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Health Policy Brief

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Nonprofit Hospitals' Community Benefit Requirements. Under the Affordable Care Act, many nonprofit hospitals must meet new requirements to retain their tax-exempt status.

WHAT'S THE ISSUE?

The majority of hospitals in the United States operate as nonprofit organizations and, as such, are exempt from most federal, state, and local taxes. This favored tax status is intended to be an acknowledgement of the "community benefit" provided by these institutions.

Public controversy over whether nonprofit hospitals provided community benefits sufficient to justify their favored tax status gave rise to congressional scrutiny during 2005–09 and culminated in the inclusion of new community benefit requirements in the Affordable Care Act (ACA). Not only are these new requirements intended to improve transparency and accountability, but they are also part of a strategy to address the ACA priorities of preventive care and population health through community health improvement activities.

WHAT'S THE BACKGROUND?

According to the American Hospital Association (AHA), in 2014 about 78 percent of the 4,974 US community hospitals were nonprofit entities (58 percent private nonprofit and 20 percent operated by state or local governments). The remaining 22 percent are for-profit, investor-owned institutions.

Nonprofit hospitals may qualify for favored tax treatment under federal—as well as a variety of state and local income, property, and sales—tax laws. In addition to tax exemptions, nonprofit status allows hospitals to benefit from tax-exempt bond financing and to receive charitable contributions that are tax-deductible to the donors.

History of federal community benefit requirements

Exemptions from income taxes for charitable institutions date back to the first income tax code enacted in 1913. In 1954 Section 501(c)(3) of the Internal Revenue Code was codified and provided for the exemption from federal income tax for organizations that operated exclusively for religious, charitable, scientific, or educational purposes. Prior to 1969, to qualify for tax-exempt status a hospital had to provide, "to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it." In 1969 this charitable care standard was replaced with a more general requirement that compelled hospitals to engage in activities that benefit the communities they serve. Under the "community benefit" standard, spending that promotes community health, in addition to charity care, counts toward meeting the requirements for tax exemption.

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7.5%

During fiscal year 2009, tax-exempt hospitals spent an average of 7.5 percent of their operating expenses on community benefits.

"The new ACA requirements do not include a specific minimum value of community benefits that a hospital must provide to qualify for tax-exempt status."

The Internal Revenue Service (IRS) allowed hospitals broad latitude in determining what activities and services constituted community benefit. This resulted in great variation in what was considered a community benefit activity and how its value was measured. The community benefit standard remained basically unchanged until 2008, when the IRS added a requirement that hospitals submit additional information regarding community benefits on the new Schedule H worksheet attached to their Form 990, which must be filed annually with the IRS by nonprofit organizations.

Schedule H categories of community benefit activities include the net, unreimbursed costs of charity care (providing free or discounted services to patients who qualify under the hospital's financial assistance policy); participation in means-tested government programs, such as Medicaid; health professions education; health services research; subsidized health services; community health improvement activities; and cash or in-kind contributions to other community groups (such as donating funds to a community health screening event or hosting a blood drive). Hospitals can also claim what the IRS terms *community building activities*, such as investments in housing or environmental improvements, if they separately submit evidence documenting the relationship between such investments and health improvement. Schedule H also requires the reporting of bad debt (amounts uncollected from patients who did not qualify for charity care) and shortfalls associated with Medicare payments, but the IRS does not count these amounts as community benefits.

State community benefit requirements

State and local governments typically condition their sales, property, and corporate income tax exemptions for nonprofit entities to an organization's 501(c)(3) status. In addition, many states have their own community benefit laws that vary substantially from state to state in scope and detail, including the amount and type of evidence that must be reported, and that may exceed requirements of federal law. State community benefit requirements for nonprofit hospitals may be tied to certificate-of-need approval, hospital licensure, or partial reimbursement for charity care. A comprehensive state-by-state profile of community benefit requirements and tax exemptions has been compiled by the Hilltop Institute, a nonpartisan health research organization located at the University of Maryland, Baltimore County, which has expertise in improving publicly financed health care.

Amount and types of community benefits provided

Historically, the vast majority of community benefit spending by hospitals has been related to charity care—that is, providing patient care services for free or at a reduced charge. Only a small fraction has been on community health improvement. A landmark study by Gary Young and colleagues published in the *New England Journal of Medicine* in 2013 found that during fiscal year 2009, tax-exempt hospitals spent an average of 7.5 percent of their operating expenses on community benefits. There was wide variation among individual hospitals, however, with those near the top providing about 20 percent of operating expenses on community benefits and those near the bottom of the scale spending only about 1 percent on community benefits.

