

What Have You Done for Me Lately? Assessing Hospital Community Benefit

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OVERVIEW — *This issue brief reviews key aspects of the ongoing policy debate related to not-for-profit hospitals, the advantages they derive from tax exemption, and the benefits they provide to communities served. It provides a historical context for how federal standards for assessing hospitals' tax-exempt status have evolved and describes recent activities to explore additional policy changes. Legislative and regulatory actions at the state and local level are also examined. Evidence on the performance of not-for-profit hospitals in comparison to their for-profit competitors on measures of cost, quality, and access is summarized, and perspectives on the need to preserve a not-for-profit presence in health care are explored. Efforts to develop standardized metrics for measuring community benefit are described, and alternative conventions for reporting charity care contributions are discussed.*

What Have You Done for Me Lately? Assessing Hospital Community Benefit

The image and defining mission of the “hospital” has changed dramatically over the last two centuries. In the early 1800s, the hospital was a charitable asylum, offering little more than comfort to the poor and helpless souls who went there when grievously sick, frequently to die. Today, hospitals are gleaming temples of modern medical technology, promising treatment and recovery—and generating handsome revenue in the process. Evolving from social charities formed to minister to society’s outcasts, hospitals now represent “the most visible embodiment of medical care in its technically most sophisticated form.”¹ Originally dependent on philanthropic donations and direct government support to fund their charitable endeavors, hospitals are now a major industry drawing most of their funding from third-party payers. Tax-exempt hospitals (including both not-for-profit and government-owned institutions) account for over 80 percent of total hospital capacity nationally and had revenues in excess of \$503 billion in 2004.²

Since payments from health insurers became hospitals’ principal form of income in the mid-20th century, hospitals have become increasingly aware of both their reimbursement levels and cost structures. This bottom-line orientation has, in turn, encouraged business practices that may conflict with charitable goals. Not-for-profit hospitals have come to look and behave more like profit-seeking enterprises, while the number of uninsured has risen significantly and competition from for-profit rivals has grown. Not surprisingly, the public’s perception of hospitals’ charitable role has blurred, and policymakers’ scrutiny of the tax exempt status of not-for-profit institutions has intensified.

Policymakers at all levels of government are again beginning to question whether not-for-profit hospitals provide a benefit to the public and if this benefit is commensurate with the value of the tax exemption they receive. These questions have manifested in a variety of ways, including congressional hearings, evaluative studies, formal inquiries and investigations, litigation, and legislative activity in the states. Myriad forces have come together to heighten policymakers’ attention to hospital community benefit.

A wave of scandals and ethics concerns has spurred Congress to examine the integrity of the not-for-profit sector broadly, and hospitals in particular. Press reports have highlighted allegations that indigent patients are sometimes billed at exorbitant rates, subject to aggressive debt collection

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practices, and forced into bankruptcy. At the same time, examples of lavish management compensation packages, executive perks, and board privileges have tarnished the public image of hospitals and other charities.

Congress has direct oversight responsibility to address these transgressions and ensure that tax exempt organizations uphold their fiduciary obligations. However, questions surrounding the public service mission of not-for-profit hospitals have implications for a much wider array of policy decisions. Issues as diverse as bio-terrorism preparedness, graduate medical education, and Medicare payment policy can pivot on the extent to which hospitals are obligated to serve broad societal interests. Some might argue that the current policy debate on hospital community benefit merely represents the latest chapter in a long history of changing expectations regarding the nature and extent of these obligations. This paper provides a brief review of this history and summarizes the current status of efforts to define and document hospitals' community benefit.

HOSPITAL TAX EXEMPTION: HISTORY LESSON

Since the federal income tax statutes were established in 1913, not-for-profit hospitals have been treated as charitable institutions exempt from taxation. Section 501(c)(3) of the Internal Revenue Code specifies that organizations "operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes" will receive special consideration under federal tax law provided that the earnings of such organizations in no way inure to the benefit of any private shareholder or individual.³

Although hospitals are not specifically identified as qualified organizations under 501(c)(3), not-for-profit hospitals have historically been regarded as "charitable" enterprises entitled to special treatment under federal tax law. The earnings of qualified 501(c)(3) organizations are not subject to federal income tax. Furthermore, individual and corporate donations to such organizations are tax deductible for donors, and the interest on bonds issued by municipalities on behalf of such organizations is tax free. (Government hospitals are also tax exempt, but these institutions typically secure this status by being a unit of local, state, or federal government, rather

Common Terms

Charity Care

Care for which the hospital expects no payment. Charity care determinations are typically made prospectively (or as soon as practically possible) for patients deemed unable to pay. Patients are not typically billed, and collection efforts are not pursued. Accounting standards allow for charity care to be booked based on the charges that would have been incurred, but the major hospital associations recommend valuation based on the cost of delivering care or an amount representing the discount given from cost if partial payment is expected. Dollar amount is treated as a deduction from gross revenue in financial reports.

Bad Debt

Dollar amount incurred related to care for which payment is expected but cannot be collected from a patient or third party payer. Charges are initially booked in accounts receivable and written off as an operating expense once determined uncollectible.

Uncompensated Care

Commonly used to represent a combined total of charity care and bad debt amounts.

Contractual Allowance

The difference between charges and the payment amount negotiated between the hospital and third party payer. Subtracted from net revenue and not included in accounts receivable balances.

Shortfall

Difference between the cost of delivering care and the amount collected for care delivered to patients insured by government-sponsored insurance programs (Medicare and Medicaid).

than through 501(c)(3). For the purposes of this paper, “not-for-profit hospital” refers to private, tax-exempt facilities and excludes government hospitals, unless otherwise noted.)

