

Is Hospital ‘Community Benefit’ Charity Care?

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ABSTRACT

Context: The Affordable Care Act is drawing increased attention to the Internal Revenue Service (IRS) Community Benefit policy. To qualify for tax exemption, the IRS requires nonprofit hospitals to allocate a portion of their operating expenses to certain “charitable” activities, such as providing free or reduced care to the indigent.

Objective: To determine the total amount of community benefit reported by Wisconsin hospitals using official IRS tax return forms (Form 990), and examine the level of allocation across allowable activities.

Design: Primary data collection from IRS 990 forms submitted by Wisconsin hospitals for 2009.

Main Outcome Measure: Community benefit reported in absolute dollars and as percent of overall hospital expenditures, both overall and by activity category.

Results: For 2009, Wisconsin hospitals reported \$1.064 billion in community benefits, or 7.52% of total hospital expenditures. Of this amount, 9.1% was for charity care, 50% for Medicaid subsidies, 11.4% for other subsidized services, and 4.4% for Community Health Improvement Services.

Conclusion: Charity care is not the primary reported activity by Wisconsin hospitals under the IRS Community Benefit requirement. Opportunities may exist for devoting increasing amounts to broader community health improvement activities.

INTRODUCTION

The term “community benefit” refers to the 1969 Internal Revenue Service ruling defining the charitable obligations of nonprofit hospitals as a condition of their tax-exempt status. While non-profit hospitals have received tax exemption for many years, it was not until the early 20th century that hospitals were required to meet certain criteria to qualify for the

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exemption.¹ Prior to the enactment of the 1969 community benefit standard, hospitals were governed by a financial ability standard, which specified that nonprofit hospitals must provide free or low-cost services to those unable to pay.² Although no formal benchmarks existed for the amount of benefit a hospital was to provide, several tax exempt experts have stated that the IRS used a general standard of 5% of operating expenses to qualify for tax exemption.^{3,4}

Previous reports have reviewed the history and importance of this policy in considerable detail.⁵⁻⁹ The current policy environment for community benefit began with the IRS Revenue Ruling 69-545 of 1969, which allowed for more activities to be counted toward tax-exemption but failed to establish concrete standards.² In 2006 the Congressional Budget Office (CBO) estimated that in 2002 the total national forgone tax revenues were \$12.2 billion.⁹ They also used 2003 Medicare data for 5 states and calculated that nonprofit hospitals had an “uncompensated care share” of 4.7% of expenses.⁹ Using a unique Maryland data set, Gray and Schlesinger reported total community benefits of 7.4% in 2005.¹⁰ More recently a 2009 California hospital survey¹¹ showed that 14% of community benefit was reported for charity care, 63% for unreimbursed government programs, and 23% for other community benefits.

However, ambiguity remained regarding what exactly counted as community benefit, leading the IRS in 2008 to standardize the Form 990 filing required for tax exemption to the current 8 categories listed below.¹² This measure came following several previous legal challenges to hospital tax status and congressional hearings into the community benefit standard in 2006, led by Senator Chuck Grassley of Iowa.¹² More recently, community benefit has received more attention through provisions of the Affordable Care Act requiring more

detailed reporting of content category in the revised Form 990 Schedule H.¹³

To understand the scope and amount of activity reported under this provision, we examined the Form 990 filings for Wisconsin hospitals for 2009, the first year the revised form was required. We believe this is the first peer-reviewed report of the new 2009 data, in which we examine what level and type of community benefit was reported during this year in Wisconsin, and provide brief commentary on some aspects of community benefit policy options.

METHODS

The data were derived from electronic copies of 2009 IRS Form 990 nonprofit tax filings from the Guidestar website.¹⁴ Guidestar hosts a financial database on the nonprofit sector that directly posts copies of original tax filings and similar financial documents of non-profit organizations, obtaining its data directly from the IRS. One hundred twenty-seven of the 131 Wisconsin nonprofit general hospitals, satellite facilities, and children's hospitals were examined; 4 small rural facilities were omitted due to unavailability of data. We examined 108 forms for the 127 facilities, since health systems often file multiple facilities on the same form. The data were analyzed state-wide and by hospital size categories—large hospitals with revenues greater than \$300 million (n = 17), medium hospitals with revenues less than \$300 million but greater than \$100 million (n = 23), and small hospitals with revenues less than \$100 million (n = 68). We used these categories based on a comprehensive national survey of community benefit conducted by the American Hospital Association in 2012.¹⁵

There are 8 categories of allowed community benefit activity reported on the 990 filings. These are defined in IRS guidelines as follows:¹⁶

- *Financial assistance at cost*, commonly referred to as charity care. This is free or reduced-cost care provided to those financially unable to afford treatment, such as the underinsured or those not enrolled in Medicaid.
- *Unreimbursed Medicaid*, which is the “net cost” to the organization for providing these programs. It is the disparity between cost of treatment for Medicaid patients and the government reimbursement rate.
- *Other unreimbursed means-tested government programs*, which is the “net cost” to the organization for providing these programs. It is the disparity between cost of treatment for these patients and the government reimbursement rate.
- *Subsidized health services* are clinical inpatient and outpatient services provided by the hospital, despite a financial loss, that would be otherwise undersupplied to the community. Typically these are services with thin or negative

profit margins for the hospital, such as burn units, and meant to insulate the hospital financially for providing these services.

