

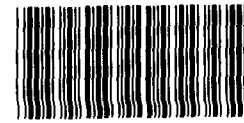
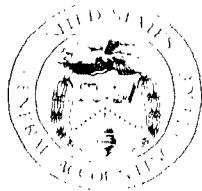
GAO

Report to the Chairman, Select  
Committee on Aging, House of  
Representatives

May 1990

NONPROFIT  
HOSPITALS

Better Standards  
Needed for Tax  
Exemption



141681

419



United States  
General Accounting Office  
Washington, D.C. 20548

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Human Resources Division

B-237838

May 30, 1990

The Honorable Edward R. Roybal  
Chairman, Select Committee on Aging  
House of Representatives

Dear Mr. Chairman:

This report responds to your request and later discussions with members of the Committee staff regarding the role played by nonprofit hospitals in delivering care to the medically indigent. We undertook this study in light of increasing cost constraints in the hospital sector that may be influencing hospitals to devote fewer resources to providing care to the indigent and conducting other charitable activities. This report concludes that the Congress should consider revising the criteria for hospitals' tax exemption if it believes that providing charity care should be a fundamental basis for such an exemption.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the cognizant congressional committees and subcommittees, the Commissioner of Internal Revenue, the Secretary of Health and Human Services, and the Director of the Office of Management and Budget. We also will make copies available to others upon request.

This report was prepared under the direction of Janet Shikles, Director, Health Financing and Policy Issues, who may be reached on 275-5451 if you or your staff have any questions. Other major contributors are listed in appendix IV.

Sincerely yours,

Lawrence H. Thompson  
Assistant Comptroller General

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# Executive Summary

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## Purpose

In the wake of increasing pressure on hospitals to contain their costs, there are concerns that some hospitals are reducing their provision of indigent care and other charitable activities. While changes in the market affect all types of hospitals, nonprofit hospitals are under more scrutiny because of their preferred treatment as charities under the tax code. The House Select Committee on Aging asked that GAO assess the role of nonprofit hospitals in providing (1) acute medical care to those who are unable to pay and (2) other community services, such as health education and screening.

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## Background

Just over half of the nation's hospitals are private nonprofit (nonprofit) institutions; the rest are operated either by governments or on a for-profit basis.

If they meet certain tests established by the Internal Revenue Service (IRS), nonprofit hospitals are exempt from federal taxation; these hospitals are also generally exempt from state and local taxes. Poor people without public or private insurance gain access to nonemergency hospital services only if the hospital is willing to admit them with little expectation of payment. (See p. 12.) Between 1956 and 1969, the test for tax-exempt status included specific reference to providing (to the extent the hospital's finances allowed) services to those not able to pay. Since 1969, however, IRS has not required such care so long as the hospital provides benefits to the community in other ways. (See p. 15.)

GAO analyzed the distribution of uncompensated care among hospitals in five states to analyze the role of nonprofit hospitals in supplying such care. (See pp. 17-19.) Uncompensated care includes both charity care and bad debt expense. Where data were available, GAO also focused on that portion that represented charity care. In addition, GAO conducted case studies in five communities and surveyed a nationwide sample of hospitals regarding the types of community services provided. (See pp. 19-20.)

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## Results in Brief

In the five states GAO reviewed, government-owned hospitals provided a disproportionate amount of the uncompensated care. Both nonprofit and for-profit hospitals provided a smaller share of the state's uncompensated care than they provided of general hospital services.

Moreover, the burden of uncompensated care was not distributed equally among the nonprofit hospitals in these five states. Large, urban

teaching hospitals had a higher share of the uncompensated care expense than did other nonprofit hospitals. Among the rest of the nonprofit hospitals, the tendency was for those hospitals with the highest operating margins (and, therefore, the greatest ability to finance charity care) to have the lowest rates of uncompensated care. Variations in uncompensated costs can be attributed both to the hospitals' geographic locations and to their particular operating policies, such as admissions practices.

About 80 percent of the nonprofit hospitals in these states reported total uncompensated care costs in excess of GAO's estimate of the value of their federal tax exemption. Where GAO was able to get information on the charity portion of uncompensated care costs, however, it found that a far lower percentage incurred charity care costs in excess of GAO's estimate of the value of their tax exemption: 71 percent in New York and only 43 percent in California.

A majority of nonprofit hospitals offered community services in addition to providing charity care. These services were generally offered to the community as a whole, however, and were not necessarily directed at the poor.

