways that resemble *Estelle* in controversies implicating civil institutions—see *Strutton v. Meade*, 668 F.3d 549 (8th Cir. 2012); *Sain v. Wood*, 512 F.3d 886 (7th Cir. 2008); *Elizabeth M. v. Montenez*, 458 F.3d 779 (8th Cir. 2006); and *Moore ex rel. Moore v. Briggs*, 381 F.3d 771 (8th Cir. 2004).

149 Amanda Peters, *The Meaning, Measure, and Misuse of Standards of Review*, 13 LEWIS & CLARK L. REV. 233, 233 (2009) (finding based on an empirical review that judicial standards "are often abused in practice").

irrespective of judicial malpractice. Appellate courts could conceivably make *Youngberg* more manageable by issuing clarifying opinions, but this would only strengthen the influence of *Youngberg*'s inherent inadequacies.¹⁵⁰ It suffers from at least three serious defects.

First, the *Youngberg* standard is vulnerable to the charge that it demands judicial abandonment of a core right.¹⁵¹ It instructs courts to apply a strong presumption of constitutionality to actions undertaken according to professional judgment, and at the same time provides no strict limit to what qualifies as professional judgment.¹⁵² As a result, *Youngberg* protects a range of harms. Professional judgment is not necessarily consistent with inmates' rights. A physician might well be exercising some professional judgment in withholding painkillers from an inmate in extreme pain because she fears inciting a substance abuse problem. Yet the inmate's right to adequate treatment could still be compromised.

Second, by deemphasizing claimants' rights, *Youngberg* can be read as expressively bankrupt.¹⁵³ Its deep deference to professionals emphasizes the importance of their right to practice freely, according to their own standards. *Youngberg*'s silence about the rights of the confined could be interpreted as suggesting that any benefit they might receive under the standard is secondary to the protection of professionals' right to follow their judgment.

Finally, *Youngberg* is only as robust as the resources available to professionals.¹⁵⁴ And prisons, and by implication their professional staff, are increasingly resource-starved.¹⁵⁵ This doctrinal flimsiness is so prejudicial to

150 See, e.g., *Capps*, 559 F. Supp. at 917 ("This state of the psychiatric art makes it all the more difficult for me to distinguish between cases that show inmates receiving, on the one hand, constitutionally inadequate treatment, and, on the other hand, treatment about which mental health professionals could reasonably differ.").

151 E.g., Stefan, *supra* note 135, at 642 (arguing that "the court's crucial role in our constitutional system" is lost under the *Youngberg* standard).

152 *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (specifying that "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment").

153 Richard H. Pildes, *Why Rights Are Not Trumps: Social Meanings, Expressive Harms, and Constitutionalism*, 27 J. LEGAL STUD. 725, 760 (1998) ("The expressive dimension of governmental action plays a central, but underappreciated, role in constitutional law.").

154 See, e.g., *West v. Atkins*, 487 U.S. 42, 56 n.15 (1988) (noting that professional judgment is shaped by the government's limited resources).

155 NATHAN JAMES, CONG. RESEARCH SERV., R42937, THE FEDERAL PRISON POPULATION BUILDUP: OVERVIEW, POLICY CHANGES, ISSUES, AND OPTIONS 1 (2014)

committed individuals that the *Youngberg* Court felt called upon to apologize: “[The] presumption [of professionalism] is necessary to enable institutions of this type—often, unfortunately, overcrowded and understaffed—to continue to function.”¹⁵⁶ This creates the paradox that institutions inflicting the most egregious harm¹⁵⁷ might be least likely to be found liable. Indeed, the conditions in many civil institutions under *Youngberg*’s purview have long been described as abysmal.¹⁵⁸ The Court’s creation of *Youngberg* has done little to change this terrible reality.