The basis for demonstrating the charitable nature of not-for-profit hospitals has shifted over time. The first clearly defined standard for assessing a hospital’s charitable purpose was tied to the provision of care to the poor. The Internal Revenue Service’s (IRS’s) revenue ruling 56-185, issued in 1956, stated that an exempt hospital must be “operated 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.” This ruling specifically indicated that bad debts would not be considered charity care and suggested that hospitals should proactively differentiate between charity care and care for which payment was expected.

The IRS revised this policy after the establishment of the Medicare and Medicaid programs, adopting a broader definition of charitable purpose that did not solely depend on (or even require) the provision of charity care. In 1969 the “community benefit” standard established by IRS ruling 69-545 laid out criteria to affirm the tax-exempt status of a particular hospital:

- The hospital is governed by a community board
- Earnings are applied to improvements in patient care, medical training, education, research, expansion and repair of facilities, and amortization of debt
- Transactions between the hospital and members of its medical staff are conducted at arm’s length and reflect fair market value
- Medical staff privileges are available to all qualified physicians in the area consistent with the facility’s size and capabilities
- Care is provided to all those in the community who could pay, either by themselves or through private health insurance, or through a public program such as Medicare
- The hospital operates a full-time emergency room treating all persons requiring emergency care, regardless of ability to pay

These criteria were never formally codified through regulatory or legislative action but are generally consistent with the statutory language that applies to all 501(c)(3) organizations. The revenue ruling was challenged and upheld in federal court and continues to guide determinations of charitable intent today.

The IRS adopted this broader definition of hospitals’ charitable purpose for a variety of reasons. In the late 1960s, there was widespread belief that uncompensated care would soon be greatly reduced or even eliminated due to the newly established public health insurance programs. In the face of substantial political pressure to ensure hospitals would not

lose their favorable tax status, the IRS accepted the argument that communities benefited from hospitals' investment in the development and application of modern medical science and maintained that this broad interpretation of community benefit satisfied charitable intent. Any immediate effect of hospitals' limiting charity care in response to the relaxed requirements under federal tax law was buffered by the fact that many hospitals were also obligated to provide uncompensated care in compliance with Hill-Burton funding.⁴

Hospital community benefit requirements have become increasingly flexible since the 1969 ruling. The IRS characterized revenue ruling 69-545 as an expansion, rather than a reversal, of its standard for determining charitable intent. Subsequent administrative policy changes have provided even greater latitude to hospitals. In 1983, the IRS ruled⁵ that a not-for-profit hospital was not required to operate an emergency room to secure tax exemption if a state or local planning agency determined that such services were adequately provided by another medical institution in the community. The ruling also indicated that specialty hospitals, such as cancer or eye hospitals, would not be required to operate emergency rooms if they focused on conditions unlikely to require emergency care and could otherwise demonstrate a benefit to the community served. In essence, IRS administrative policy maintains that the conditions dictating an individual hospital's tax-exempt status are contingent on the circumstances and needs of the community it serves.

Although the vast majority of not-for-profit hospitals continued to maintain emergency rooms, concerns about access to emergency services and patient "dumping" began to surface in the early 1980s fueled in part by a rising number of uninsured persons and a declining number of Hill-Burton-obligated facilities. Rather than clarifying not-for-profit hospitals' obligation to provide emergency services through the tax code, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986.⁶ EMTALA imposed emergency service requirements on hospitals as a condition of participating in the Medicare program without making any distinctions between not-for-profit and for-profit facilities. Amended in 2003, EMTALA requires participating hospitals to screen and provide stabilizing treatment (within the hospital's capability) to all patients presenting in emergency departments.

Beyond failing to establish a clear, measurable standard for hospital tax exemption, some argue that federal policies have, in fact, accelerated

Hill-Burton

The Hospital Survey and Construction Act of 1946 (commonly known as the Hill-Burton Act) established a program of federal grants designed to assist hospitals with capital improvements to modernize their facilities. Hospitals using Hill-Burton funds were required to provide uncompensated care services for 20 years after receiving funds. In 1975, Congress amended Hill-Burton to provide for grants, loan guarantees, and interest subsidies for health facilities and strengthened compliance standards and monitoring under Title XVI of the Public Health Service Act. Grantees awarded Title XVI assistance after 1975 were required to provide uncompensated care in perpetuity. Title XVI funding was suspended in 1997, and only 269 hospitals nationwide are currently obligated to provide uncompensated care services under Title XVI funding requirements.

hospitals' shift toward a more "business-like" orientation. Cost-based reimbursement principals under Medicare treated depreciation and interest as expenses, which facilitated bond-financed capital investment by creating a predictable revenue stream to service debt repayment. Changes to federal tax policy in the early 1970s furthered the appeal of bond financing by reducing barriers to municipal sponsorship of tax-exempt hospital bonds.

Hospitals' access to bond-financed capital is largely determined by bond ratings, which are tied to measures of financial performance. A bigger bottom line improves bond ratings and allows for more favorable interest rates. As capital development became increasingly reliant on bond market valuation rather than philanthropic assessments of need, the focus on hospitals' fiscal health began to displace attention to community health concerns.

Tax-Exempt Bond Financing

State and local governments can issue bonds to finance their own investments (governmental bonds) and can also issue bonds on behalf of private entities (private-activity bonds). Governmental bonds are tax exempt. Most private-activity bonds are taxable, but some private-activity bonds are tax exempt for a limited number of activities specified in the federal tax code. Examples of activities eligible for tax-exempt bond financing include not-for-profit hospital services, student loans, the provision of manufacturing structures and equipment, and mortgages for owner-occupied housing.

Annual caps limit the amount of tax-exempt private-activity bonds for most categories of eligible activities, but the tax-exempt bond financing available to not-for-profit hospitals is not subject to these limitations. Of the \$50 billion in tax-exempt private-activity bonds issued by state and local governments in 2002, about \$10 billion went to not-for-profit hospitals.

