AMERICAN HEALTH LAW ASSOCIATION

2021 AHLA Tax Issues for Health Care Organizations

5. State Oversight of Hospital Community Benefits

October 18-19, 2021

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Agenda

- Overview of Federal community benefit rules
- The Post-ACA Landscape
- Recent Federal activity
- Establishing thresholds for community benefit expenditures
- And now there's Oregon…
- Other policy levers used by states to encourage compliance

Overview of Federal community benefit rules

Overview of Federal community benefit rules

Revenue Ruling 56-185's Financial Ability Standard

To qualify as a tax-exempt hospital, an organization **had** to satisfy the following requirements:

- Established as a nonprofit organization to provide care for the sick
- Operated to the extent of its "financial ability" for those not able to pay for services rendered
  - May charge those able to pay for services rendered
  - May furnish services at reduced rates
  - May set aside earnings for facility improvements and additions
- Open Medical Staff
- Net earning must not inure directly or indirectly to the benefit of any private individuals

Charity care was an absolute requirement: "if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered."

Overview of Federal community benefit rules

Revenue Ruling 69-545's Community Benefit Standard

To qualify as a tax-exempt hospital, an organization must satisfy a facts and circumstances test focusing on:

- Promotion of health – class of persons broad enough to benefit the community as a whole
- Open emergency room to all without regard to ability to pay
- Governed by a Community Board
- Open Medical Staff
- Medicare and Medicaid Non-discrimination
- Use of Surplus Funds

Charity care is a positive factor but not an absolute requirement

Overview of Federal community benefit rules

Long and winding road from Rev. Rul. 69-545 to Section 501(r)

- IRS “Final Report” – Hospital Compliance Project
- Schedule H to 2008 Form 990
- FTC and DOJ Hearings
- Congressional Interest
  - 2006 CBO Report
  - 2007 Senator Grassley’s Staff Discussion Draft
  - 2009 Failed ARRA Amendments
  - 2009 Baucus Proposal
- The Patient Protection and Affordable Care Act (Pub. L. No. 111-148)

Overview of Federal community benefit rules

2008 Form 990 introduces Schedule H

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ To be completed by organizations that answer "Yes" to Form 990, Part IV, line 20.

▶ Attach to Form 990.

OMB No. 1545-0047

2008

Open to Public Inspection

Name of the organization | **Employer identification number**

Part I **Charity Care and Certain Other Community Benefits at Cost** *(Optional for 2008)*

		Yes	No
1a	Does the organization have a charity care policy? If "No," skip to question 6a		
b	If "Yes," is it a written policy?		
2	If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. ☐ Applied uniformly to all hospitals ☐ Applied uniformly to most hospitals ☐ Generally tailored to individual hospitals		
3	Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients.		
a	Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %		

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Overview of Federal community benefit rules

Section 501(r)

To be tax-exempt as a Section 501(c)(3) organization, a hospital must meet:

- the community health needs assessment (CHNA) requirement set forth in Section 501(r)(3);
- the emergency care policy requirement set forth in Section 501(r)(4)(B);
- the financial assistance policy requirement set forth in Section 501(r)(4)(A); and
- the limitation on charges and billing and collection requirements set forth in Sections 501(r)(5) and 501(r)(6)

Must provide audited financial statements with Form 990

Overview of Federal community benefit rules

Section 501(r)

"The provisions take steps to differentiate tax-exempt hospitals from for-profit hospitals and provide further transparency about tax-exempt hospitals' fulfilling their charitable mission.

Congress, the IRS, and the public will now have additional tools and information to ensure that charitable hospitals act charitably."

Sen. Chuck Grassley (R-Iowa)