If the Congress wishes to encourage nonprofit hospitals to provide charity care and other community services, it should consider revising the criteria for tax exemption.

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## Principal Findings

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### Uneven Distribution of Uncompensated Care

Nonprofit hospitals provide a lower percentage of their states' uncompensated care than the percentage of hospital care they provide in the states. For example, in California, nonprofit nonteaching hospitals provide 55 percent of the total days of hospital care but only 27 percent of the state's uncompensated care expenses. Further, uncompensated care expenses were not distributed proportionately through the nonprofit sector, but were concentrated in large teaching hospitals in cities. (See pp. 21-23.)

On average, the nonprofit hospitals with the lowest uncompensated care rates had better financial results than other nonprofit hospitals. In contrast, those with the highest uncompensated care rates had the poorest financial results. (See pp. 24-26.)

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**Some Hospitals' Potential Tax Liability Exceeds Uncompensated Care Provided**

Hospitals whose potential tax liability exceeded their uncompensated care expenses had proportionately higher net incomes than other hospitals in their state. Between 43 and 71 percent of the nonprofit hospitals in the five states provided less charity care than what GAO estimated as the value of their tax exemption. (See pp. 27-29.)

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**Goals and Policies Do Not Encourage Elective Treatment for the Uninsured**

A hospital's goals and policies influence the amount of uncompensated care it provides. In the five communities GAO visited, the strategic goals of some hospitals did not focus on the health needs of the poor or underserved in their communities. Instead, the goals most often related to increasing their share of the patients within their market area, resembling goals of investor-owned institutions. Further, physician staffing and charity admissions policies discouraged admissions of those unable to pay, except in emergency cases. (See pp. 32-34.) In two of the communities, one hospital bore a disproportionate share of emergency or obstetrical care for the indigent, causing its administrators to take steps to reduce its role in caring for the community's poor because of the resulting financial burden. (See p. 36.)

Location and proximity to other hospitals willing to provide uncompensated care are also factors in determining a hospital's level of uncompensated expense. For example, in three communities, hospitals that were near a public or major teaching hospital known to serve the uninsured were not affected seriously by uncompensated expenses because the burden fell on that other hospital. (See p. 35.)

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**Some Community Services Provided by Most Hospitals**

A high percentage of nongovernmental hospitals, regardless of ownership type, provide community services, such as health screening, clinic services, and immunizations. Nonprofit hospitals were more likely than investor-owned hospitals to offer these services but were (1) equally likely to charge patients a fee for them and (2) more likely to recover the costs of providing them. (See pp. 41-43.)

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**Matters for  
Congressional  
Consideration**

Currently, there are no requirements relating hospitals' charitable activities for the poor to tax-exempt status. If the Congress wishes to encourage nonprofit hospitals to provide charity care to the poor and uninsured and other community services, it should consider revising the criteria for tax exemption. Criteria for exemption could be directly linked to a certain level of (1) care provided to Medicaid patients, (2) free care provided to the poor, or (3) efforts to improve the health status of underserved portions of the community.

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**Abbreviations**

AIDS      acquired immunodeficiency syndrome  
IRS        Internal Revenue Service



# Introduction

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Medical care is provided by government-owned (public), private non-profit (nonprofit), and for-profit organizations. The nonprofit form of ownership predominates in the hospital sector. Nonprofit hospitals provide medical and other health-related services to their communities and devote earnings to hospital improvements, instead of to private gain. Under a provision in the tax code exempting charities from federal income tax, most nonprofit hospitals have historically been exempt from such tax. They often also have received several other financial advantages.<sup>1</sup>

Growing efforts by employers, insurers, and government to contain the rapid growth of health care costs have led to an increasingly cost-conscious hospital sector. Increased numbers of uninsured people have strained some inner-city hospitals' capacity in this new cost-conscious environment. While hospital occupancy rates have decreased nationwide, government-owned hospitals in large cities have high occupancy rates and are sometimes full. Some health policy analysts, legislators, and government officials believe that access to some private hospitals has decreased for the medically indigent and that the financial burden of treating those unable to pay has fallen disproportionately on a relatively small number of public hospitals.

Recent efforts to contain health care costs raise concerns about nonprofit hospitals' continued ability and willingness to undertake certain charitable activities, especially those targeted to the poor. Nonprofit hospitals' activities are under special scrutiny because of their preferred treatment as charities under the tax code. The Chairman, House Select Committee on Aging, asked us to assess the role of nonprofit hospitals in (1) providing acute medical care to those who are unable to pay and (2) providing other community services, such as health education and screening.