Access to tax-exempt financing lowers the cost of capital for not-for-profit hospitals. Purchasers of tax-exempt bonds do not pay income taxes on the interest proceeds of that bond and are therefore willing to accept a lower interest rate than they would from

an otherwise equivalent taxable debt. The Congressional Budget Office (CBO) estimates that, in 2006, the cost of capital for not-for-profit hospitals was 10.8 cents per dollar of investment, compared with 12.9 cents per dollar for for-profit hospitals.

CBO has raised concerns that hospitals are leveraging their preferential tax treatment to engage in a form of arbitrage (that is, earning risk-free profit). Not-for-profit hospitals are not subject to income taxes related to interest earned on securities and other investments they hold. Therefore, they have an incentive to finance capital investment through tax-exempt bond issuances, rather than drawing on financial reserves they have accumulated and invested in higher yielding (normally taxable) securities.

Hospital representatives argue that not-for-profit facilities must keep precautionary savings on hand in order to respond to unforeseen financial difficulties and cannot liquidate their investment assets to fund capital development. Critics disagree over the appropriate level of precautionary savings hospitals should maintain.

Source: Congressional Budget Office, Nonprofit Hospitals and Tax Arbitrage, December 2006; available at www.cbo.gov/ftpdocs/76xx/doc7696/12-06-HospitalTax.pdf.

This bottom-line orientation was perpetuated by additional policy changes in the 1980s. The development of prospective payment under Medicare in 1983 established new incentives for economic efficiency, reduced cost-shifting opportunities, and intensified pressures to maintain profitability. Under prospective payment, hospitals are reimbursed a fixed price per case and are not guaranteed rate increases to accommodate growth in their underlying costs. Prospective payment did not eliminate Medicare's support for capital investment, but it did significantly reduce the certainty of generating revenues to finance debt and raised the importance of effective cost management and strategic decision making.⁷ Changes in tax policy in the early 1980s gave not-for-profit organizations more latitude in designing executive compensation packages to reward superior management skills. These changes allowed for greater use of incentive-based payments for management tied to hospitals' financial performance. Taken together, these policy changes have converged with market dynamics, such as the rise of multi-hospital systems, to affect the priority accorded to hospital community benefit.

CURRENT STATE OF PLAY

Federal policymakers have periodically questioned whether not-for-profit hospitals provide community benefits at a level commensurate with the tax advantages they enjoy. However, a more robust federal standard for conferring tax exemption (in the form of either legislation or regulation) has yet to emerge. The IRS has never revoked tax exemption from a not-for-profit hospital based solely on a failure to demonstrate community benefit. The agency has also never promulgated formal regulations to clarify its administrative rulings regarding hospital tax exemption. Until recently, Congress has likewise shown little appetite for sharpening the specificity of federal tax law in order to create more exacting standards for judging hospital charitable intent. Although federal tax law is quite specific in characterizing other types of charitable enterprises, historically Congress has avoided making statutory change to address the tax-exempt status of hospitals.

Recent congressional inquiries have raised specific concerns about some practices of not-for-profit hospitals, questioning whether they undermine hospitals' charitable mission and tax-exempt status.⁸ Congressional hearings and several lawsuits have focused on hospitals' billing practices related to uninsured patients in light of reports that the uninsured were billed at highly inflated rates and subjected to aggressive debt collection techniques. The compensation packages of hospital executives have also been examined. Policymakers have suggested that the salary and benefit structures of some hospitals provide excessive compensation that constitutes private benefit in direct conflict with a not-for-profit charter.

In response to congressional interest, the IRS fielded a survey of approximately 600 hospitals in 2006 seeking to assess compliance with existing tax exemption criteria.⁹ The survey probed services offered, payer mix,

nature of emergency services available, governance structure, policies related to medical staff privileges, research activities, medical education, uncompensated care, billing practices, community programs, and executive compensation practices. The Government Accountability Office (GAO) also conducted a voluntary survey of the 100 largest not-for-profit systems' compensation, benefits, and governance practices.¹⁰ A low response rate prompted harsh criticism from congressional leaders—along with promises to introduce legislation early in the 110th Congress to strengthen charitable obligations. Absent further legislative or regulatory activity, the federal tax status of hospitals continues to be governed by rather ambiguous, and somewhat dated, IRS rulings.

WHERE THE ACTION IS

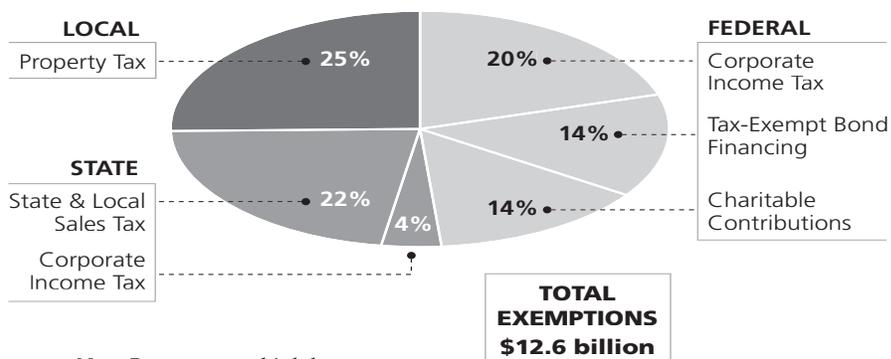
The financial implications of state and federal tax exemption are considerable. A recent report by the Congressional Budget Office (CBO) estimated the value of tax exemption for hospitals to be \$12.6 billion nationwide in 2002.¹¹ Approximately one half of this monetary value was derived from federal tax exemption and the other half from state and local tax policies. Exemption from local property taxes was the single largest contributor to the value of tax exemption, representing one quarter of the total (Figure 1).