Statement on March 24, 2010

August 23, 2012

Overview of Federal community benefit rules

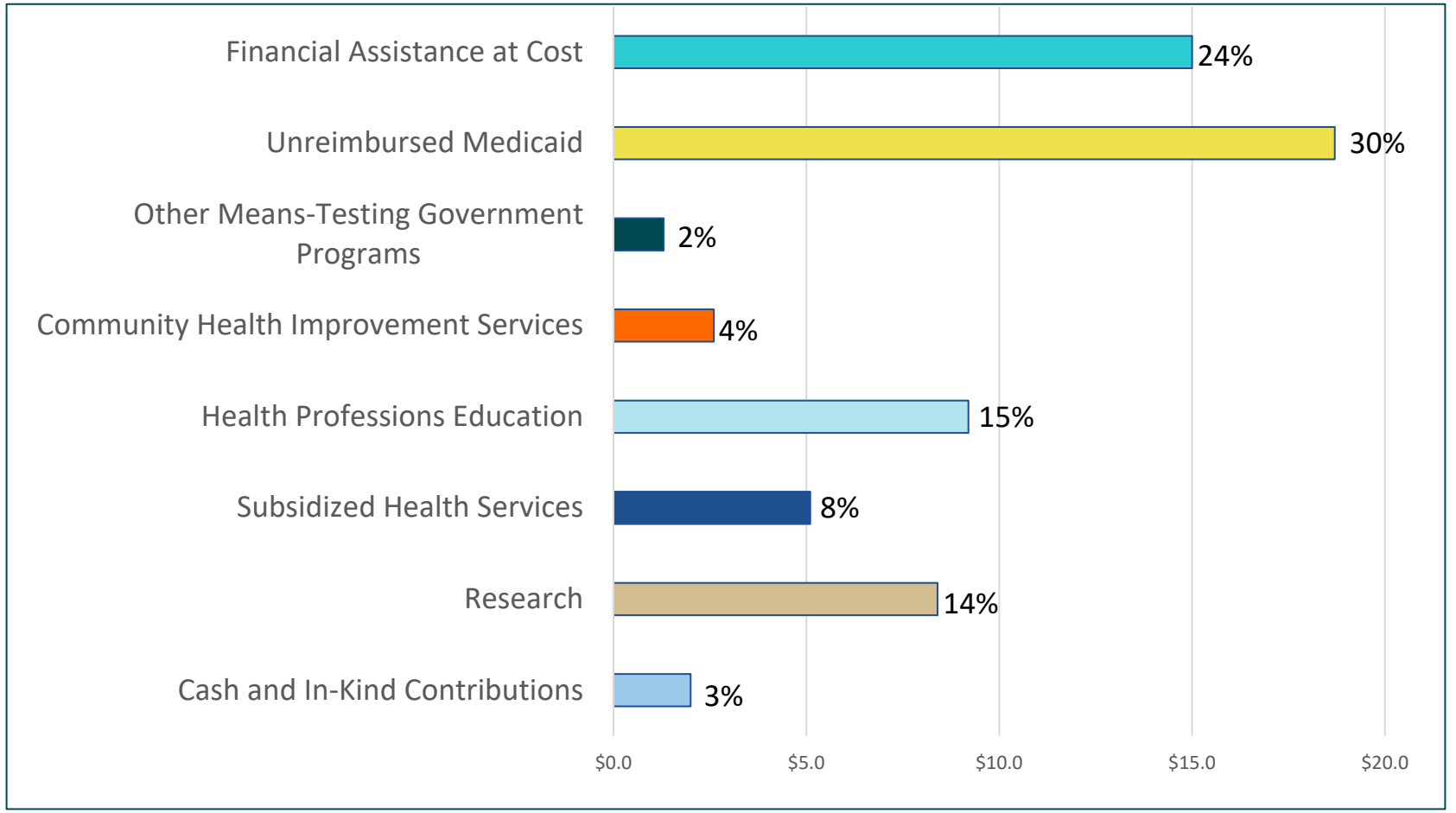
Section 501(r) following the ACA's passage

- Most provisions of Section 501(r) were effective immediately
  - However, until final regulations were issued, good faith compliance with interpretation of statutory requirements sufficed
- IRS released several forms of interim guidance [e.g., Notices 2010-39 and 2011-52]
- Schedule H to Form 990 was overhauled in 2011 to add 501(r) questions
- Proposed regulations were issued June 26, 2012 for 501(r)(4) through 501(r)(6)
- Proposed regulations were issues April 5, 2013 on 501(r)(3)'s CHNA requirements
- Final regulations were issued December 2014, effective for tax years starting on/after Dec. 29, 2015 (i.e., calendar year 2016 and forward)

The Post-ACA Landscape

Community Benefit Expenditures by US Nonprofit Hospitals, 2011

Total Expenditures: $62.4 Billion



Source: IRS. (2015, January. *Report to Congress on private tax-exempt, taxable, and government-owned hospitals.*

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Hospital Community Benefits by the Numbers

60% of the nearly 5,000 US hospitals are nonprofit[1]

The value of the nonprofit hospital tax-exemption was $24.6 billion in 2011[2]

Only 62% of nonprofit hospitals provide community benefits in excess of the value of their tax exemptions[3]

While hospitals increased community spending after passage of the ACA—from 7.6% of operating expenses in 2010 to 8.1% in 2014—spending on community health remained essentially flat[4]

The proportion of charity care is declining relative to Medicaid shortfall[3]

Nonprofit hospitals with substantial net income provided disproportionately lower levels of charity care compared to hospitals with lower net income[5]

[1]Singh, S.R., Young, G.J., Loomer, L., & Madison, K. (2018, April). State-level community benefit regulation and nonprofit hospitals' provision of community benefits. *Journal of Health Politics, Policy and Law*.
[2]Rosenbaum, S., Kindig, D.A., Bao, J., Byrnes, M.K., & O'Laughlin, C. (2015, July). The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. *Health Affairs*.
[3]Zare, H., Eisenberg, M.D., & Anderson, G. (2021). Comparing the value of community benefit and tax-exemption in non-profit hospitals. *Health Services Research*.
[4]Young, G.J., Flaherty, S., Zepeda, E.D., Singh, S.R., & Cramer, G.R. (2018, January). Community benefit spending by tax-exempt hospitals changed little after ACA. *Health Affairs*.
[5]Bai, G., Yehia, F., & Anderson, G.F.. (2020, February 17). Charity care provision by US nonprofit hospitals. *JAMA Internal Medicine*.

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In Part II of Schedule H, Hospitals Report on Community Building Activities

In FY 2016 Schedule H filings representing 2,093 hospitals from 2,100 hospital organizations:

- 54.3% reported spending on community building, but it represented a median of only 0.04% of total operating expenses
- Overall, hospital organizations contributed $434 million toward community building

Source: Chen, K., Chen, K., & Lopez, L. (2020, October 23). Investments in community building among nonprofit hospital organizations in the United States. *JAMA Network Open.*

By Expanding Medicaid, the ACA Aimed to Reduce Hospital Uncompensated Care

- Medicaid expansion provides coverage to individuals w/ incomes up to 138% of the federal poverty level
- 39 states including the District of Columbia have expanded Medicaid
- The 12 non-expansion states are AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, WY[1]

➢ Medicaid expansion has contributed to reductions in uncompensated care, but the hoped-for increases in community benefit expenditures have not materialized.