- *Community health improvement services* include activities or programs subsidized by the organization for the express purpose of community health improvement, documented by a community health needs assessment. Examples include immunization programs for low-income children or diabetes health education courses.
- *Health professional education* includes the net cost associated with educating certified health professionals.
- *Research* includes the cost of internally funded research as well as the cost of research funded by a tax-exempt or government entity.
- *Cash and in-kind contributions* include contributions, monetary or otherwise, to community benefit activities made by the organization to community groups. These activities must be marginally health related, such as partially sponsoring a local, open athletic race.

There are 3 additional supplemental categories that are reported but not allowed to be counted as community benefit. During the reformation and standardization of Form 990 in 2008 by the IRS, many stakeholders such as the Catholic Hospital Association and the American Hospital Association were consulted to determine what should be counted as community benefit.¹² Although some of the consulted organizations urged the inclusion of one or more of the supplemental categories, the IRS chose to omit them, yet still required their reporting on the 990 form. These supplemental categories are:

- *Bad debt*, which includes the portion of bad debt that the organization believes could be of community benefit.
- *Unreimbursed Medicare*, which includes the surplus or shortfall from the organization's Medicare Cost Report.
- *Community building expenses*, which protect or improve community health and safety, including housing, economic development, environmental improvement, leadership development, and coalition building.

RESULTS

In 2009, \$1.064 billion was reported as community benefit by nonprofit hospitals in Wisconsin (Table 1). This represents on average 7.52% of total expenses, and ranged from -2.59% to 20.5%, the negative being the result of a regulation accounting anomaly across the 108 forms examined. Some variation in overall provision of community benefit existed among the 3 size categories of hospitals, posting figures of 8.05%, 7.60%, and 7.34% of total expenses, respectfully. However, this small amount of variation was expected based on the financial capabilities of the larger versus smaller facilities.

This table also displays the total amount and percentage of

expenditures reported across the 8 allowable categories. The 3 largest amounts reported are for unreimbursed Medicaid at 3.95%, subsidized health services at 1.29%, and charity care at 1.26% of total expenditures. There is small variation in these distributions across the 3 hospital size categories, with the 2 greatest variations occurring in the education and subsidized services categories between large and small hospitals (data not shown). In the education category, large hospitals outspent small hospitals relative to total expenditures by 1.19%. In the subsidized services category, small hospitals spent 0.8% more than large ones.

The 3 supplemental categories reported but not allowed to be counted as community benefit add a total of \$760.7 million to the reported amounts, and if allowed would add 4.56% of expenditures to those in Table 1. Unreimbursed Medicare is by far the largest contributor to this total (Table 2).

DISCUSSION

Based on the policy history of hospital tax exemption through the provision of charity care, many others—including the authors—might have expected that charity care would be the primary activity reported as community benefit. This is not the case in Wisconsin (and likely elsewhere) since charity care is only 9% of the \$1.06 billion reported in 2009. About half is in the unreimbursed Medicaid category, followed by education and subsidized services at 12% and 11% respectively. Very little community benefit funds are reported for community health improvement—only 4.4% of all community benefit dollars. Community building, though not directly counted, constitutes an even lower portion of overall expenditures.

If the Affordable Care Act achieves its policy goals, it will likely reduce considerably the need for charity care and potentially expand Medicaid in many states, including Wisconsin. However, if the need for charity care is reduced as predicted, community benefit has the potential to become a significant funding stream to create and expand public and community health initiatives throughout hospital service areas.