Authorities at the state and local level have been more aggressive than federal policymakers in defining hospitals' charitable obligations and enforcing compliance with those standards. States and localities typically confer tax advantages to not-for-profit hospitals, but the conditions required for tax exemption vary substantially in both scope and specificity. In general states and localities will only confer tax exemption to hospitals designated as 501(c)(3) organizations by the IRS, but many impose additional requirements.

State laws related to hospital tax exemption include:¹²

- **Requirements for charity care policies.** A number of states have passed or considered laws that require not-for-profit hospitals to have a written charity care policy and to make this policy known to patients. However, these laws generally do not establish standard criteria for patient

FIGURE 1
Value of Tax Exemptions Provided to Not-for-Profit Hospitals, 2002



Note: Percentage total is below 100 percent due to rounding.

Source: Congressional Budget Office, Nonprofit Hospitals and the Provision of Community Benefits, December 2006, p. 5; available at www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf.

Raising the Bar

Texas was the first state to legislatively require not-for-profit hospitals to meet a quantified level of community benefit to retain tax exemption. In 1993, the Texas legislature mandated that not-for-profit hospitals provide charity care and government-sponsored indigent care at a reasonable level in relation to community needs, available resources of the hospital, and the tax-exemption benefits received by the hospital.

Hospitals are obligated to provide charity care and government-sponsored indigent care in an amount equal to one of the following:

- A level which is reasonable in relation to community needs (as determined through a community needs assessment), the available resources of the hospital, and the tax-exempt benefits received by the hospital;
- At least four percent of the hospital's net patient revenue
- At least 100 percent of the hospital's tax-exempt benefits (excluding federal income tax)

Hospitals are permitted to deduct bad debts from net patient revenues in determining compliance with these thresholds. The law requires annual reporting by hospitals regarding the costs of charity care, government-sponsored indigent care, and bad debts incurred. Following enactment of the mandate, charity care provision increased in hospitals that were not meeting the thresholds established and declined only a small amount for hospitals above thresholds.

eligibility and may not require hospitals to articulate specific criteria in their own institutional policy.

- **Indigent care standards.** A few states have mandated the level of charity care or community service that hospitals must provide in order to receive tax exemption. These quantitative requirements are typically linked to financial measures, such as proportion of operating revenue devoted to community benefit or fixed dollar amounts of charity care. Some states have set uniform, statewide eligibility criteria to identify patients who must qualify for charity care, although individual hospitals may establish more generous eligibility thresholds.
- **Billing guidelines.** Spurred by class action lawsuits claiming that hospitals were billing uninsured patients at exorbitant rates, some states enacted laws that set maximum payment guidelines for indigent patients. These laws typically tie indigent billing to Medicare or third party payment rates.

Cracking Down

The Illinois Department of Revenue recently denied tax exemption to Provena Covenant Medical Center, finding its commitment to charity care was insufficient to qualify as a charitable institution. In 2002, the hospital system provided an estimated \$831,724 in charity care (about 0.7 percent of total revenue), whereas the property tax exemption it was requesting was valued at \$1.1 million.* The state's decision affirmed the actions of the Champaign County Board of Review, which denied the hospital's petition for a property tax exemption in the 2002 tax year. Hospital officials maintain that the state's action is not supported by legal precedent and ignores the significant resources the institution contributes to fund care delivered to Medicaid patients, for whom reimbursement levels fall far below the cost of delivering care. The hospital system estimates that in 2005 Medicaid reimbursements fell approximately \$48 million short of the actual costs of providing care to Medicaid patients.** The hospital system is appealing through the courts.

* *BNA's Health Care Policy Report*, 14, no. 40 (October 9, 2006): p. 1315.

** *William Foley, "Ramifications of the Provena Ruling," Modern Healthcare*, 36, issue 45 (November 13, 2006): p. 18.

- **Reporting requirements.** Some states require hospitals to document their community benefit activities through periodic reports, which typically include both quantitative and qualitative measures.

Challenges to hospital tax exemption based on perceptions of insufficient community benefit are not uncommon at the state and local level, but such challenges are not widely prevalent. These cases often center on local property tax exemption, and determinations of community benefit are likely to be based explicitly on the amount of charity care provided. Experts believe that local officials may be more inclined to challenge tax exemption because hospitals burden municipal resources and represent a significant potential source of new tax revenue for budget-strapped local governments. In some large cities, predominantly those that depend heavily on property taxes, not-for-profit organizations have been pressured to make payments in lieu of taxes to defray the expenses of the municipal services they use.

Federal tax auditors have examined the fiscal practices of a number of hospitals, but these audits have not typically centered on possible community benefit violations. Federal tax investigations have largely focused on concerns related to private inurement. The IRS has the power to levy fines and penalties against tax-exempt hospitals found to have used the organization's revenues to enrich private individuals (often through lucrative benefits given to hospital management or medical staff). However, revocation of tax-exempt status is the only remedy available in cases where hospitals fail to meet the community benefit standard. The severity of this action may deter federal officials from raising fundamental questions related to community benefit and likely prompts a narrower focus on blatant financial improprieties.

A DISTINCTION WITHOUT A DIFFERENCE?

Many attempts to judge the utility of conferring tax exemption to not-for-profit hospitals are based on comparisons with their for-profit counterparts. Most Americans appear to prefer that health care be governed by humanitarian ideals, rather than profit-seeking motives. However, they are also very confused about the distinctions between for-profit and not-for-profit organizations. A public opinion survey conducted in 1996 found that roughly half of respondents either had no idea how not-for-profit health care organizations differed from for-profits or could not describe those differences in simple terms.¹³

The public's lack of clarity cannot be easily dismissed as ignorance. The growing prevalence of legally complex joint ventures between not-for-profit institutions and for-profit entities challenges knowledgeable parties' ability to clearly differentiate across organizations. Tax law related to such joint ventures continues to emerge, making it increasingly difficult to draw bright lines by ownership status. The growth of large not-for-profit chains composed of multiple hospitals in disparate geographic locations also confounds the validity of a "community board," which purportedly governs based on the interests of the community served.

