Provision of Community Benefits by Tax-Exempt U.S. Hospitals

Gary J. Young, J.D., Ph.D.

Northeastern University Center for Health Policy and Healthcare Research
and
D’Amore-McKim School of Business; Bouve College of Health Sciences, Northeastern University

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Research Team

Chia-Hung Chou, Ph.D.¹
Jeffrey Alexander, Ph.D.²
Shoou-Yih Daniel Lee, Ph.D.²
Eli Raver¹

¹Northeastern University Center for Health Policy and Healthcare Research

²University of Michigan School of Public Health
Policy Context

• Most nonprofit hospitals are exempt from federal, state, and local taxes.
  – I.R.C. 501(c) (3); community benefit standard.

• There have been increasing demands for greater accountability from tax-exempt hospitals regarding community benefit.

• Hospitals’ property tax exemptions have been challenged based on insufficient community benefit.
Policy Context

ACA establishes new requirements for tax-exempt hospitals, I.R.C. 501(r):

- Develop written financial assistance policies.
- Limit what is charged for services.
- Observe fair billing and debt collection services.
- Conduct community health needs assessments and develop plans for addressing identified needs.
Research Context

• What do tax-exempt hospitals provide in terms of community benefits?

• What are key determinants of the type and level of benefits provided (i.e., hospital, community, and market)?
Research Context

Previous research limitations:

• Lack of standard approaches to defining and measuring community benefit.

• Lack of nationally available, uniform data.
Research Context

I.R.S. Adoption of Form 990, Schedule H (mandatory in 2009)

- Charity care
- Unreimbursed costs from means-tested government insurance programs
- Subsidized health services
- Community health improvement/community benefit operations
- Cash/Inkind contributions to community groups
- Research
- Health professions education
Schedule H also requires hospitals to report data for three additional measures:

- Bad debt
- Medicare shortfall
- Community building activities
Study Methods

• Data -- merged 2009 Schedule H reports with 2009 AHA Survey and Area Resource File.

• Study population
  – Defined as all tax exempt, private, acute care hospitals (unit of analysis is the hospital; reports from systems were excluded).
  – Approximately 1,800 of 2,900 hospitals included in study. (study population under represented system-affiliated hospitals).

• I.R.S. community benefit measures
## Universe versus Study Population

<table>
<thead>
<tr>
<th></th>
<th>Universe (N=2,894)</th>
<th>Sample (N=1,835)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No. of Beds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 100</td>
<td>44.9%</td>
<td>45.2%</td>
</tr>
<tr>
<td>101--299</td>
<td>34.6%</td>
<td>36.7%</td>
</tr>
<tr>
<td>&gt;299</td>
<td>20.5%</td>
<td>18.1%</td>
</tr>
<tr>
<td><strong>Religious-affiliation status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secular</td>
<td>84.0%</td>
<td>85.7%</td>
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<tr>
<td>Church</td>
<td>16.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>System-affiliation status</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td>44.2%</td>
<td>52.5%</td>
</tr>
<tr>
<td>System</td>
<td>55.8%</td>
<td>47.5%</td>
</tr>
<tr>
<td><strong>Teaching status (COTH)</strong></td>
<td></td>
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</tr>
<tr>
<td>Non-teaching</td>
<td>92.7%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Teaching</td>
<td>7.3%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

* P < 0.05
Methods

• Analysis
  – Descriptive statistics for community benefit measures standardized based on total hospital operating expenditures.

  – Analytical models
    • Two community benefit variables
      • Patient care (i.e., charity, unreimbursed costs, subsidized health care services).

      • Community service (i.e., community outreach, research, education, contributions).

    • Potential determinants: (hospital characteristics, community characteristics, and market characteristics -- supply and demand for community benefits (community/market defined by county))
## Results: Community Benefits as Percentage of Operating Expenses

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Interquartile Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>7.5</td>
<td>6.4</td>
<td>3.9 – 9.1</td>
</tr>
<tr>
<td>Charity Care</td>
<td>1.9</td>
<td>1.9</td>
<td>0.6 – 2.6</td>
</tr>
<tr>
<td>Unreimbursed Costs</td>
<td>3.4</td>
<td>4.3</td>
<td>0.8 – 4.7</td>
</tr>
<tr>
<td>Subsidized Health Services</td>
<td>1.1</td>
<td>2.8</td>
<td>0.0 – 1.0</td>
</tr>
<tr>
<td>Community Health Improvement</td>
<td>0.4</td>
<td>1.0</td>
<td>0.0 – 0.4</td>
</tr>
<tr>
<td>Cash/In-Kind Contributions</td>
<td>0.2</td>
<td>2.4</td>
<td>0.0 – 0.1</td>
</tr>
<tr>
<td>Research</td>
<td>0.1</td>
<td>0.7</td>
<td>0.0 – 0.0</td>
</tr>
<tr>
<td>Health-professions Education</td>
<td>0.4</td>
<td>1.1</td>
<td>0.0 – 0.3</td>
</tr>
</tbody>
</table>
Distribution of Community Benefit Expenditures among Benefit Types

- Charity care: 25.3%
- Unreimbursed costs for means-tested government programs: 45.3%
- Subsidized health services: 14.7%
- Health professions education: 5.3%
- Research: 1.3%
- Cash or in-kind contributions to community groups: 2.7%
- Community health improvement: 5.3%
Distribution of Hospital Community Benefit Expenditures

Average = 7.5%
Results: Distribution of Hospitals among Community Benefit Measures

- > 30% of study hospitals in top quartile for three or more of the seven CB measures;
- >12% of study hospitals in top quartile for four or more of the CB measures.

- .01 correlation between patient care and community service measures.
Results: Analytical Models

• Key determinants for patient-care benefits:
  – State community benefit reporting requirements

• Key determinants for community-service benefits:
  – State community benefit reporting requirements
  – Sole community provider
  – Teaching hospital (i.e., COTH membership)
Hospital Community Benefit Expenditures, According to the Percentage of Uninsured Residents
Conclusions

• Significant variation among tax-exempt hospitals with respect to level and type of benefits.

• Most community benefit expenditures are directed to patient care. Little is spent on community health improvement.

• Few hospitals provide relatively high levels of community benefits for all measures.

• No evidence that community benefits are provided where they are most needed. Hospitals located in socio-economically disadvantaged communities may lack resources to provide higher levels of benefits.
Conclusions

• State-level reporting requirements for community benefit *may* promote higher levels of community benefits.

• Controversy over defining community benefits will likely continue – e.g., 7.5% vs. >11% if bad debt included.
Policy Implications

• Whether community benefits are sufficient is a policy consideration but the high degree of variation among hospitals raises questions of fairness and accountability.

• Health reform generally may encourage shift in pattern of community benefit expenditures in the direction of community health improvement.

• ACA requirements for community needs assessments create opportunities for policy makers and hospitals to examine how well benefits and needs correspond at the community level.