➢ Medicaid expansion was associated with a 0.68% decline in spending on charity care and a 0.17% decline in bad debt.
➢ But declines were offset by a 0.85% increase in unreimbursed Medicaid expenses and a 0.24% decrease in non-care direct community benefit spending.[2]

➢ Medicaid expansion was associated with a 2% reduction in the provision of uncompensated care and a 2% increase in unreimbursed Medicaid expenses.[3]

[1]Kaiser Family Foundation.
[2]Kanter, GP, Nabet, B, Matone, M, Rubine, DM. (2020, May 29). Association of state Medicaid expansion with hospital community benefit spending. *JAMA Network Open.*
[3]Stoecker, C, Demosthenidy, M, Shao, Y, Long, H. (2020, February 26). Association of nonprofit hospitals' charitable activities with unreimbursed Medicaid care after Medicaid expansion. *JAMA Network Open.*

Nonprofit Hospitals' Compliance with Community Health Needs Assessments (CHNAs)

Per §9007 of the ACA:

- Nonprofit hospitals must conduct a CHNA at least every three years
- The CHNA must take into account input from persons in the community, including those with expertise in public health

Only 11% of nonprofit hospitals reported conducting their CHNA during the first three-year window post-ACA[1]

A recent study of 500 randomly selected nonprofit hospitals found that only 60% had posted both a CHNA report and an implementation strategy on their website[2]

Local heath departments that collaborated with hospitals on CHNAs:

- More likely to be involved in joint implementation activities
- Joint involvement in implementation strategies associated with greater investment in community health improvement[3]

[1]Herring, B., Gaskin, D., Zare, H., & Anderson, G. (2018). Comparing the value of nonprofit hospitals' tax exemptions to their community benefits. *Inquiry.*
[2]Lopez, L., Dhodapkar, M., & Gross, CP. (2021, August 24). US nonprofit hospitals' community health needs assessments and implementation strategies in the era of the Patient Protection and Affordable Care Act. *JAMA Network Open.*
[3]Carlton, E.L. & Singh, S.R. (2018, May). Joint community health needs assessments as a path for coordinating community wide health improvement efforts between hospitals and local health departments. *AJPH Research.*

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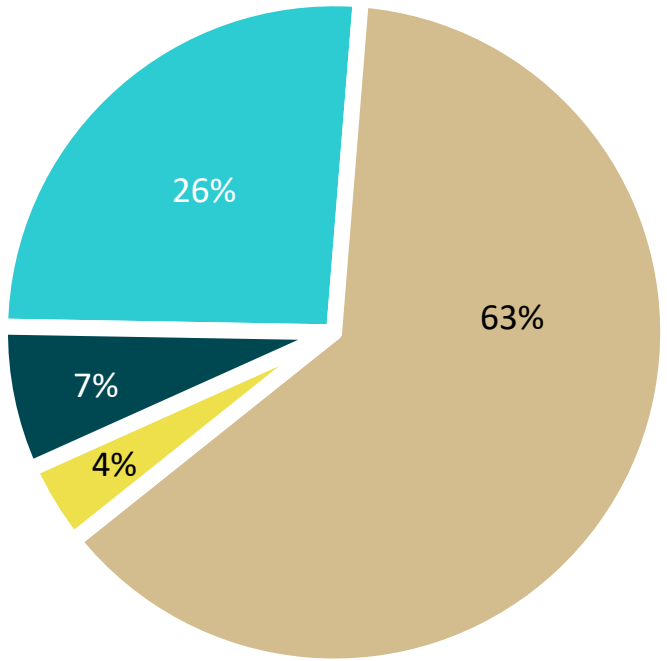
Collaboration by Local Health Departments (LHDs) with Nonprofit Hospitals on CHNAs



Source: National Association of County and City Health Officials (NAACHO). (2019). *National profile of local health departments.*

In 2019, NAACHO reported that just under two-thirds of LHDs collaborated or are currently collaborating with a nonprofit hospital on a CHNA

No nonprofit hospitals serving in jurisdiction

Has collaborated or is currently collaborating

Discussing future collaboration

Not engaged in discussion or collaboration

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Addressing Social Determinants of Health

IRS Final Rules (December 31, 2014):*

- ❑ The CHNA process should prioritize "not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."
- ❑ The CHNA process should include "an evaluation of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNAs."

Recommendations to more effectively promote community health through hospital community benefit policy include:

- ➢ Provide greater transparency on the connection between the CHNA process and community benefit spending
- ➢ Broaden the definition of community health improvement to encourage innovation and upstream investment by hospitals

*IRS. (2014). Additional rules for charitable hospitals, 79 Fed. Reg. 78953.

Does State-Level Regulation Impact Spending on Community Benefits by Nonprofit Hospitals?