VI. RESUSCITATING GAMBLE: THE DOUBLE-DOSE REMEDY

Recognizing the deficiencies of a purely judicial fix, this Part turns to Congress to investigate the possibilities of a multi-branch remedy. In so doing, it helps alleviate the tunnel vision that afflicts scholarship on mentally ill inmates. Most articles consider what *single* solution is the most promising.¹⁵⁹ The interwoven doctrinal and political issues underlying the plight of mentally ill inmates, however, demand this Note’s inclusive approach.¹⁶⁰ The dilemma is essentially “a spider web, in which the tension of the various strands is determined by the relationship among all the parts of the web.”¹⁶¹

A. Legislating Equality

Backdoor approaches, like statutory reform, could address *Estelle*’s doctrinal flaws without changing the standard itself. Prisons’ de facto mental hospital

(explaining that the federal prison system is struggling with “the increasing cost” of its operations).

¹⁵⁶ *Youngberg*, 457 U.S. at 324.

¹⁵⁷ Stefan, *supra* note 134, at 691 (“The patient’s treatment may not represent the result of a decision or judgment at all, but simply a default in the absence of alternatives.”).

¹⁵⁸ See, e.g., Alex Hecht, *Civil Rights of Institutionalized People*, MD. B.J., Jan.-Feb. 2003, at 32, 32 (describing the “dire, often life-threatening, conditions” in which some mentally ill civilly committed individuals live).

¹⁵⁹ See, e.g., Posner, *supra* note 12, at 363 (proposing changes in the standard for inmates’ right to treatment but not looking to Congress).

¹⁶⁰ This approach is not intended to be *all*-inclusive. Its scope is restricted to government actors, and it does not include a few government solutions—such as increased federal intervention through more aggressive enforcement of the Civil Rights of Institutionalized Persons Act (42 U.S.C. § 1997a(a) (2012))—because their interaction with the *Estelle* standard is relatively remote. It also leaves potential private sector solutions—like social impact bond programs that increase prison resources—to works that focus on and can thus fully examine the implications of private sector involvement.

¹⁶¹ *Brown v. Plata*, 131 S. Ct. 1910, 1936 (2011) (citations omitted).

status¹⁶² points to hospital laws as a potentially apt analogue and framework for reform. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals, within their capability, to provide appropriate health screening to everyone who presents at emergency rooms.¹⁶³ *Estelle*'s central failing—its restriction of liability to conditions prisons are aware of—could be mitigated by a requirement like EMTALA's.¹⁶⁴ By putting prisons on notice, screening would create strong grounds for arguing that a failure to treat violates *Estelle* because prisons could no longer hide behind lack of awareness. Under an EMTALA-like rubric, the dispositive inquiry would be whether prisons' judgment about how to respond to detected mental illnesses is deliberately indifferent to medical standards. This shift to scrutiny of prison professionals' actions, away from consideration of their awareness of illness, would bring *Estelle* closer to *Youngberg*.¹⁶⁵

This leap between the prison and hospital realms is not pie in the sky. A small number of courts have already tried to save *Estelle* by interpreting it as requiring screening.¹⁶⁶ Some have found a duty to conduct mental health screenings in particular.¹⁶⁷ Yet, however attractive a screening requirement might be as a solution to the doctrinal puzzle, it is less appealing in terms of feasibility.

162 See, e.g., Christina Canales, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725, 1725 (2012) (arguing that “prisons have become the new mental health system”); Slovenko, *supra* note 16 (“[J]ails and prisons have become the new mental hospitals.”).

163 42 U.S.C. § 1395dd(a) (2012).

164 Currently, federal correctional institutions are not bound by a statutory duty to screen inmates' health. Bureau of Prisons guidance, which is at the Bureau's discretion, is the only national requirement. U.S. DEP'T OF JUSTICE, FY 2014 PERFORMANCE BUDGET—CONGRESSIONAL SUBMISSION: FEDERAL PRISON SYSTEM, SALARIES AND EXPENSES 28 (2014), <http://www.justice.gov/sites/default/files/jmd/legacy/2014/05/08/bop-se-justification.pdf> (“[Bureau of Prisons (“BOP”)] policy requires that every inmate admitted to a BOP facility be given an initial psychological screening.”). Evidence suggests that prisons do not adhere to these discretionary guidelines. See *Ill-Equipped*, *supra* note 27, at 101 (“[I]n many prison systems screening and tracking of mentally ill prisoners is problematic. Prisoners with mental illness are not identified upon entry into prison and are left untreated.”).