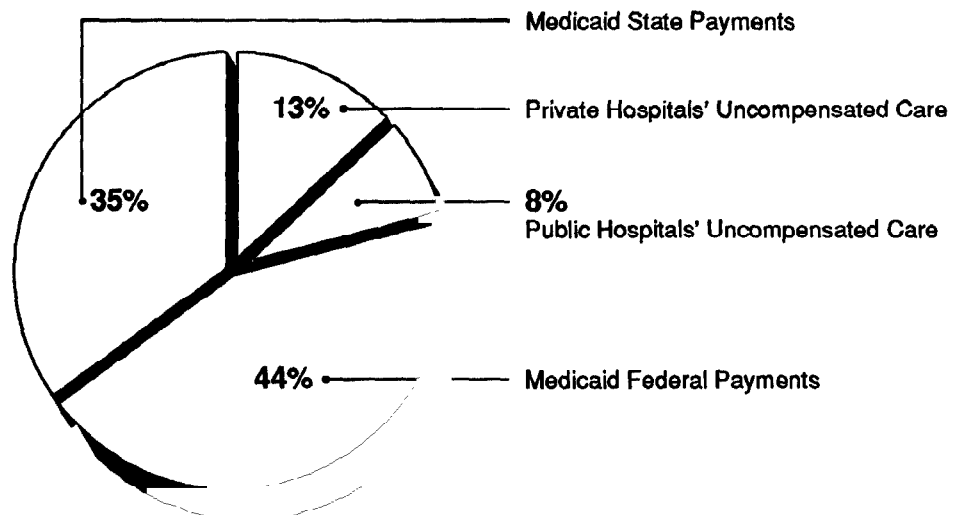
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<sup>1</sup>The lost federal tax revenues attributable to nonprofit hospital tax exemption have been estimated at \$4.5 billion. The tax advantages that nonprofit hospitals may receive include (1) exemption from income tax; (2) exemption from property and other local taxes; (3) access to charitable donations, which are tax deductible for the individual or corporate donor; and (4) tax-exempt bond financing.

## Indigent Care Financed by Government and Hospitals

Indigent care<sup>2</sup> is funded from three major sources: (1) Medicaid,<sup>3</sup> financed principally with federal and state tax funds; (2) other federal, state, and local tax-supported programs; and (3) hospital profits from paying patients, philanthropy, or other revenue. Figure 1.1 shows the proportion of indigent hospital care financed from each of these sources in the United States during 1986.

Figure 1.1: Indigent Hospital Care Funding (1986)



Note: Aggregate data are not available for uncompensated care provided by private physicians and state or local funding (other than Medicaid) for primary medical care to the indigent.

Source: Congressional Research Service and American Hospital Association, Hospital Statistics, 1988.

More than 85 percent of hospital services to the indigent are financed with federal, state, or local tax funds. The principal financing for care to those who cannot pay is the federal-state Medicaid program, in which each state designs and administers its own program within federal guidelines. Federal and state governments share the costs of this program. In addition, when revenues from fees charged to insured or paying patients by local government-owned hospitals are insufficient to

<sup>2</sup>We defined indigent care as care to both Medicaid eligibles and those ineligible for public assistance but unable to pay.

<sup>3</sup>Medicaid was enacted to enhance the poor's access to health care. Although each state designs and administers its own Medicaid program, at a minimum the program must cover people receiving cash payments from the Aid to Families With Dependent Children program and (in most states) people receiving them from the Supplemental Security Income program. By July 1, 1990, states must also cover pregnant women and infants with family incomes at or below the federal poverty level.

cover their costs, those governments usually finance the differences. Generally, government-owned hospitals treat all persons, regardless of their ability to pay. Many government-owned and nonprofit hospitals were constructed or renovated in whole or in part with money provided through the federal Hill-Burton program.<sup>4</sup> In these cases, the hospitals were required to provide a reasonable amount of uncompensated services to the indigent population.<sup>5</sup>

At least one-third of the nation's estimated 31 million uninsured people are poor but ineligible for public assistance. Hospital care for these people is now largely dependent on the willingness of hospitals and physicians to provide care at no charge. Private and government-owned hospitals finance uncompensated care<sup>6</sup> through (1) donations, grants, or philanthropy or (2) net income from paying patients. Government-owned hospitals may also finance some uncompensated care from tax revenues. The number of hospitals and the distribution of uncompensated care among hospital types are shown in table 1.1.