A full community benefit policy analysis is beyond the scope of this paper. Legitimate discussion has taken place about whether there should be a threshold or minimum amount of community benefit required, or for certain allowable activities.⁸ However, in states that established such a threshold (eg, Texas at 5% of expenses), the overall levels of community benefit have sometimes declined slightly as hospitals under and over

Table 1. Wisconsin 2009 Community Benefit Reporting

State Totals	Total (US dollars)	Average Percent (of total expenditures)	Percent Range
Charity care	96,629,458	1.26	0-9.50
Unreimbursed Medicaid	536,292,658	3.95	-3.77*-9.02
Other means tested government programs	12,908,862	0.11	0-2.70
Community health improvement services	47,137,597	0.40	0-7.10
Health professionals education	136,358,971	0.37	0-6.38
Subsidized health services	121,300,534	1.29	0-17.78
Research	15,951,185	0.04	0-1.48
Cash and in-kind contributions	18,194,501	0.16	0-1.14
Community benefit total	1,064,802,784	7.52	-2.59*-20.50

^aThese negative numbers come from 4 hospitals due to 2009 hospital tax assessment revenues and differences between calendar year and fiscal year dates. However, negative figures were listed on only 2 of the 108 forms examined, with a negligible effect of the overall data.

Table 2. Wisconsin 2009 Form 990 H Supplemental Category Reporting

Supplemental Categories	Total Expenditures (in US dollars)	Average Percent of Expenditures
Community building expenses	8,512,232	0.08
Bad debt attributable to charity care	25,923,373	0.35
Unreimbursed Medicare	726,280,309	4.13
Supplemental measures total	760,715,914	4.56

the benchmark converged near the marker.¹⁷

Ensuring that hospitals are fulfilling their community obligations is significant however, considering the amount of forgone tax revenues at stake if they were actually taxed. The most recent national estimate of the amount of taxes these non-profits would have to pay if they were for-profit entities was \$12.6 billion for 2002 by the CBO in 2006;⁷ this included local property tax (\$3.1 billion), state and local sales taxes (\$2.8 billion), federal corporate income tax (\$2.5 billion), tax exempt bond financing (\$1.8 billion), charitable contributions (\$1.8 billion), and state corporate income tax (\$0.5 billion).

This study was stimulated by our belief in the need for dependable revenue streams to support the multiple determinants of health beyond health care including behaviors, the social environment, and the physical environment.^{18,19} There is currently no standard for the allocation across the 8 categories on the 990 form. Legitimate discussion could include whether one government program (IRS) should subsidize others (Medicaid or other means-tested government programs, such as State Health Insurance Assistance Program [SHIP]), the cost basis for the subsidized categories, the basis for determining which subsidized services might not otherwise be provided to the community, and whether these losses are unique to nonprofit hospitals.

Regarding the supplemental categories, court cases have

acknowledged that “beneficial community impact” can go beyond mere community benefit. However, a recent unpublished analysis by the American Hospital Association of 571 IRS 2009 Form 990s across the nation reported an average 11.3% total community benefit, but this figure includes the 2.4% Medicare “unallowable” shortfall.¹⁵ They also report 8.4% in a combined community benefit category but do not separate out charity care, the Medicaid shortfall, other means-tested government programs, subsidized services, or other components as done here. It is not clear why subsidizing unreimbursed Medicare is not considered allowable community benefit, while unreimbursed Medicaid and other “subsidized services” programs are allowed.

We recognize the many important community health activities carried out by both large and small hospitals; indeed, in this study some hospitals reported up to 7% in the community health improvement services category. While there appears to be some flexibility and indistinctness in 2011 IRS guidance with community building supplemental services and the definition of allowable community health improvement services (“reduce geographic, financial, and cultural barriers to accessing health services, leverage or enhance public health department activities”), many of those specified as not allowable under the supplemental Schedule H are exactly those required for broad population health improvement, such as economic development and multisector coalition building.²⁰

The Wisconsin Hospital Association (WHA) also publishes an annual report on community benefit using information from their own annual survey;²¹ their results are similar to those reported here, although the categories are not identical since the WHA used the categories suggested by the Catholic Health Association. Similar analysis from other states and future years is needed to determine if the patterns seen in Wisconsin apply to larger states, or to those with more uninsured individuals or lower Medicaid payment rates. The WHA commented that the larger amounts in unreimbursed Medicaid in 2009 are likely due to concurrent expansion of the BadgerCare program in Wisconsin. It is also possible that future years might show different results, since 2009 was at the bottom of a recessionary period.

CONCLUSION

It is increasingly accepted that improving the health of our communities will require slowing the growth in health care spending and making increased investments in public health, prevention, and the social and environmental determinants of health. As the need for charity care declines under health reform, it would seem appropriate for community benefit activities to increasingly reflect and contribute to these needs. We would hope that

the community health assessment processes initiated under the Accountable Care Act would identify the priority for many of the activities currently not allowed as community building to be allowed and encouraged. As community benefit expert Kevin Barnett recently stated, “exclusion of these kinds of activities sends a message that nonprofit hospitals should not be seeking to address the underlying causes of persistent health problems ... we should be encouraging rather than impeding hospital engagement of diverse stakeholders to address the underlying causes of health problems in local communities. Increased awareness and joint advocacy between hospitals, public health institutions, and communities is needed to correct this error.”¹⁹

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