165 Despite *Youngberg*'s flaws, this shift is still desirable. See Rosalie Berger Levinson, *Wherefore Art Thou Romeo: Revitalizing Youngberg's Protection of Liberty for the Civilly Committed*, 54 B.C. L. REV. 535, 559 (2013) (“Despite its drawbacks, however, the *Youngberg* standard has become the best shield for plaintiffs against arbitrary government decision making.”).

166 See, e.g., *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 208 (D.P.R. 1998) (holding that a failure to screen for infectious diseases is unconstitutional); *Inmates of Occoquan v. Barry*, 717 F. Supp. 854, 867 (D.D.C. 1989) (holding that a lack of syphilis and tuberculosis screening constitutes deliberate indifference).

167 See, e.g., *Inmates of Allegheny Cty. Jail v. Peirce*, 487 F. Supp. 638, 642 (W.D. Pa. 1980) (finding an Eighth Amendment violation in the lack of a “screening system for new admittees to identify those with mental health problems”).

It would encounter serious roadblocks, starting with the problem that mentally ill inmates are not a politically sympathetic group.¹⁶⁸ The difficulty would be aggravated by the fact that despite recent expansions in access to healthcare,¹⁶⁹ access to mental healthcare remains acutely inadequate.¹⁷⁰ Strengthening this right for inmates would likely not be popular when non-offenders are wanting. Moreover, even when Congress does summon the will to enact laws to improve care for mentally ill inmates, the promised opening of the purse strings does not necessarily follow.¹⁷¹

B. A Uniform Standard as One Piece of the Puzzle

The barriers to a legislative fix are not insurmountable,¹⁷² but their existence suggests that the most promising remedy will likely involve both legislative and judicial change. The lack of public and congressional solicitude for mentally ill inmates is susceptible to judicial influence. There is evidence that Supreme Court

168 See, e.g., Drissel, *supra* note 15 (“People who commit criminal offenses are often marginalized. The general population has expressed little interest in ensuring or financing their welfare Similarly, our society stigmatizes individuals with mental illness.”); see also Andrew P. Wilper et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 671 (2009) (“Providing inmates with health care is politically unpopular.”).

169 Katherine L. Record, *Litigating the ACA: Securing the Right to Health Within a Framework of Negative Rights*, 38 AM. J.L. & MED. 537, 543 (2012) (“[T]he new law extends access to care to an unprecedented number of Americans.”).

170 See, e.g., Abby Goodnough, *Expansion of Mental Health Care Hits Obstacles*, N.Y. TIMES (Aug. 28, 2014), <http://www.nytimes.com/2014/08/28/us/expansion-of-mental-health-care-hits-obstacles.html> (“The need [for mental health treatment] is widely viewed as great: Nearly one in five Americans has a diagnosable mental illness . . . but most get no treatment.”).

171 *Human Rights at Home*, *supra* note 26, at 281 (statement of Michael P. Randle, Dir., Ill. Dep’t of Corrections) (“Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) in 2004 While the Act authorized \$50 million to be granted toward these efforts, only \$21.5 million has been appropriated between fiscal years 2006-2009. Due in part to this lack of funding, coupled with record deficits, States and counties have found themselves in dire circumstances with respect to treatment and management of the mentally ill.”).

172 Congress recently reauthorized a statute that funds programs that link local criminal justice and mental health systems. Screening programs are eligible for MIOTCRA funding. Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008, Pub. L. No. 110-416, § 4, 122 Stat. 4352, 4353-54 (codified at 42 U.S.C. § 3797aa(h) (2012)). Congress also recently demonstrated growing solicitude for mentally ill inmates by convening a hearing focused on their plight. See *Human Rights at Home*, *supra* note 26, at 2-3.

positions affect public sentiment,¹⁷³ and Congress, in turn, is influenced by constituents' opinions.¹⁷⁴ Thus, even if the uniform application of *Youngberg* to the civilly committed and inmates would not result in meaningful change in courts because of *Youngberg*'s doctrinal flaws and judges' maladroitness, it could help unlock legislative change.