More than 85 percent of aggregate community benefit expenditures were related to patient care services, with 25 percent for charity care, 45 percent for the unreimbursed costs of means-tested government programs, and 15 percent for subsidized health services. The remaining 15 percent were for activities such as education, research, and contributions to community groups. The variation in community benefit spending was not associated with the level of community need, as measured by the percentage of uninsured residents or per capita income in a hospital's service area. The only factor that was associated with greater community benefit spending was state-level requirements for broad community benefit reporting.

Value of tax-exempt status

Tax-exempt status is worth a lot to nonprofit hospitals. The Congressional Budget Office estimated that the value of federal, state, and local tax exemptions, tax-deductibility of charitable contributions, and tax-exempt bond financing, was $12.6 billion in 2002. This figure was recently updated to $24.6 billion in 2011, in a study published in *Health Affairs* by Sara Rosenbaum and colleagues at the George Washington University. The distribution of types of community benefits did not change, however, with less than 8 percent devoted to community health improvement activities.

85%

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WHAT'S THE LAW?

The ACA added Section 501(r) to the Internal Revenue Code, which contains four new requirements related to community benefits that nonprofit hospitals must meet to qualify for 501(c)(3) tax-exempt status.

They are as follows:

- Conducting a community health needs assessment with an accompanying implementation strategy;

- Establishing a written financial assistance policy for medically necessary and emergency care;

- Complying with specified limitations on hospital charges for those eligible for financial assistance; and

- Complying with specified billing and collections requirements.

The new ACA requirements **do not** include a specific minimum value of community benefits that a hospital must provide to qualify for tax-exempt status.

The IRS conducted a long implementation process for the ACA community benefit requirements, with guidance, notices, and proposed rules issued over a five-year period following enactment of the ACA. Final IRS regulations, consolidating these actions, were issued December 31, 2014.

Community health needs assessments

Each nonprofit hospital must conduct a community health needs assessment at least once every three years and develop strategies to meet the needs identified in the assessment. In doing so, a hospital must seek broad community input, including from public health officials. The regulations require that the assessment address not only financial and other barriers to care but also the need to prevent illness; ensure adequate nutrition; and address social, behavioral, and environmental factors that influence the community's health or emergency preparedness. The assessment must be documented in a written report and made widely available to the public, including on a website. Hospitals also must develop implementation strategies to meet the community health needs documented through the assessment. Hospitals that fail to comply are subject to a $50,000 excise tax penalty.

Financial assistance policy

Each nonprofit hospital must develop a written financial assistance policy that contains basic information about whether the hospital offers free or discounted care; the eligibility requirements for financial assistance and a description of how to apply for the assistance; the basis for how much patients are charged for care; the collection procedures they will use; and measures the hospital will take to widely publicize the policy in the community. The policy must apply to all emergency and medically necessary care. Hospitals may exclude some services not considered medically necessary (as defined by the hospital). In addition, there must be a separate policy that states that the hospital will provide emergency medical care to all individuals, regardless of whether they qualify for financial assistance.

Limitations on hospital charges

For financial assistance policy–eligible patients needing emergency or medically necessary care, nonprofit hospitals may charge only the amounts generally billed to insured patients for the same services. The amount generally billed may be the Medicare fee-for-service amount, the Medicaid amount, or a combination of Medicare and private insurance averages.

Billing and collection

Nonprofit hospitals may not engage in extraordinary collection actions before making a reasonable effort to determine if the patient is eligible for assistance under the hospital's financial assistance policy.

For hospitals operated by a hospital organization, the requirements apply separately to each facility. The community health needs assessment and the financial assistance policy must also apply to any physician practices that are part of a hospital organization and are not separate taxable entities. The community benefit requirements also apply to government hospitals that wish to receive, or retain, 501(c)(3) status. Since government hospitals do not have to file IRS Form 990, the regulations exempt them from reporting requirements related to Form 990. They must, however, comply with all other requirements, including making their assessment reports

and financial assistance policies widely available to the public on a website.

Enforcement is the responsibility of the secretary of the treasury, through the IRS. Provisions are made for noncompliance that the IRS determines to be neither willful nor egregious. In such cases, hospitals will be given an opportunity to correct the deficiencies. Otherwise, noncompliance will result in a revocation of tax-exempt status for the institution.