Some state strategies to enhance accountability and oversight through regulations:

- Reporting community benefits
- Conducting CHNAs
- Providing minimum level of community benefits
- Adhering to minimum income eligibility standards for charity care

A 2018 study found that only CHNAs were consistently associated with greater community benefit spending.

Source: Singh, S.R., Young, G.J., Loomer, L., & Madison, K. (2018, April). State-level community benefit regulation and nonprofit hospitals' provision of community benefits. *Journal of Health Politics, Policy and Law.*

The ACA Requires Nonprofit Hospitals to have Financial Assistance Policies

- Eligibility for financial assistance varies widely across the states and from hospital to hospital
  - A review of financial assistance policies found that 21 states have their own requirements but only 9 (CA, IL, MD, NH, OK, OR, RI, TX, WA) mandate income-based thresholds for patient eligibility[1]
- Currently an estimated 79 million Americans are struggling to pay their medical bills and have accumulated medical debt[2]

[1]The Hilltop Institute. *Hospital community benefit state law profiles.*
[2]The Commonwealth Fund. (2008, August 1). *Losing ground: How the loss of adequate health insurance is burdening working families—findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007.*

Recent Federal Activity

Recent Federal Activity – Senate Finance Committee


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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510–6200

Senator Charles Grassley continues to monitor aggressive debt-collection practices by exempt hospitals

- Who remembers Heartland Hospital/Mosaic Life Care (Missouri and Kansas) in 2015?

Sen. Grassley's December 2, 2020 letter to members of the Senate Judiciary Committee:

- Methodist Le Bonheur Healthcare (Memphis, TN) and UVA Health System (Charlottesville, VA)
- Both made changes to their debt collection practices and financial assistance policies as a result of Sen. Grassley's 2019 inquiries
- Sen. Grassley is calling for IRC Section 501(r) to be strengthened, not softened

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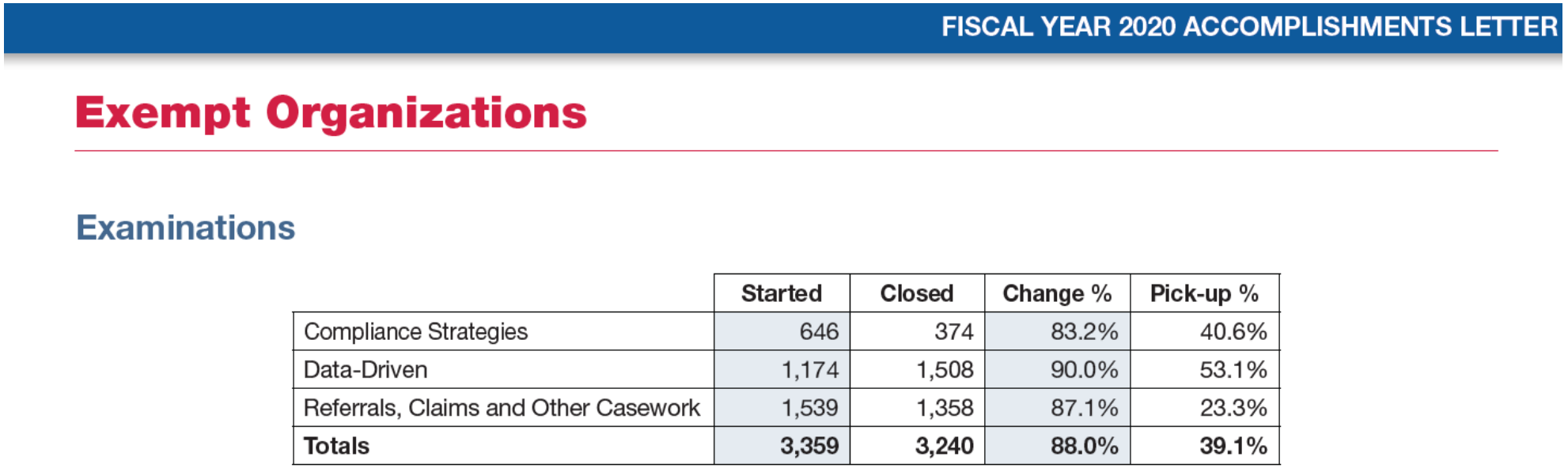
Recent Federal Activity – IRS Accomplishments Letter