What is more, this symbiosis truly runs in both directions. Each mode of reform has the power to counteract the other's flaws—legislation could save *Estelle* (or its replacement), and a Court decision that explicitly recognizes mentally ill inmates' right to equal treatment could make legislation more likely. Although this remedy requires two government institutions to act instead of one, the formidability of this task is not cause for criticism. On the contrary, the challenges of implementation are a reflection of the intractability of mentally ill inmates' plight. This realism is a prerequisite for success.

C. Resistance to Reform

Thus far, this Note has presumed the desirability of improving care for mentally ill inmates, even in acknowledging doctrinal and legislative challenges. This Part engages with counterarguments that do not take this premise for granted, as well as some objections to this Note's proposal that do. This discussion is broken into four Sections addressing potential grounds for objection: (1) fairness; (2) practicability; (3) effectiveness; and (4) adverse outcomes. In responding to these charges, it finds that they do not, individually or collectively, undermine the desirability of improving treatment.

1. Fairness

Objections to improving care for mentally ill inmates could be raised on fairness grounds. Under this logic, helping individuals who have harmed society

173 This Note is arguing that insofar as public sentiment is influenced by the Court's positions, judicial standards thereby influence publicly elected Members of Congress. Large bodies of scholarship analyze the interactions between public sentiment, Supreme Court jurisprudence, and Congress, and this Note leaves this ongoing debate to these devoted works. For an example of one of the many pieces that support this Note's premise that the Court influences the public, see James W. Stoutenborough et al., *Reassessing the Impact of Supreme Court Decisions on Public Opinion: Gay Civil Rights Cases*, 59 POL. RESEARCH Q. 419 (2006).

174 Similarly, this Note is not taking a position on the controversial issue of how responsive, exactly, Congress is to constituents. For an example of one of the many works that dive deeply into this issue, see Lisa O. Monaco, *Give the People What They Want: The Failure of "Responsive" Lawmaking*, 3 U. CHI. L. SCH. ROUNDTABLE 735, 737 (1996) (arguing "that the national legislature is increasingly responsive to individual manifestations, such as phone calls, letters, e-mails, and faxes, of constituent preferences").

should not be the first step in solving a problem that affects law-abiding citizens.¹⁷⁵ This argument makes two mistakes. First, it draws a rigid line between “criminals” and “citizens” that does not exist. Mentally ill inmates cycle in and out of prison so often that they are known as “frequent flyers.”¹⁷⁶ Improving their care also benefits the public because these inmates spend large chunks of time as free citizens too. In addition, mentally ill inmates’ offenses are often nonviolent¹⁷⁷ and stem from their illnesses,¹⁷⁸ which could mitigate their culpability. In this light, mentally ill inmates are not bona fide “criminals” and are no less entitled to care than non-offenders.

Second, this counterargument overlooks the fact that improving treatment for mentally ill inmates and caring for the public are not mutually exclusive. There is no direct link between healthcare spending in and outside of prisons; reductions in expenditures on prisoners do not necessarily accrue to the benefit of the non-incarcerated ill.¹⁷⁹ Indeed, if there are manifest benefits to improving care in prisons, this could motivate investment on the outside. Prisons could function as laboratories of democracy.

2. *Practicability*

Detractors could also argue that there are practical barriers to improving treatment for inmates. The most obvious contention is that improving care is prohibitively costly, but this straightforward attack does not hold up.

175 See, e.g., Kate Douglas, *Prison Inmates Are Constitutionally Entitled to Organ Transplants—So Now What?*, 49 ST. LOUIS U. L.J. 539, 544 (2005) (“[T]axpayers . . . dislike the idea that tax dollars go to provide inmates with a medical procedure that many law-abiding citizens are unable to afford.”); Posner, *supra* note 12, at 363 (“[B]ased on notions of fairness—it is not right that society spends a lot of money giving prisoners better medical care than poor citizens who have not committed crimes.”).

176 *More Mentally Ill Persons Are in Jails and Prisons than Hospitals*, TREATMENT ADVOCACY CTR. & NAT’L SHERIFFS’ ASS’N 10 (2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf (“In the Los Angeles County Jail, 90 percent of mentally ill inmates are repeat offenders, with 31 percent having been incarcerated ten or more times.”).