Annual report to Congress

The ACA requires that the secretary of the treasury, in consultation with the secretary of health and human services, submit to Congress an annual report that includes information on the levels of charity care, bad debt expenses, unreimbursed costs for care provided to beneficiaries of means-tested government programs (for example, Medicaid), and unreimbursed costs for care provided to non-means-tested program beneficiaries (for example, Medicare), rendered by private and government-owned nonprofit hospitals. The report must also provide information on the costs incurred by private tax-exempt hospitals for community benefit activities.

The first report, containing information from calendar year 2011, was produced in January 2015. In aggregate, private tax-exempt hospitals provided less than 10 percent of their total expenses as community benefit, consisting of about 2 percent charity care, 3 percent unreimbursed Medicaid and other means-tested government programs, and 4 percent other community benefits, of which less than 0.5 percent was for community health improvement services.

"There are disagreements over what should count as a community benefit and to what extent hospitals should be held accountable."

WHAT'S THE DEBATE?

As Congress considers major tax reforms, nonprofit hospitals in general vigorously advocate to retain their tax-exempt status, as well as their ability to obtain tax-exempt financing and to accept tax-deductible charitable contributions. However, there are disagreements over what should count as a community benefit and to what extent hospitals should be held accountable. There are also concerns about the capacity of the IRS to adequately enforce community benefit requirements.

Hospitals have long considered bad debt and Medicare shortfalls as part of the community benefits they provide, but federal regulations do not recognize those costs as community benefit expenses. The authors of the *New England Journal of Medicine* study cited above estimated that the inclusion of bad debt alone would increase the average level of total hospital expenditures on community benefits in their study from 7.5 percent to more than 11.0 percent.

The Alliance for Advancing Nonprofit Health Care (AANHC), composed of a number of nonprofit health care providers and nonprofit health care plans, advocates replacing the ACA community benefit requirements with an annual, quantitative standard equal to the amount they would pay in federal tax without a federal tax exemption. If an institution did not meet the standard, it would have to pay a federal tax equal to the shortfall. The AANHC argues that this would be fairer and easier because under the current situation there remains significant variation in the amount of community benefits provided and it is impossible to ascertain if every nonprofit hospital is doing enough to justify its tax-exempt status.

The AHA and the Catholic Hospital Association sent a joint letter to Congress in opposition of such a change. They argued that a dollar-value standard cannot capture the degree to which community need is met or the impact on the health of the community.

A significant part of the debate over community benefits is the extent to which nonprofit hospitals should shift their community benefit efforts away from providing financial assistance to patients and toward addressing broader community needs, as identified in their community health needs assessments. There are some disincentives in the current law for doing this.

Sara Rosenbaum and Bechara Choucair, in a post in the *Health Affairs* Blog, argue that the current situation places a burden on hospitals to justify each individual community building expenditure as one that will promote community health, providing a disincentive for hospitals wary of having the IRS refuse to recognize the activity as a community benefit. They propose that the IRS, with input from the Centers for Disease Control and Prevention, establish safe harbors recognizing certain community building activities as community health improvements based on evidence from published studies and government reports.

Janet Corrigan and colleagues at the Dartmouth Institute for Health Policy and Clinical Practice, in New Hampshire, argue in a

viewpoint article published in the *Journal of the American Medical Association* that hospital community benefit programs should be reoriented toward regionwide community benefit approaches. The current system, with its focus on the immediate service areas of hospitals, risks widening health disparities as suburban hospitals focus on relatively well-off communities, while urban hospitals have more limited resources to invest in their neighborhoods because of higher burdens of uncompensated care. To accomplish this, barriers need to be removed to regional coordination, including IRS establishment of safe harbors to allay concerns about antitrust violations and clarification of which community building activities (for example, housing) qualify as community benefits.

WHAT'S NEXT?

Transformation of the health care system as a result of all of the provisions in the ACA, including increased insurance coverage, new models of health delivery, and new payment systems, is just in the beginning stages. All of these changes have an impact on hospitals and the amount and types of community benefits they provide. Data from new community benefit reporting requirements will allow analyses on types and amounts of community benefit expenditures; the impact of increased insurance coverage on reducing demands for charity care, while increasing costs associated with participating in means-tested government programs; and geographic variations in the types of benefits provided.

As the experience with community benefit policy is assessed, policy makers at all levels of government may wish to evaluate the differences between federal and state community benefit requirements and determine which policies have a positive effect on engaging hospitals in their communities. They may also identify requirements that could be standardized to reduce administrative burdens on hospitals.

The effects of all of these changes will need to be evaluated over time to determine how they affect hospitals' responsibilities and obligations to their communities. ■

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