**Table 1.1: U.S. Hospitals by Uncompensated Care and Ownership Type (1988)**

Dollars in billions

Type	No. of hospitals	Total uncompensated care	Percent distribution of uncompensated care	Average uncompensated care rate <sup>a</sup>
Nonprofit	3,440	\$8.4	58	4.8
For-profit	1,149	1.4	9	5.2
State and local government	1,849	4.8	33	7.6
<b>Total</b>	<b>6,438</b>	<b>\$14.6</b>	<b>100</b>	

Note: Excludes federal hospitals.

<sup>a</sup>Uncompensated care as a percentage of total revenue.

Source: American Hospital Association, Annual Survey of Hospitals, 1988 estimated file.

<sup>4</sup>Between 1946 and 1974, the Hill-Burton program provided federal grants for constructing public and nonprofit hospitals. In return, the hospitals were required to give assurance that they would make available, in the facility constructed with the financial assistance, a reasonable volume of services to persons unable to pay for medical services, if this was financially feasible.

<sup>5</sup>The number of hospitals with outstanding Hill-Burton debt and obligations is decreasing. Hill-Burton obligated hospitals are presumed to have met their obligation if they make available annually the lower of (1) a dollar volume of services equal to 3 percent of the sum of operating costs minus Medicare and Medicaid payments or (2) 10 percent of the federal assistance received. The length of the obligation is 20 years (in the case of grant recipients), or for the duration of the hospital's indebtedness (in the case of recipients of loans, loan guarantees, or interest subsidies).

<sup>6</sup>Uncompensated care, which is defined as care provided to a patient that a hospital is not reimbursed for, consists of two parts: bad debt and charity care.

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## Changing Marketplace Alters Hospital Incentives to Provide Indigent Care

To the extent that recent private and public sector cost-containment initiatives result in reduced hospital net incomes, it may be more difficult for some hospitals to incur expenses for community service activities, such as providing charity care. Some legislators and policy analysts believe that hospital access for the indigent has declined. Nonprofit hospitals' community role is the focus of scrutiny because investor-owned hospitals—subject to local, state, and federal taxes—are not treated as charities and many government-owned hospitals are reportedly unable to provide capacity sufficient to treat all indigent patients.

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## Changes in Technology and Financing Spur Changes to Nonprofit Hospitals

Advances in medical technology transformed the nature of hospital care and broadened the patient base of hospitals from mostly the poor and disadvantaged to include also the middle and upper classes. Before the 20th century, the demand for general hospitals was relatively small: nonprofit hospitals were created by various groups for those who had special health problems or who were unable to receive physicians' services at home, such as the poor or those away from home. When these hospitals were established, hospital care was primarily custodial because drugs and other treatment for illnesses were lacking and the risks of infection and death from surgery were great. Traditionally, most nonprofit hospitals refrained from charging a significant amount above the relatively low cost because it was assumed that patients were too poor to pay for their care. Development of medical technology, especially ways of treating disease and controlling infection, made hospitals more appealing to middle- and upper-income patients. As technology became more expensive and more people demanded access to hospitals, a smaller percentage of patients were free or charity cases.

During the 20th century, the role of private philanthropy in financing hospitals was also reduced. As a result, nonprofit hospitals had a decreasing role in channeling philanthropy into communities. Hospitals became less reliant on philanthropic endowments and more reliant on medical insurance and public financing, such as that available through the Hill-Burton program. By the late 1950s, some form of insurance payment was made for about 75 percent of patients in nonprofit hospitals.

Nonprofit hospitals' role as providers of free care was further reduced by the enactment of the Medicare and Medicaid programs in 1965. By paying the costs of care for millions of the elderly and the poor, these programs reduced the need for the hospital and its medical staff to provide care at no charge. Many of the patients who would have been charity cases were now insured patients.