Empiric studies have also failed to clearly delineate the defining characteristics of not-for-profit hospitals. Comparative assessments are premised on the assumption that for-profit hospitals provide some level of community benefit in the form of broad community access to medical services, as well as uncompensated care to the poor, despite having only a limited legal obligation to do so. These studies generally explore the extent to which not-for-profit hospitals provide benefits above and beyond those supplied by for-profit competitors. Some of these studies are explicitly tied to questions of evaluating the merits of tax exemption, whereas others address the policy implications of these comparisons in more implicit ways.

The results of such comparative assessments are mixed and do not offer a clear indication of whether not-for-profit hospitals operate in a manner that is substantially different from for-profit institutions. A hospital's ownership status has obvious import for governance, management incentives, and available sources of capital to fund growth and development. However, the effect of these structural characteristics on the nature of patient care is ambiguous.

Although not-for-profit hospitals often outperform for-profit competitors on measures of economic efficiency, quality of care, and accessibility of care, such analyses do not consistently favor not-for-profit hospitals. Results from comparative studies appear to be highly dependent on the sample of hospitals analyzed, suggesting significant variation across hospitals. Furthermore, available studies use a variety of measures, complicating attempts to synthesize findings.

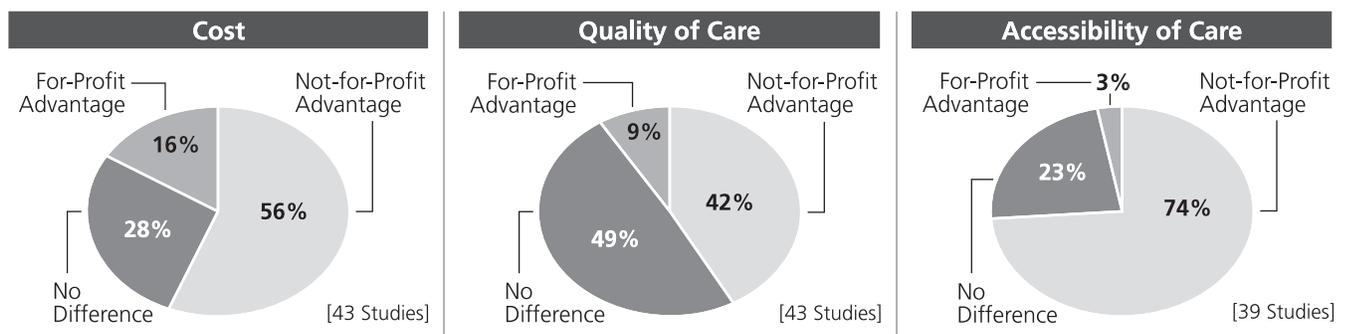
However, some broad conclusions can be drawn by exploring the results of a systematic literature review recently conducted by Drs. Mark Schlesinger and Bradford Gray¹⁴ as summarized in Figure 2 and described below, in terms of cost, quality, and access.

Cost — A slight majority of available studies examining hospital cost find that not-for-profit hospitals are less expensive than for-profits, as measured by indicators such as administrative overhead, cost per admission, revenue per admission, and inefficiency markers. However, nearly one third of available studies show no difference between not-for-profit and for-profit hospitals and 16 percent of the studies suggest that for-profits are less expensive. For-profit hospitals do appear to be more aggressive than not-for-profit hospitals in marking up prices. Relative to costs, the prices charged by not-for-profit hospitals tend to be lower than those set by for-profits.¹⁵

Quality — Data on quality of care do not demonstrate a compelling difference in hospital performance by ownership type. Almost half of available studies show no difference in quality of care, and 9 percent show an advantage to for-profit institutions. In studies measuring adverse outcomes, five out of ten favor not-for-profits, whereas three out of ten favor for-profits.

Access — A preponderance of the literature suggests that not-for-profit institutions offer greater access to care than for-profit hospitals. Of the 39 studies examining accessibility of care, 29 favor not-for-profit hospitals, 9 show no difference, and only 1 favors for-profits. Studies examining the provision of unprofitable services have consistently found that not-for-profit hospitals are more likely to offer such services than their for-profit counterparts.

FIGURE 2
Hospital Performance by Ownership Type (Percentage of Studies)



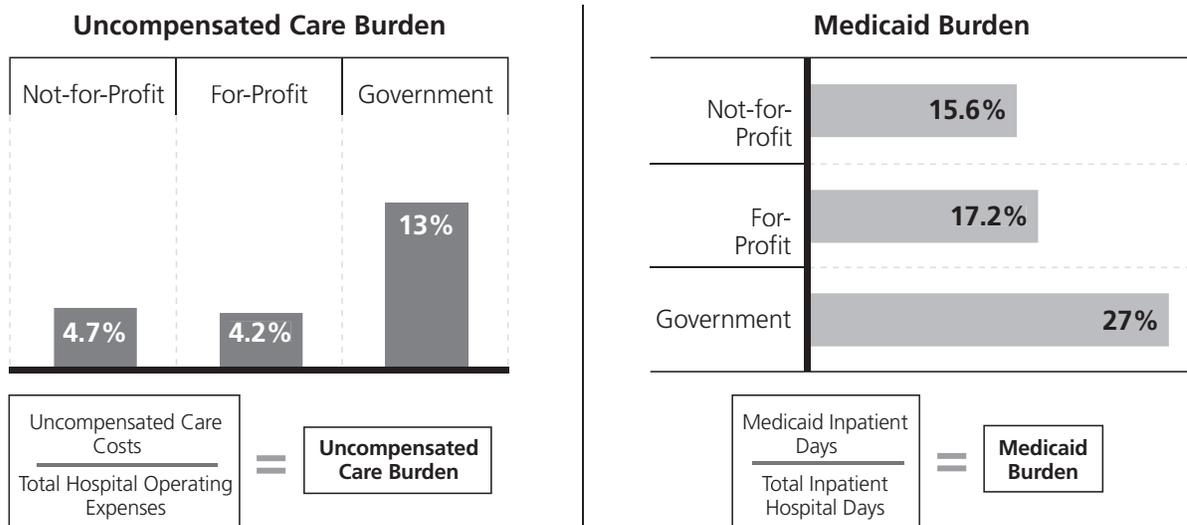
Source: M. Schlesinger and B. Gray, "Why Non Profits Matter in American Medicine: A Policy Brief," a white paper distributed at the Aspen Luncheon Seminar, June 20, 2005, Washington, DC; available at www.nonprofithealthcare.org/documentView.asp?docid=492&sid=