FISCAL YEAR 2020 ACCOMPLISHMENTS LETTER

Exempt Organizations

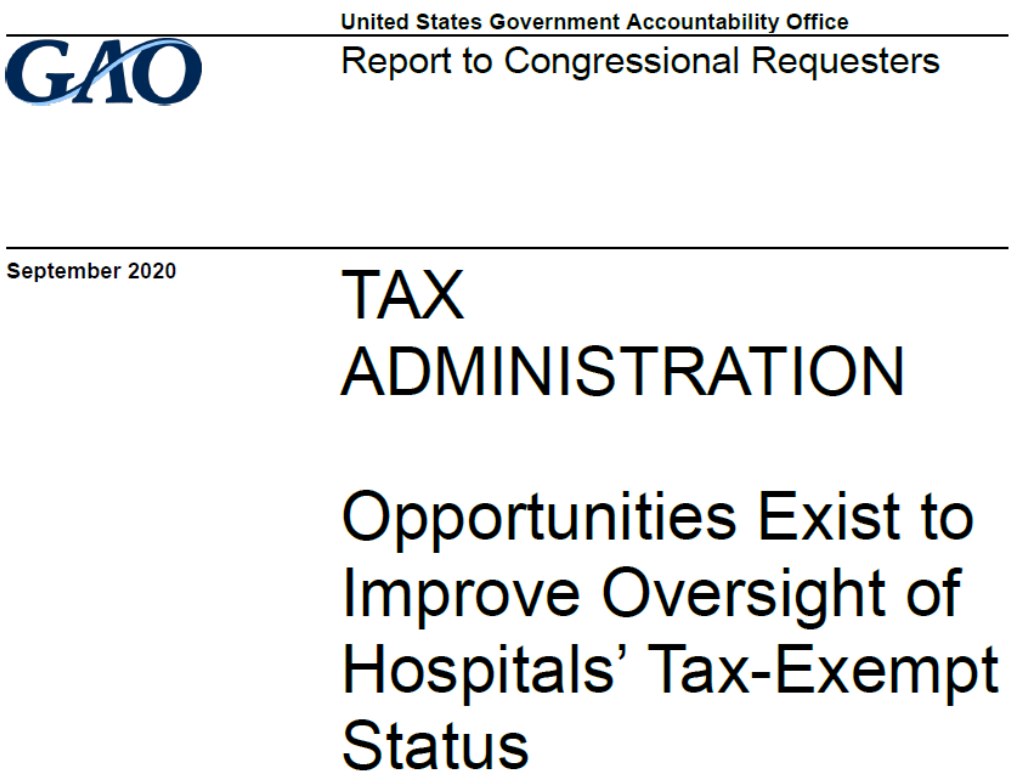
Examinations

	Started	Closed	Change %	Pick-up %
Compliance Strategies	646	374	83.2%	40.6%
Data-Driven	1,174	1,508	90.0%	53.1%
Referrals, Claims and Other Casework	1,539	1,358	87.1%	23.3%
Totals	**3,359**	**3,240**	**88.0%**	**39.1%**

IRS continues to review hospitals for section 501(r) compliance

- Fiscal Year 2020 Accomplishments Letter
  - Focus remains on hospitals with UBI where expenses materially exceed gross income on 990-T
  - Section 501(r) enforcement via examinations, compliance checks, and “soft audit” letters
  - 66 hospitals were referred for examination; 65 for possible ACA non-compliance

Recent Federal Activity – GAO Report to Congress



United States Government Accountability Office Report

GAO-20-679 (Published: 9/17/20; Released: 10/19/20)

https://www.gao.gov/products/gao-20-679

- Concludes that the IRS does not have a well-documented process to ensure or demonstrate it is consistently reviewing the community benefits provided by tax-exempt hospitals
- Makes four recommendations with which the IRS agrees
- Reveals details about the IRS's ongoing Community Benefit Activity Reviews
- Suggests IRS's data-driven audit approach does not flag curious Form 990, Schedule H, Part I, Line 7 answers

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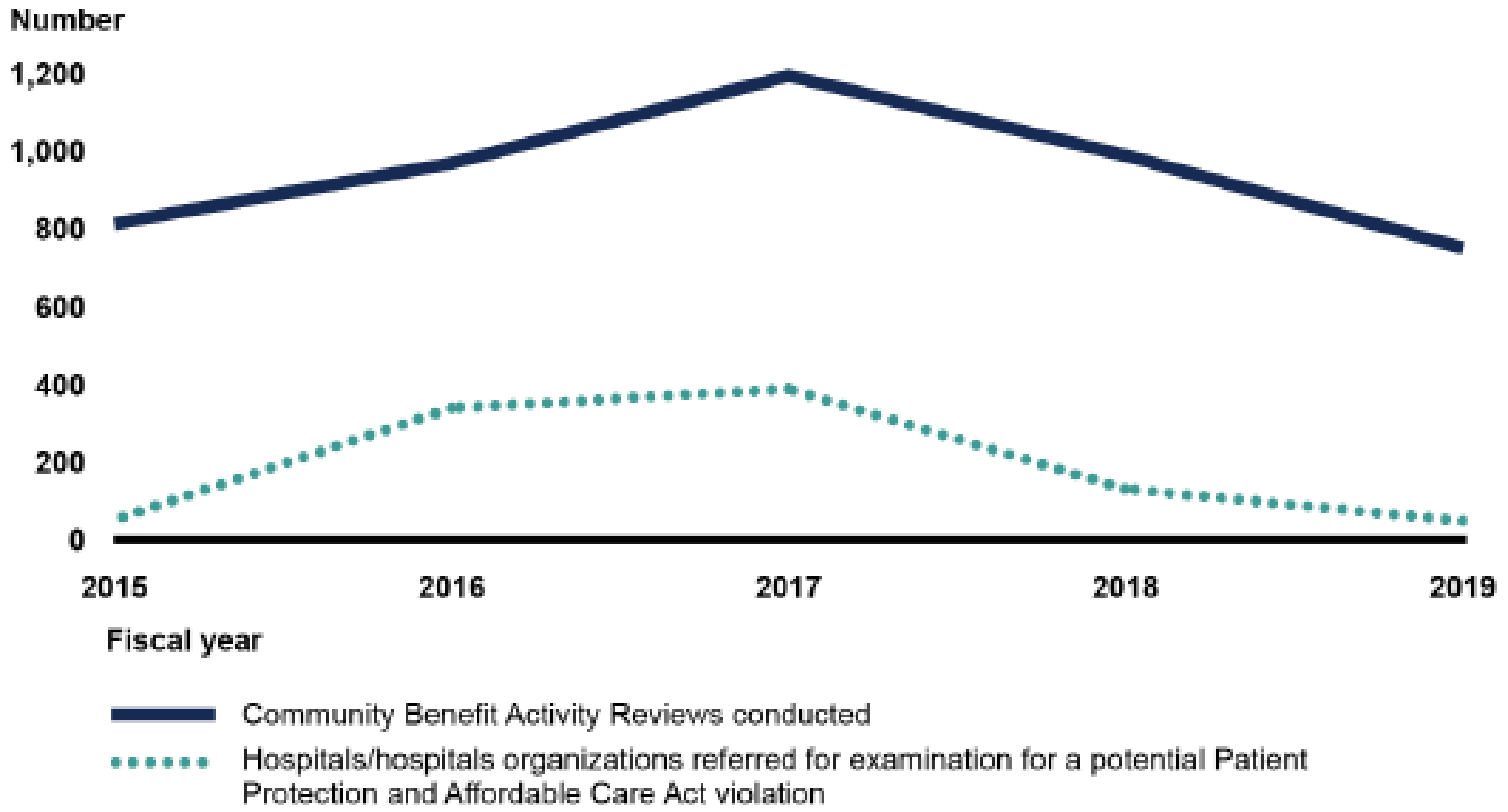
Recent Federal Activity – GAO Report to Congress