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## Growing Investor-Owned Hospital Enterprise

Another change in the hospital marketplace—the emergence and growth of national investor-owned hospital companies—was spurred by the availability of money accompanying the rise of third-party payments by insurers, employers, and the Medicare and Medicaid programs. Since the 1960s, the rate of growth of investor-owned hospital systems has outpaced that of nonprofit systems. Investor-owners have added 500 hospitals and nearly 62,000 beds since 1975, more than doubling their previous holdings. In 1988, investor-owned hospitals represented about 18 percent of nonfederal short-term hospitals nationwide. Although in no state do investor-owned hospitals represent more than 50 percent of all nonfederal short-term hospitals, they represent more than 30 percent of hospitals in about seven southern and western states. As well as consolidating into larger organizations and diversifying into related ventures, investor-owned enterprises are combining with nonprofit hospitals to create hybrid organizations.

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## Changes in Financing Make Care to Medically Indigent a Concern

During the 1980s, changes in the way hospitals are reimbursed raised concerns about the extent to which hospitals would be able to provide care to those who cannot pay. Increased competition between hospitals for patients and government-, employer-, and insurer-initiated attempts to contain costs make hospitals less able to subsidize uncompensated care.

Hospitals have typically financed uncompensated care through various combinations of philanthropy, cost shifting,<sup>7</sup> and general subsidies from state and local governments. Hospitals' ability to subsidize uncompensated care may be decreasing as private insurers and employers attempt to contain their costs and state and local governments face fiscal pressures. These factors, combined with the cost-containment initiatives in the Medicare and Medicaid programs, have resulted in a general decline in profits throughout the hospital sector.

There are some indications that access to hospital care for the medically indigent in this cost-containment environment is declining. Demand for intensive hospital care needed to treat gunshot victims, acquired immunodeficiency syndrome (AIDS) patients, and illicit drug users, a substantial portion of whom are indigent, has outstripped the available capacity of some hospitals in large cities. Reportedly, the hospitals of last resort

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<sup>7</sup>By billing private insurers at rates exceeding costs, hospitals frequently attempt to shift some of the costs of uninsured patients to insured patients.

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in these cities treat patients in hallways as their emergency rooms overflow.

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## Nonprofit Hospitals Scrutinized Because of Tax-Exempt Status

The changing hospital marketplace has led some policymakers and researchers to question whether there is a significant difference between the amounts of charity care provided by nonprofit hospitals and investor-owned hospitals, who are subject to local, state, and federal taxes. Because of inconsistencies in the ways hospitals identify charity care, researchers have measured levels of uncompensated care instead. By this measure, national data show there is little difference in overall rates of uncompensated care between nonprofit and investor-owned hospitals. Studies have shown, however, that when uncompensated care data are analyzed on a state-by-state basis, nonprofit hospitals in some states have higher average rates of uncompensated care than investor-owned hospitals. The rates of uncompensated care for both hospital organizational types vary substantially, and some nonprofit hospitals have uncompensated care rates below the average rate of investor-owned hospitals. Relatively little research has been performed, however, to assess whether such hospitals distinguish themselves in other ways as charitable institutions.

The Internal Revenue Service (IRS) has long granted an income tax exemption to hospitals meeting its qualifications for charitable organizations under section 501(c)(3) of the Internal Revenue Code.<sup>8</sup> To qualify, a hospital applicant must show that it is organized and operated for a charitable purpose, that no part of its net earnings inure to an individual, and that it does not conduct political or substantial lobbying activities. Although hospitals are not exempt specifically in the Internal Revenue Code, IRS has long extended the tax exemption to qualifying hospitals. Importantly, nonprofit hospitals no longer need to provide care to indigents in order to retain tax-exempt status as they once did. However, qualifying hospitals must, in other ways, evince their exclusive commitment to the community, rather than to private benefit, in order to obtain the exemption. For a detailed discussion of the history of the hospitals' tax exemption criteria, see appendix I.

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<sup>8</sup>Section 501(c)(3) of title 26 of the United States Code exempts from federal income taxation "corporations and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific...purposes..." (emphasis added). In regulations implementing section 501(c)(3), IRS requires charities to be organized and operated exclusively for a charitable endeavor, and not for the benefit of private interests.



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Recently, IRS and Treasury officials have voiced concerns about complex nonprofit organizations, especially universities and nonprofit hospitals, with substantial unrelated for-profit businesses.<sup>9</sup> If some nonprofit hospitals are acting essentially as investor-owned institutions do, different tax treatment for them is harder to justify.