A recent five-state analysis conducted by CBO appears to confirm that care is more accessible in not-for-profit institutions, but the differences observed were fairly small. CBO found that, on average, not-for-profit hospitals shouldered slightly higher levels of uncompensated care costs (a combination of charity care and bad debt) than did otherwise similar for-profit hospitals (Figure 3).¹⁶ However, among individual hospitals, the level of uncompensated care varied widely and the distributions for not-for-profit and for-profit hospitals largely overlapped. The Medicaid burden for not-for-profit hospitals was actually slightly lower than the share provided by for-profit facilities.

The CBO also found that certain specialized services widely thought to be less profitable (burn intensive care, emergency services, high-level trauma care, and labor and delivery services) were slightly more likely to be offered by not-for-profit hospitals than for-profit facilities. However, after adjusting for other differences in hospital characteristics, such as size and teaching status, statistically significant differences remained only for emergency services and labor and delivery services (Table 1, next page).

The CBO analysis clearly demonstrates the important role government hospitals have played in providing socially desirable services. Government facilities are more likely than not-for-profit or for-profit hospitals to provide both indigent care and specialized, less-lucrative patient services. Just as

FIGURE 3
Average Uncompensated Care and Medicaid Burden,
by Hospital Ownership Type



Source: Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006, pp. 15 and 19; available at www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf.

the presence or absence of for-profit competitors is thought to influence the business practices of not-for-profit facilities, the presence or absence of a government hospital within a market can have a substantial impact on the provision of unprofitable services by other facilities. In some (but not all) cases, uncompensated care can be highly concentrated within the government-run institution, substantially easing the charity care burden that might otherwise be borne by not-for-profit hospitals.

TABLE 1
Proportion of Hospitals That Provide Specialized Patient Services, by Hospital Type

PATIENT SERVICES	HOSPITAL TYPE		
	Not-for-Profit	For-Profit	Government
Burn Intensive Care	6.8	1.0	22.0
Emergency Room Care	98.5	96.6	97.1
High-Level Trauma Care	33.0	9.3	48.0
Labor & Delivery Services	83.5	72.2	86.5

Congressional Budget Office, Nonprofit Hospitals and the Provision of Community Benefits, December 2006, p. 20; available at www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf.

DOES IT MATTER?

While comparisons to for-profit institutions are informative, it is important to remember that the hospital market is still overwhelmingly dominated by the not-for-profit sector. Hospital representatives often refer to “competitive” market conditions in explaining their need to focus on financial objectives. However, these financial pressures are often driven by the demands of risk-adverse debt financiers, efficiency-conscious purchasers, and competition from other not-for-profit rivals, rather than direct challenges from for-profit competitors. Approximately 68 percent of hospital beds in the United States are operated by not-for-profit organizations, 15 percent by government, and 16 percent by for-profit enterprises.¹⁷ Many markets, particularly in the Northeast and Midwest, have little to no for-profit hospital penetration.

However, competition from for-profit specialty facilities that are not full-service hospitals, such as ambulatory surgery centers and diagnostic imaging centers, appears to be increasing. These specialty-line services often represent hospitals’ most profitable activities, and competition for market share in these services can have a significant effect on hospitals’ financial stability. Most hospitals have relatively modest profit margins. Therefore the loss of business in lucrative product lines has the potential to jeopardize a hospital’s overall financial viability, limiting their ability to cross-subsidize less profitable services and, in extreme cases, threatening their continued operations.¹⁸

The effect of a substantial increase in for-profit penetration, which could be triggered by tightening tax exemption for hospitals, is unclear. The behaviors of both for-profit and not-for-profit institutions are undoubtedly influenced by prevailing incentives to increase market share in profitable services. If policymakers decided to “raise the bar” for granting tax exemption to hospitals, it is uncertain how many institutions would convert

to for-profit status and how such conversions would influence the business decisions of both for-profit and remaining not-for-profit competitors. Even in markets with no for-profit presence, competition for market share among not-for-profits in lucrative service lines drives strategic and operational decision making. Arguably, increasing for-profit penetration would only serve to magnify the intensity of existing competitive pressures.

Some observers strongly believe that the not-for-profit ethic is pivotal to ensuring a socially responsible health care system. Not-for-profit advocates worry that limiting hospital tax exemptions would only undermine public health, perilously compromising access to care for any patient perceived as potentially unprofitable. Some fear that hospitals, unfettered by community benefit obligations and driven solely by profit-motive, would be disinclined to serve patients lacking adequate insurance coverage, patients insured by health plans with unfavorable reimbursement rates, or patients requiring services that do not represent self-sustaining product lines. In addition, advocates of not-for-profit hospitals note that attaching specific public policy goals to tax exemptions is not common. Private universities, for example, are not required to offer a certain number of scholarships as a condition of their tax exemptions.