Figure 4: Results of Community Benefit Activity Reviews (CBAR), Fiscal Years 2015-2019



Source: GAO analysis of Internal Revenue Service data. | GAO-20-679

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Recent Federal Activity – GAO Report to Congress

Table 1: Percent of Tax-Exempt Hospitals Reporting Compliance with Patient Protection and Affordable Care Act Requirements, by Tax Year

	2014	2015	2016
Conduct Community Health Needs Assessments Every 3 Years	85	89	90
Maintain a Financial Assistance Policy	16	33	62
Set a Limit on Charges	91	92	94
Set Billing and Collections Limits	56	70	77

Source: GAO analysis of Internal Revenue Service data. | GAO-20-679

Table 2: Number of Hospital Organizations with Little to No Community Benefit Spending, Tax Years 2014-2016

	2014	2015	2016
No financial assistance	64	68	48
No community benefit spending	48	45	30
Less than 1 percent community benefit spending	142	137	108

Source: GAO analysis of Internal Revenue Service data. | GAO-20-679

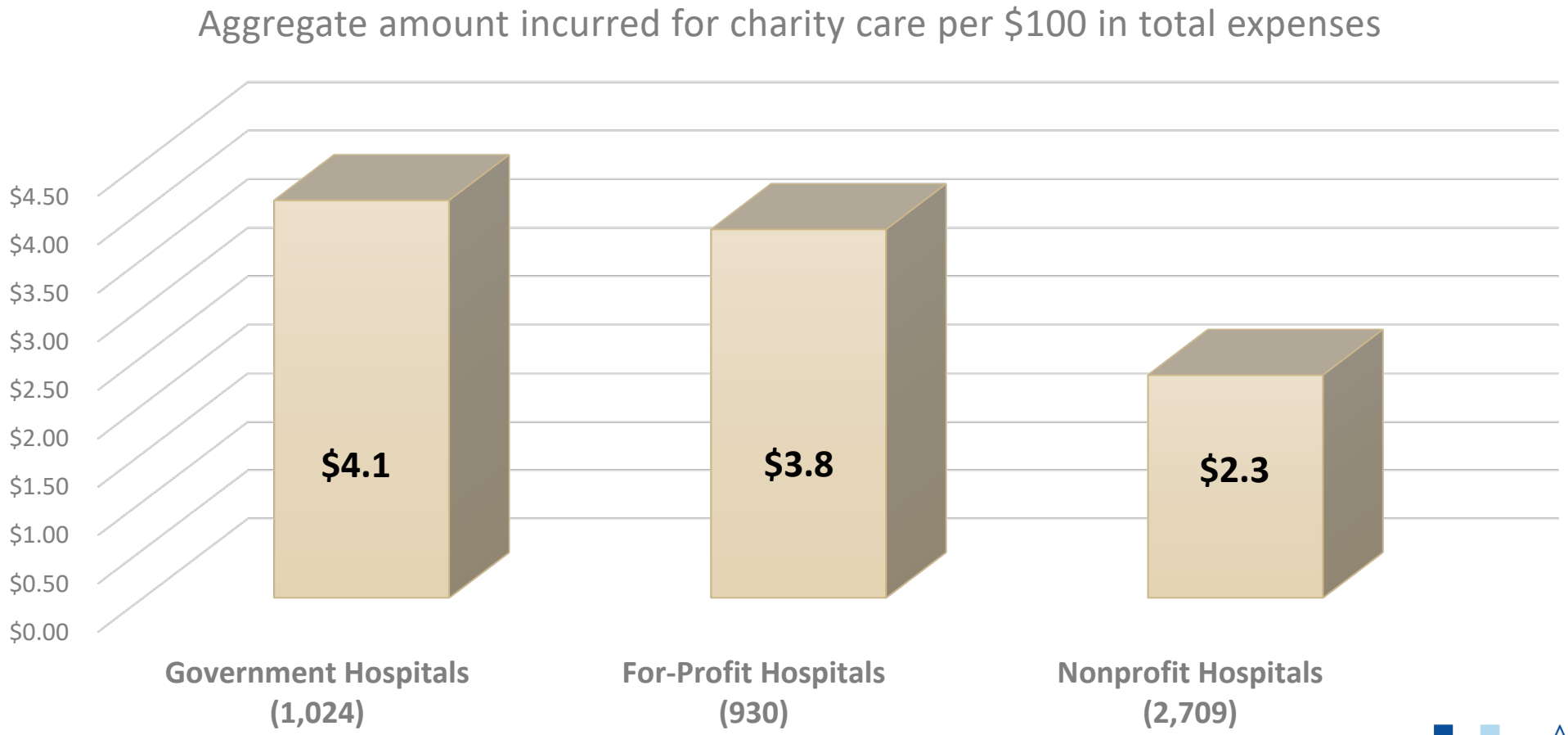
Recent Federal Activity – GAO Report to Congress