177 Christine M. Sarteschi, *Mentally Ill Offenders Involved with the U.S. Criminal Justice System*, SAGE OPEN, July-Sept. 2013, at 1, 9 (2013), <http://sgo.sagepub.com/content/3/3/2158244013497029> (“Forty-eight percent of the federal mentally ill inmates have been charged with drug trafficking crimes.”).

178 *Ill-Equipped*, *supra* note 27, at 24 (“Thousands of mentally ill are left untreated and unhelped until they have deteriorated so greatly that they wind up arrested and prosecuted for crimes they might never have committed had they been able to access therapy, medication, and assisted living facilities in the community.”).

179 Posner, *supra* note 12, at 363 (“[T]here is no reason to believe that reducing the amount that states spend on medical services for prisoners will result in better services for the poor.”).

Incarcerating the mentally ill *without* providing adequate treatment, as is done today, is in fact the costlier proposition. Inmates whose illnesses go untreated cost the prison system more because they have longer stays and drain non-medical management resources because of disciplinary issues.¹⁸⁰

Other practical concerns, in contrast, are more justifiably characterized as intractable. Prison medical staffs are of notoriously poor quality because of low pay and the discomfort of working in prisons.¹⁸¹ This barrier is not absolute, however. The growing sensitivity to inmates' plight¹⁸² could attract higher quality professionals.

Yet even if prisons addressed staffing problems, one could argue that improving services would incentivize malingering. Mental illness has no surefire test,¹⁸³ and a colorable argument could be made that everyone in prison is mentally ill in some sense. Part of the punishment of confinement is its psychological harm.¹⁸⁴ Non-mentally-ill inmates might present for care to receive comforting services they do not need. Although this concern has some legitimacy, in today's prison healthcare context it is not a relevant line of analysis. The risk of over-inclusive and wasteful care pales in comparison to the likelihood inadequate treatment.¹⁸⁵

3. Effectiveness

From a mental health professional's perspective, improving care in prisons might be for naught. With mentally ill inmates cycling in and out, and with few treatment options on the outside, improved prison care could be undone by a lack

180 TREATMENT ADVOCACY CTR., *State Survey*, *supra* note 18, at 10.

181 *Brown v. Plata*, 131 S. Ct. 1910, 1927 (2011) ("Prisons were unable to retain sufficient numbers of competent medical staff, and would hire any doctor who had a license, a pulse and a pair of shoes.") (citations omitted).

182 See, e.g., Mary Clare Reim, *The Surprising Ingredient for Bipartisan Reform: Hit Show 'Orange Is the New Black,'* DAILY SIGNAL (June 12, 2014), <http://dailysignal.com/2014/06/12/surprising-ingredient-bipartisan-reform-hit-show-orange-new-black> ("For many viewers, the show provides a spooky wake up call to the all-too-disturbing reality of mass incarceration. . . . It's not just 'Orange is the New Black' viewers who are beginning to feel uneasy and morally troubled about the current U.S. prison system.").

183 Jacob Sullum, *Finding a Place for the Mentally Ill*, CATO UNBOUND (Aug. 20, 2012), <http://www.cato-unbound.org/2012/08/20/jacob-sullum/finding-place-mentally-ill> (noting that "there is no objective biological or psychological test" for mental illnesses).

184 Andrew Cohen, *Supermax: The Faces of a Prison's Mentally Ill*, ATLANTIC (June 19, 2012), <http://www.theatlantic.com/national/archive/2012/06/supermax-the-faces-of-a-prisons-mentally-ill/258429> ("[T]he inhumane treatment of the men has made them mad, or at least exacerbated their preexisting mental health problems.").

185 Ditton, *supra* note 24, at 9 (finding that at least forty percent of mentally ill inmates receives no form of treatment).

of continuity.¹⁸⁶ This concern is well-founded, but instead of counseling against improving care in prisons, it points to the related importance of post-release support. Congress has recognized this need by allotting funding to programs that provide recently released inmates with care.¹⁸⁷ Moreover, quality care in prison could identify mental illness in some individuals for the first time. Although accessing care on the outside is challenging, individuals might be more receptive to and able to benefit from treatment if they are aware that they need it.