Others believe that the “hospital as charity” boat has long since sailed. Critics see existing tax policy as largely ineffective and irrelevant in influencing hospital decisions regarding service mix and care for the poor. Some believe that different types of incentives, such as licensure directives, teaching program requirements, and contractual agreements, now play (or could be made to play) more powerful roles in ensuring that community benefits are realized. Others focus on the opportunity costs of forgoing tax revenue from hospitals. Some believe that the financial resources presently protected by tax exemption could be more effectively deployed if redirected toward insurance coverage or concentrated on hospitals that demonstrate a meaningful commitment to community benefit.

COMMUNITY BENEFIT: IN THE EYE OF THE BEHOLDER?

Determining whether a hospital provides an appropriate level of community benefit is no mean feat. Comparisons to for-profit counterparts provide a less-than-ideal way to gauge the merits of conferring tax exemption to hospitals. Many have argued for more direct mechanisms to measure and assess the community benefits that not-for-profit hospitals provide. Such discussions often begin with the fundamental question of whether the broadly defined community benefit standard is still relevant. Some critics maintain that obligations to serve uninsured and vulnerable patients should be the primary, or at least a more specifically stipulated, metric for evaluating community benefit.

It is unclear how many hospitals would “earn” their tax exemption based solely on the amount of charity care provided. One study found that 75

percent of the 500 hospitals sampled had tax benefits in excess of the amount of charity care provided (with charity care valued at cost and exclusive of bad debt).¹⁹ When 50 percent of bad debt was included with charity care, 55 percent of hospitals still had excess tax benefits. Particularly when government subsidies for uncompensated care [such as Medicare- and Medicaid-Disproportionate Share Hospital (DSH) payments] are factored into the equation, many hospitals do not provide unsponsored, proactively designated charity care at levels commensurate with the value of their tax exemption.

Hospitals have used a wide variety of conventions in calculating the amount of “free” care they provide. Some hospitals make such calculations based on the dollar amounts charged to indigent patients; others attempt to estimate the actual cost of delivering care to such patients. Given that charges are considered to give a highly inflated sense of the resources directed to free care, the lack of consistency in these practices compromises the validity of comparisons across institutions. Similarly, some hospitals restrict estimates of free care to care delivered to patients deemed eligible for the institution’s charity care program. Others may include bad debt, as well as losses incurred for care delivered to patients insured through Medicare and Medicaid. Still other hospitals do not report any data on the amount of free care they provide.

Although efforts are underway to improve consistency in the reporting of community benefit activities, mandatory reporting requirements are not specific and consensus on a voluntary standard approach has yet to emerge. IRS reporting requirements allow hospitals to provide qualitative descriptions of their “exempt purpose achievements” and many hospitals have traditionally complied by attaching copies of annual reports or other written narratives to their tax filings. As of December 2006, most hospitals are required to file their tax returns electronically using Form 990 (Return of Organization Exempt from Income Tax) and will be unable to attach separate documents.

The Catholic Hospital Association (CHA) and the Voluntary Hospital Association (VHA) recently developed standard templates for 990 filing that conform to those organizations’ community benefit reporting guidelines. These guidelines suggest that hospitals should:

- Report charity care at cost, not charges
- Report unpaid costs of government-sponsored indigent care programs, such as Medicaid and SCHIP
- Exclude bad debt, contractual allowances, and quick pay discounts from charity care costs
- Exclude Medicare shortfall (unpaid costs) from charity care
- Report the net expense for community benefit services, such as health professions education and research

The American Hospital Association (AHA) has issued somewhat different guidance on reporting community benefit activities, which would permit hospitals to include as community benefit expenses any shortfalls associated with Medicare, as well as bad debt. The AHA believes (i) the Medicare shortfall should be included because participation in Medicare is required in order to secure federal tax exemption, and (ii) the inclusion of bad debt is appropriate because the majority of bad debt is attributable to patients with incomes below 200 percent of the federal poverty level.²⁰

While standard metrics for quantifying the “free care” component of community benefit are still under development, improving the comparability of qualitative information to characterize hospitals’ charitable efforts appears even more challenging. The CHA/VHA 990 filing template provides an overview of the kinds of information that should be included to describe a hospital’s community benefit efforts, such as populations targeted by community benefit programs, levels of unmet need in the community, and impact of program on participants. This qualitative template builds on guidance first developed in 1989 to help hospitals plan, document, and evaluate their community benefit efforts.

Similar attempts to establish qualitative community benefit standards have been spearheaded by other organizations. For example, in the early 1990s, the W.K. Kellogg Foundation funded a demonstration project to accredit a select group of hospitals for their community benefit activities using a set of qualitative standards and a third party review process similar to that used by the Joint Commission (formerly known as JCAHO, or the Joint Commission for the Accreditation of Health Care Organizations). More recently, a large consortium of hospitals from California, Texas, Arizona, and Nevada came together to develop and pilot a uniform accounting and performance monitoring system to document and guide community benefit efforts.²¹

The less tangible aspects of community benefit are inherently difficult to capture in a standardized, objective fashion because they are inextricably linked to the variability of community needs. Determining whether a hospital provides community benefits at a level sufficient to demonstrate its charitable mission—and justify its tax exempt status—may always require assessment by neutral, third-party observers.

CONCLUSION

Insurance coverage declines contribute to the financial pressures facing hospitals and also raise troubling concerns about the predominant power of financial incentives given the role of hospitals as charitable organizations. Economic considerations have led hospitals to minimize their uncompensated care burden at a time when the need for charity care appears to be growing. Ongoing debate regarding the societal value of hospital services has surfaced a variety of difficult questions: What level of uncompensated care should hospitals reasonably be expected to shoulder in exchange for tax-exempt status? Do existing tax laws place adequate priority on charity

care relative to other forms of community benefit? Should other forms of community benefit be considered only if the community need for free or reduced-price services has been met? Could more prescriptive community benefit standards have a perverse effect, leading to an increase in for-profit conversions and greater constraints on access to care?