Update as of September 2021:

- **Matter for Congressional Consideration:** Congress has not enacted legislation to clarify which specific services and activities should be counted toward community benefit under the Internal Revenue Code
- **Recommendations for Executive Action:**
  - IRS has made minor adjustments to Form 990, Schedule H instructions to indicate that responses should include all of the community benefit factors (GAO believe more should be done here)
  - IRS has declined to assess community benefit on a "hospital-by-hospital" basis (GAO has requested documentation and clarification of IRS's assessment of the reporting benefits and costs here)
  - IRS updated (in April and July 2021) guidance for its PPACA hospital review group (i.e., those performing compliance reviews of tax-exempt hospital organizations at least once every three years)
  - IRS is in the process of establishing an audit code in its Case Management System under Healthcare Issues 18010.000 for "Healthcare - Community Benefit Standard for Exemption."

Recent ~~Federal~~ Activity – April 2021 Health Affairs

Analysis suggests Gov't and Nonprofit Hospitals' charity care is not aligned with favorable tax treatment



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Establishing Thresholds for Community Benefit Expenditures

A Closer Look: Thresholds for Community Benefit Expenditures

- In 1993, Texas enacted legislation requiring nonprofit hospitals to spend a minimum of 4% of net patient revenue on charity care
- A study using financial data from 1992 through 1997 found:
  - Hospitals spending **below** the 4% threshold increased their charity care spending to meet the threshold
  - Hospitals spending **above** the threshold had a marginally significant decrease in charity care spending
  - **The Texas law did not, on average, lead to increased charity care spending**

Source: Kennedy, F.A., Burney, L.L., Troyer, J.L., & Stroup, J.C. (2010). Do non-profit hospitals provide more charity care when faced with a mandatory minimum standard? *Journal of Accounting and Public Policy.*

Failed State Initiatives to Establish Thresholds or Other Requirements for Community Benefit Expenditures

California
2019 AB 204

- The bill would have required development of regulations to standardize the calculation of the economic value of community benefits and make reporting mandatory
- The value of charity care to be based on a percentage of Medicare rates

Florida
2019 SB 1712

- The bill would have required hospitals to "provide charity care in an amount equal to or greater than the applicable district average among licensed providers of similar services"
- In lieu of providing charity care, a hospital could donate to a state trust fund
- The value of charity care would be based on Medicaid reimbursement rates

Connecticut
2019 HB 7408

- The bill would have required nonprofits (including hospitals) to pay a fee to municipalities for providing road maintenance and police, fire, and emergency services

Establishing Thresholds for Community Benefit Expenditures

Are Nonprofit Hospitals Doing "Enough"?

- 31 states have community benefit public reporting requirements
- More states are beginning to question whether hospitals "earn" their exemptions
- To date, only a handful of states have laws imposing ***minimum*** community benefits:
  - Illinois [35 ILCS 200/15-86(c)]
  - Nevada [NRS 439B.320]
  - Pennsylvania [Pa. Stat. §375(d)(1)]
  - Texas [Texas Tax Code Ann.§11.1801(a)]
  - Utah [Standards of Practice, Standard 2 (Property Tax Exemptions), Appendix 2B, Standard V, pgs. 31-32 (Rev. May 5, 2020)]

And now there’s Oregon –

And now there's Oregon –

Motto: "Alis volat propriis" – "She Flies With Her Own Wings"

- House Bill 3076 introduced significant changes to Oregon's hospital community benefits policy
- Requires nonprofit hospitals and their nonprofit affiliated clinics to establish financial assistance policies meeting specified criteria, including reducing charges to low-income patients
- Establishes consumer rights with respect to billing and charges for services provided by nonprofit hospitals and their nonprofit affiliated clinics.
- Requires each hospital to post certain information on its website, including information regarding its community health needs assessment and three-year strategy to address health care needs of community.
- Requires Oregon Health Authority to establish community benefit spending floor for hospitals and affiliated clinics.
- Specifies process for setting community benefit spending floor and factors to be considered.

And now there's Oregon –

House Bill 3076 amends the definition of "community benefit"

SECTION 10. ORS 442.200 is amended to read:

442.200. As used in this section and ORS 442.205:

(1) "Charity care" means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. "Charity care" does not include bad debt, contractual allowances or discounts for quick payment.