4. *Adverse Outcomes*

Opponents could point to possible unintended negative consequences. Without concurrent improvement in care on the outside, the mentally ill might be incentivized to commit crimes to access care in prison.¹⁸⁸ In addition, improving treatment could weaken prison safety if resources are shifted from security management.¹⁸⁹ Both of these arguments are one-sided. The first does not consider the fact that the downsides to incarceration—removal from family, friends, and jobs, for instance—likely outweigh the allure of treatment for many. The second does not account for the fact that resources allocated to care accrue to safety as well. Better symptom management can improve ill inmates' ability to navigate their incarceration with minimal risk to themselves and others.¹⁹⁰

There is another sense in which the cure could be viewed as worse than the disease—bolstering treatment rights could result in overmedication. Evidence suggests that some prison mental health staff protect against liability by erring in this direction.¹⁹¹ Arguably, a more robust right could aggravate this propensity.

186 *Position Statement of AACP on Persons with Mental Illness Behind Bars*, AM. ASS'N COMMUNITY PSYCHIATRISTS (Mar. 15, 2001), http://www.communitypsychiatry.org/pages.aspx?PageName=Position_Statement_of_AACP_on_Persons_With_Mental_Illness_Behind_Bars ("Upon release their decompensated mental state, combined with unavailability of . . . community mental health and dual diagnosis treatment, puts these individuals at risk for . . . psychiatric hospitalization, and re-incarceration.").

187 *See, e.g.*, Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008, Pub. L. No. 110-416, § 4, 122 Stat. 4352, 4353-54 (codified at 42 U.S.C. § 3797aa(h) (2012)).

188 Chris Halsne, *Expensive Trend: People Committing Crimes To Get Free Jail Health Care*, FOX NEWS (July 7, 2014), <http://kdvr.com/2014/07/07/expensive-trend-people-committing-crimes-to-get-free-jail-health-care>.

189 *Turner v. Safley*, 482 U.S. 78, 90 (1987) (holding that inmates' rights must be balanced against prison safety needs and safety interests should supersede inmates' individual rights).

190 *Ill-Equipped*, *supra* note 27, at 60 ("[M]entally ill prisoners in state and federal prisons as well as local jails are more likely than others to have been involved in a fight and also more likely to have been charged with breaking prison rules.").

191 *See* Don Thompson, *California Spends Big on Anti-Psychotics*, ASSOCIATED PRESS

Yet *Estelle*, even in its current weak form, has been interpreted as guarding against overtreatment¹⁹² and *Youngberg*'s "professional" basis guards against care that does not serve therapeutic purposes. Crucially, under-treatment looms far larger¹⁹³ so a skewed solution is warranted.

Perhaps the most formidable argument against improving care is that this solution is a temporary fix. Under this reasoning, the mentally ill do not belong in prison regardless of the quality of care because the setting is inherently harmful to their health and does not deter crime. "Better" care would mask confinement's harm, and the resulting diminution in visible distress would obscure the need to remove the mentally ill from prison. This argument is less compelling, however, when the suffering of mentally ill inmates that is already public is taken into account. No reforms came about even when it was revealed that one inmate died every six to seven days in one prison system because of "constitutional deficiencies" in healthcare.¹⁹⁴ There is little reason to believe that more severe tragedies, whatever they might be, would incite action when this one has not. Therefore, obstruction of the visibility of harm is not likely to significantly derail reform efforts, and improvements in care should not be avoided for this reason.

CONCLUSION: THE ANTIDOTES

It has been decades since Gamble and Romeo sought protection of their healthcare rights from the Supreme Court. Although the Court overlooked their fundamental similarity then, in the intervening years this resemblance has only grown. Today, there are more Romeos in prison than in civil facilities. Yet the *Estelle-Youngberg* double standard that grew out of Gamble and Romeo's cases still relegates mentally ill inmates to second-class healthcare. This Note exposes the doctrinal deficiency at the heart of this injustice—the double standard violates mentally ill inmates' right to equal protection.