In light of hospitals' sustained and prominent imprint on the fabric of community life, as well as the continuing evolution of market forces on hospital practices, a speedy resolution to these policy questions is unlikely. As policymakers consider whether and how to revise standards for hospital community benefits, a variety of approaches could be considered. Policy proposals include requiring more detailed, consistent reporting on community benefit activities, mandating the provision of specific levels of charity care, and placing limits on tax-exempt financing. Although they differ in reach and mechanism, these policy proposals have all generally focused on re-examining the manner and magnitude of benefits derived from hospitals by the communities they serve.

In many ways, debate related to the charitable role of not-for-profit hospitals reveals the fundamental tensions in our health care system. Is health care a right or a marketable service? Is health a public good or an individual responsibility? As a society, we have consistently answered "all of the above" to these questions, trying to strike a delicate balance between market, regulatory, and humanitarian forces in order to craft the health care system that exists today. Policy decisions related to hospital community benefit pierce the heart of this tenuous balancing act, and portend reverberating consequences.

ENDNOTES

1. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, Inc., 1982) p.145.
2. U.S. Census Bureau, "Health Care and Social Assistance (NAICS 62)—Estimated Revenue for Tax-Exempt Employer Firms," table 8.5 in *Service Annual Survey: 2004*, p. 9, available at www.census.gov/svsd/www/services/sas/sas_data/62/sas62_85-86_2004.pdf, and "Selected Health Care Services (NAICS 621, 622, and 623)—Estimated Revenue for Employer Firms by Source," table 8.11 in *Service Annual Survey: 2004*, p. 24, available at www.census.gov/svsd/www/services/sas/sas_data/62/sas62_811-814_2004.pdf.
3. 501(c)(3) also identifies as tax exempt organizations devoted to national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals.
4. For more information, see "Hill-Burton Free and Reduced Cost Health Care" on the Health Resources and Services Administration Web site, www.hrsa.gov/hillburton/default.htm.
5. IRS revenue ruling 83-157 is available at www.irs.gov/pub/irs-tege/rr83-157.pdf.
6. 42 USC 1395dd is also known as the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA 1986) or Section 1867(a) of the Social Security Act.

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7. Cost-based reimbursement for capital-related expenses was phased out over an extended period of time after prospective payment was first implemented, and capital expenses remain embedded in the base rate established under prospective payment.
8. Committee on Finance Hearing, U.S. Senate, "Taking the Pulse of Charitable Care and Community Benefit in Nonprofit Hospitals," September 13, 2006; Committee on Ways and Means Hearing, U.S. House of Representatives, "The Tax-Exempt Hospital Sector," May 25, 2005.
9. R. Pear, "IRS Checking Compliance by Tax-Exempt Hospitals," *New York Times*, June 19, 2006, and IRS, "Compliance Check Questionnaire Tax-Exempt Hospitals," form 13790, May 2006.
10. Government Accountability Office, "Nonprofit Hospital Systems: Survey on Executive Compensation Policies and Practices," GAO-06-907R, Letter to Chairman, Committee on Ways and Means, June 30, 2006; available at www.gao.gov/new.items/d06907r.pdf.
11. Congressional Budget Office (CBO), *Nonprofit Hospitals and the Provision of Community Benefits*, December 2006, p. 5; available at www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf.
12. Kathryn J. Jervis, "A Review of State Legislation and a State Legislator Survey Related to Not-for-Profit Hospital Tax Exemption and Health Care for the Indigent," *Journal of Health Care Finance*, 32, no. 2 (Winter 2005): pp. 50–60.
13. Princeton Survey Research Associates, as cited by M. Schlesinger and B. Gray, "Why Non Profits Matter in American Medicine: A Policy Brief," a white paper distributed at the Aspen Luncheon Seminar, Washington, DC, June 20, 2005, p. 6; available at www.nonprofithealthcare.org/documentView.asp?docid=492&sid=.
14. Schlesinger and Gray, "Why Non Profits Matter in American Medicine."
15. A recent study of accounting practices among for-profit hospitals found that these institutions have been aggressively raising their charges in recent years, with gross charges growing more than 15 percent per year. On average, for-profit hospitals are booking three times more net revenue for uninsured patients (with net revenue booked as charges) in comparison to patients with insurance (with net revenue booked as charges less contractual allowances). While these amounts are typically written off as bad debt at some point, this accounting practice serves to inflate earnings on a short-term basis. See C. Becker, "Seeking Proper Recognition: Bad Debt Problem Lies with Revenue Recognition, Not Uninsured, Analyst Says," *Modern Healthcare*, 37, issue 6 (February 5, 2007): p. 30.
16. CBO, *Nonprofit Hospitals and the Provision of Community Benefits*, p. 1.
17. CBO, *Nonprofit Hospitals and the Provision of Community Benefits*, p. 3.
18. For more information on specialty hospitals, see Laura A. Dummit, "Specialty Hospitals: Can General Hospitals Compete?" National Health Policy Forum, Issue Brief 804, July 13, 2005; available at www.nhpf.org/pdfs_ib/IB804_SpHospitals_07-13-05.pdf.
19. N. M. Kane and W. H. Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption," *Milbank Quarterly*, 78, no. 2 (2000): p. 199.
20. CBO, *Nonprofit Hospitals and the Provision of Community Benefits*.
21. Public Health Institute, "Advancing the State of the Art in Community Benefit: A Users Guide to Excellence and Accountability," November 2004; available at www.phi.org/pdf-library/ASACB.pdf.



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