At the state and local levels, the fiscal stress resulting from the provision of indigent care has intensified debate about the availability of tax exemptions to nonprofit hospitals. The requirements of tax exemption have been defined differently in two recent state supreme court decisions. In the most broad-based challenge to tax exemption, the Utah Supreme Court in 1985 interpreted the state constitution as requiring that hospitals undertake some “act of giving”—such as charity care—to the community in order to qualify for property tax exemption. The following year, Utah voters turned down a referendum to change the constitution to provide tax exemption to hospitals regardless of their charitable activities. In Vermont, on the other hand, the supreme court held that the main test of whether a nonprofit hospital was a charity hinged on the availability of charity care, rather than the dollar amount of such care provided.

Local officials have attempted to remove charitable status and property tax exemptions from nonprofit hospitals in at least 12 states. In addition, at least 17 states have considered or enacted legislation to prevent unfair competition by nonprofits, and some cities have considered charging nonprofit organizations a fee for the municipal services they use. In general, these initiatives have (1) responded to complaints from the business community of unfair competitive advantage by nonprofits when they offer goods or services not directly related to health care and (2) encouraged hospitals to provide indigent care. While few hospitals have lost their tax-exempt status, proposals to require nonprofit organizations to pay municipal service fees to local governments are becoming more common. Rather than assessing fees, other localities have revised criteria for continued tax exemption, such as by requiring that nonprofit hospitals provide a minimum proportion of Medicaid and charity care in order to retain tax exemption.

Hospital associations have responded to these initiatives by creating tools, such as social accounting budgets, to help health care facilities

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<sup>9</sup>Chapoton, Deputy Assistant Revenue Secretary, Tax Policy, Department of the Treasury; and Gibbs, Commissioner of Internal Revenue; Testimony before the House Subcommittee on Oversight, Committee on Ways and Means, June 22, 1987.

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plan for, administer, and report benefits provided to their communities, especially the poor.<sup>10</sup> The W.K. Kellogg Foundation has funded the Hospital Community Benefit Standards Program to develop an accreditation program for certifying hospitals as community benefit organizations. This project has developed standards to help guide hospitals to improve community health status, address special problems of medically underserved populations, and contain the growth of community health care costs.

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## Objectives, Scope, and Methodology

The Chairman, House Select Committee on Aging, requested that we assess the role of nonprofit hospitals in providing services to the indigent. Specifically, our objectives were to analyze

- the relationship between nonprofit hospitals' uncompensated expenses and the value of their tax exemption;
- the distinctions between nonprofits that provide a high level of indigent care and those that offer a relatively low level, as well as the reasons for these differences; and
- the extent to which nonprofit hospitals provide to their communities other services, such as health screening and education, in addition to indigent care.

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## Financial Analysis

To accomplish our first two objectives, we collected hospital financial information from five states for the most recent years for which data were available.<sup>11</sup> These data are used by the states to monitor and contain costs, or to adjust Medicaid reimbursement rates.

The states—California, Florida, Iowa, Michigan, and New York—were selected to include

- different geographic regions;
- a significant number of the nation's hospitals;
- states with a high prevalence of investor-owned hospitals, as well as states whose hospitals are principally nonprofit; and

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<sup>10</sup>For example, the Catholic Health Association has reported that although the Catholic health care ministry has a religious tradition of serving the poor and the needy, recent budget constraints and the tax exemption debate call for renewed activity by their member hospitals to target the poor and improve accounting and reporting of services that hospitals provide to their communities.

<sup>11</sup>Data from fiscal year 1987 were used for Iowa, Michigan, and New York. Data from hospitals' fiscal years ending between June 30, 1986, and June 29, 1987, were used for California, and data from fiscal year 1985 were used for Florida.

- states with relatively expansive and restrictive Medicaid benefits and eligibility standards.<sup>12</sup>

Uncompensated care can be emergency, inpatient, or outpatient hospital care given to those who cannot or do not pay their bills. It includes both bad debt and charity care.<sup>13</sup> We used uncompensated care, instead of charity care, as a measure of hospitals' services to the indigent because of inconsistencies in the way hospitals distinguish between charity care and bad debt. This overstates the magnitude of charity care provided by hospitals but avoids possible biases in the results because of different ways hospitals categorize patient bills.

Another measure of care to the medically indigent that we used was the percentage of hospital care a hospital provided to those eligible for Medicaid. For, although hospitals do not consistently identify charity care, they do consistently identify the amount they bill for Medicaid patients.

We reviewed hospitals in selected states rather than a national sample of hospitals for two reasons. One, reliable national data on uncompensated care are lacking. Two, an intrastate comparison of uncompensated care is more meaningful because the amount provided by hospitals is affected by local factors, such as the features of the Medicaid program for the state in which a hospital is located.