(2) "Community benefit" means a program or activity that provides treatment or promotes health and healing**, addresses health disparities or addresses the social determinants of health** in response to an identified community need. "Community benefit" includes:

(a) Charity care;

(b) Losses related to Medicaid, [*Medicare,*] State Children's Health Insurance Program or other publicly funded health care program shortfalls **other than Medicare**;

(c) Community health improvement services;

(d) Research;

(e) Financial and in-kind contributions to the community; and

(f) Community building activities affecting health in the community.

And now there's Oregon –

Calculating the Minimum Spending Floor

- The Oregon Health Authority calculates a minimum spending floor for each hospital every two years, based on three-years worth of financial data
- Targets are linked to operating margin and can be challenged within 30 days of receipt
  - FY22 spending floor = 3-year average of unreimbursed care spending + (Direct Spending Net Patient Revenue Percentage x 3-year average operating margin multiplier)
  - FY23 spending floor = FY22 spending floor + (FY22 spending floor* 4-year average percent change in net patient revenue, capped at +/- 10%)

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/hospital-index.aspx?wp6699=l:100,so:[[6650,1]]#g_b3c87be8_b233_471b_ab83_f6e3e3e8c8e9

FY22 Minimum Spending Floor

3-year Average of Unreimbursed Care		
Oregon Health & Science University Hospital	$142,883,870	
Total 3-year Average of Unreimbursed Care	**$142,883,870**	
Direct Spending Net Patient Revenue %	**FY20 NPR**	**Type % Mod**
Oregon Health & Science University Hospital	$26,698,622	1.5%
Total Direct Spending Net Patient Revenue %	$26,698,622	
3-Year Average Operating Margin	**3-Year Avg OpMarg**	**Modifier**
Oregon Health & Science University Hospital	2.0%	0.9
Adjusted Direct Spending	**Adj Direct Spending**	
Oregon Health & Science University Hospital	$24,028,760	
Total Adjusted Direct Spending Amount	**$24,028,760**	
FY22 Minimum Spending Floor	**$166,912,630**	

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And now there's Oregon –

Health Policy & Analytics Division
Office of Health Analytics

Kate Brown, Governor

Oregon Health Authority

421 SW Oak St.
Portland, Oregon 97204

June 30, 2021

Assigned Community Benefit Minimum Spending Floor Notification

This notice is to inform you that the Oregon Health Authority has assigned a Community Benefit Minimum Spending Floor for Oregon Health & Science University, applicable to the following:

- Oregon Health & Science University Hospital

The Oregon Health Authority has assigned a minimum spending floor of

- $166,912,630 for fiscal year 2022, and
- $171,990,420 for fiscal year 2023.

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And now there's Oregon –

Way too early lessons learned

- Hospitals can be creative and strategic

Community Benefit Activity Categories	
(A) Charity care	(F) Subsidized health services
(B) Losses related to Medicaid and State Children's Health Insurance Program	(G) Research
(C) Losses related to other publicly funded health care programs, excluding Medicare;	(H) Financial and in-kind contributions to the community
(D) Community health improvement services	(I) Community building activities
(E) Health professionals' education	(J) Community benefit operations

And now there's Oregon –

Way too early lessons learned

- No requirement to spend in any **one** category
  - Academic Medical Center may focus on research and health professional education
  - Rural hospital with 60% Medicaid population might meet its floor with unreimbursed care alone
- Community Benefit Managers enjoy having a budget
  - Can be used as a cudgel against out-of-state system parents

And now there's Oregon –

Way too early lessons learned

- A lot of focus being given to capturing on-going community benefit activity
  - Software programs can be helpful for tracking purposes
  - Additional help is needed to better capture this information
- You never know who is going to show up on your doorstep
  - Forecasting is critical as fluctuations in unreimbursed cost of care are common
  - Community benefit managers are being forced to be more proactive

Other Policy Levers Used by States to Encourage Compliance

State Policy Levers for Incentivizing Hospital Community Benefit Spending and Transparency

1 **Require Broader Community Participation in CHNAs**

2 **Require a Minimum Level of Community Benefit Expenditures**

3 **Mandate Minimum Income Eligibility Standards for Charity Care**

4 **Require Community Benefit Reporting to the State and Public**

State Policy Levers for Incentivizing Hospital Community Benefit Spending and Transparency (continued)

5 **Align Community Benefit Activities with State Public Health Goals**

6 **Conduct Audits of Hospital Community Benefits**

7 **Regulate Medical Debt Collection**

8 **Regulate Hospital Pricing and the Value of Charity Care**

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Have follow-up questions? Call or email us!

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We Are AHLA

Our Vision

To lead health law to excellence through education, information, and dialogue.

Our Mission

To provide a collegial forum for interaction and information exchange to enable its members to serve their clients more effectively; to produce the highest quality, nonpartisan, educational programs, products, and services concerning health law issues; and to serve as a public resource on selected health care legal issues.

Diversity and Inclusion

In principle and in practice, the American Health Lawyers Association values and seeks to advance and promote diverse and inclusive participation within the Association regardless of gender, race, ethnicity, religion, age, sexual orientation, gender identity and expression, national origin, or disability. Guided by these values, the Association strongly encourages and embraces participation of diverse individuals as it leads health law to excellence through education, information, and dialogue.

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