In response, this Note proposes that the antidote to the unconstitutional *Estelle-Youngberg* double standard is not a uniform standard. A standard that puts mentally ill inmates on equal footing with the civilly committed would solve the doctrinal puzzle, but because of *Youngberg*'s flaws and judicial malpractice in this area of the law, in reality this reform would do little to help mentally ill inmates. Therefore, the solution must necessarily look beyond courts, and, as this

(May 1, 2013), <http://bigstory.ap.org/article/ap-exclusive-calif-spends-big-anti-psychotics> ("California's inmate mental health professionals appear to overmedicate their patients. Even a former top prison mental health administrator acknowledged that fear of lawsuits often drove the decisions about inmates' treatment.").

192 Ruiz v. Estelle, 503 F. Supp. 1265, 1339 (S.D. Tex., 1980), *aff'd in part*, 688 F.2d 266 (5th Cir. 1982).

193 Ditton, *supra* note 24, at 9.

194 Brown v. Plata, 131 S. Ct. 1910, 1927 (2011).

Note suggests, also to Congress.

The doctrinal and political issues underlying mentally ill inmates' plight demand such a multifaceted approach. Each mode of reform has the power to counteract the other's limitations—legislation could save *Estelle*, and a holding that explicitly recognizes inmates' equal right to care could make legislation more likely. Thus, there is a long and winding road ahead to save Gamble from a fate that is "little short of barbarous."¹⁹⁵ The first step likely lies outside of courts and Congress, as within the general public's power. The pervasive antipathy for the incarcerated and the mentally ill suggests that neither courts nor Congress are likely to disrupt the status quo without an underlying shift in public awareness, for fear of a backlash. To awaken courts to the similarity between Romeo and Gamble and to spur Congress to hold prisons to account, society must first shed its stigma against this vulnerable population.

195 *Boring v. Kozakiewicz*, 833 F.2d 468, 472 (3d Cir. 1987) ("To apply the Eighth Amendment standard to mentally retarded persons would be little short of barbarous.").

Volume XVI:2 Summer 2016

©2016 by the Yale Journal of Health Policy, Law, and Ethics.

All rights reserved. ISSN 1535-3532.

No Claim to Original U.S. Government Works.

Submissions: We invite the submission of germane manuscripts to the *Yale Journal of Health Policy, Law, and Ethics*. Submissions are accepted on a rolling basis. Please include (1) an electronic copy of the manuscript (double-spaced); (2) your current address, telephone number, email address, and CV; and (3) a 100-word abstract. Submissions should be emailed to yjhple.submissions@yale.edu or submitted via ExpressO or LexOpus. Details about our editorial style are available on our website.

Peer Review: Articles submitted to the *Journal* are peer reviewed. For a detailed description of our peer review process, please visit our website: www.yale.edu/yjhple.

Subscriptions: The *Journal* is published biannually. Subscriptions are \$29 per year for individuals and \$39 for institutions. Institutional rates apply to libraries, law firms, institutions, and individuals whose employer pays for subscriptions. Please add \$10 for overseas mailing.

Claims for non-receipt of issues should be made within 90 days of the month of publication for domestic subscribers and within 180 days for overseas subscribers. Thereafter, the regular back issue rate will be charged for replacement. All subscriptions will be renewed automatically unless the subscriber provides cancellation notice prior to September 1 of each new publication year. Please allow three months for overseas deliveries.

Legal Notices: The *Journal* is published by the Yale Schools of Law, Medicine, Public Health, and Nursing. The Editorial Staff, with the assistance of the Advisory Board, makes all decisions regarding the content of the *Journal*. Statements of fact and opinion are the sole responsibility of the authors and are not necessarily endorsed by the editors, Yale University, or any of Yale's professional or graduate schools. For permission to photocopy articles or other materials appearing in the *Journal*, contact the Editorial Staff at the address below.

Mailing Address

*Yale Journal of Health Policy,
Law, and Ethics*
P.O. Box 208215
New Haven, CT 06520-8215

Overnight Delivery Address

*Yale Journal of Health Policy,
Law, and Ethics*
127 Wall Street
New Haven, CT 06511

Website: <https://www.law.yale.edu/student-life/student-journals-and-publications/yjhple>

E-mail: yjhple@yale.edu

Founding Members

Chetan Gulati, J.D.
Chris Herndon, M.D.

Leslie A. Meltzer, J.D., M.Sc., Ph.D.
Jason Silvers, M.D., J.D.