Using these data sets, we:

- Determined which nonprofit hospitals provide uncompensated care in an amount higher than the value of their federal and state income tax exemption.<sup>14</sup>

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<sup>12</sup>We were also limited to states with sufficient hospital-level financial data.

<sup>13</sup>Bad debt is defined as services to patients for which payment is possible but not made, such as debts of insured patients who do not pay their copayments or deductibles, or debts of the nonpoor uninsured. Charity care is defined as services to patients who do not have the means to pay all or a portion of their bills. Each state we reviewed issues accounting guidelines and principles to help assure that uncompensated care and other data elements are reported consistently.

<sup>14</sup>To estimate the value of nonprofit hospitals' income tax exemption, we applied the average effective tax rate of a sample of for-profit hospital corporations to the nonprofits' net incomes. Because of the imprecise nature of such an estimate, the potential tax liability is presented as a range of values rather than as a point estimate. We did not adjust our estimates to account for potential changes in laws regarding the property tax exemption, tax-exempt bond financing, and tax-deductible donations if the federal tax exemption were eliminated. Hence our calculation potentially overstates the federal income tax liability but understates the total value of tax-exempt status because it does not include the value of the other tax advantages.

- Analyzed the extent to which the following factors are associated with high or low amounts of uncompensated care relative to their expenses: (1) profit,<sup>15</sup> (2) affiliation with a teaching institution, (3) rural or urban location, (4) patient mix, and (5) size.

We discuss the results of this analysis in chapter 2.

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## Community Case Studies

To analyze the reasons for varying levels of indigent care provided by hospitals within the same geographic area, we conducted fieldwork in five communities—one in each state included in our review—to provide examples of how hospitals interact at the community level and what factors most affect the distribution of indigent care. The communities we visited were San Diego, California; Albany, New York;<sup>16</sup> Ann Arbor, Michigan;<sup>17</sup> Orlando, Florida; and Des Moines, Iowa.

In each community, for the years 1984-87 and 1988, if available, we collected information on trends in (1) the community's indigent care, (2) methods of financing indigent care by state and local governments, and (3) each hospital's relative contribution of indigent care. We also collected available data and hospital officials' opinions on factors affecting the distribution of indigent care within the communities' hospitals, including hospital admissions and patient transfer policies, physician staffing policies, and types of medical services each hospital provided.

We discuss the results of our community case studies in chapter 3.

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## Questionnaire

To accomplish our third objective, we surveyed a nationally representative random sample of nonprofit and investor-owned hospitals to determine the type and extent of community services they provided in fiscal year 1988. Although there are various estimates of hospitals' uncompensated care, there is no estimate of the extent to which hospitals provide services other than acute care to their communities. Of 776 surveys that we mailed to hospitals, we received 522, or about 67 percent. In our survey, we defined community services as activities undertaken to serve

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<sup>15</sup>Like an investor-owned organization, a nonprofit organization's "profit" refers to net income—the difference between revenues and expenses. Unlike an investor-owned organization, however, none of a nonprofit organization's profit can inure to individuals, such as stockholders.

<sup>16</sup>We also reviewed two hospitals in Schenectady, New York.

<sup>17</sup>We reviewed hospitals in Ann Arbor and surrounding towns within Washtenaw County, including Chelsea, Saline, and Ypsilanti.

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the community in addition to providing acute medical care to patients. We discuss the results of our survey in chapter 4.

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We did not independently examine the internal and automatic data processing controls for the automated state data systems we used. The states rely, however, on the data obtained from these systems as a basis for Medicaid reimbursement rates and/or partial reimbursement for uncompensated care. Except for this limitation, our work, which was done from October 1988 through June 1989, was performed in accordance with generally accepted government auditing standards.

# Uneven Distribution of Indigent Care

The amount of uncompensated care provided by nonprofit hospitals is a large part of their benefit to the poor in their communities. Hospitals that treat patients who are uninsured or underinsured with little prospect of payment give community residents access to hospital care that might otherwise be unavailable. When we compared the amount of hospitals' uncompensated care expenses with the money they saved by not having to pay federal and state taxes, we found that nonprofit hospitals as a group provided more uncompensated care than their estimated tax savings. Depending on how charitable care is defined, however, between 15 and 57 percent of the nonprofit hospitals provided less charitable care than the value of the tax exemption they received.

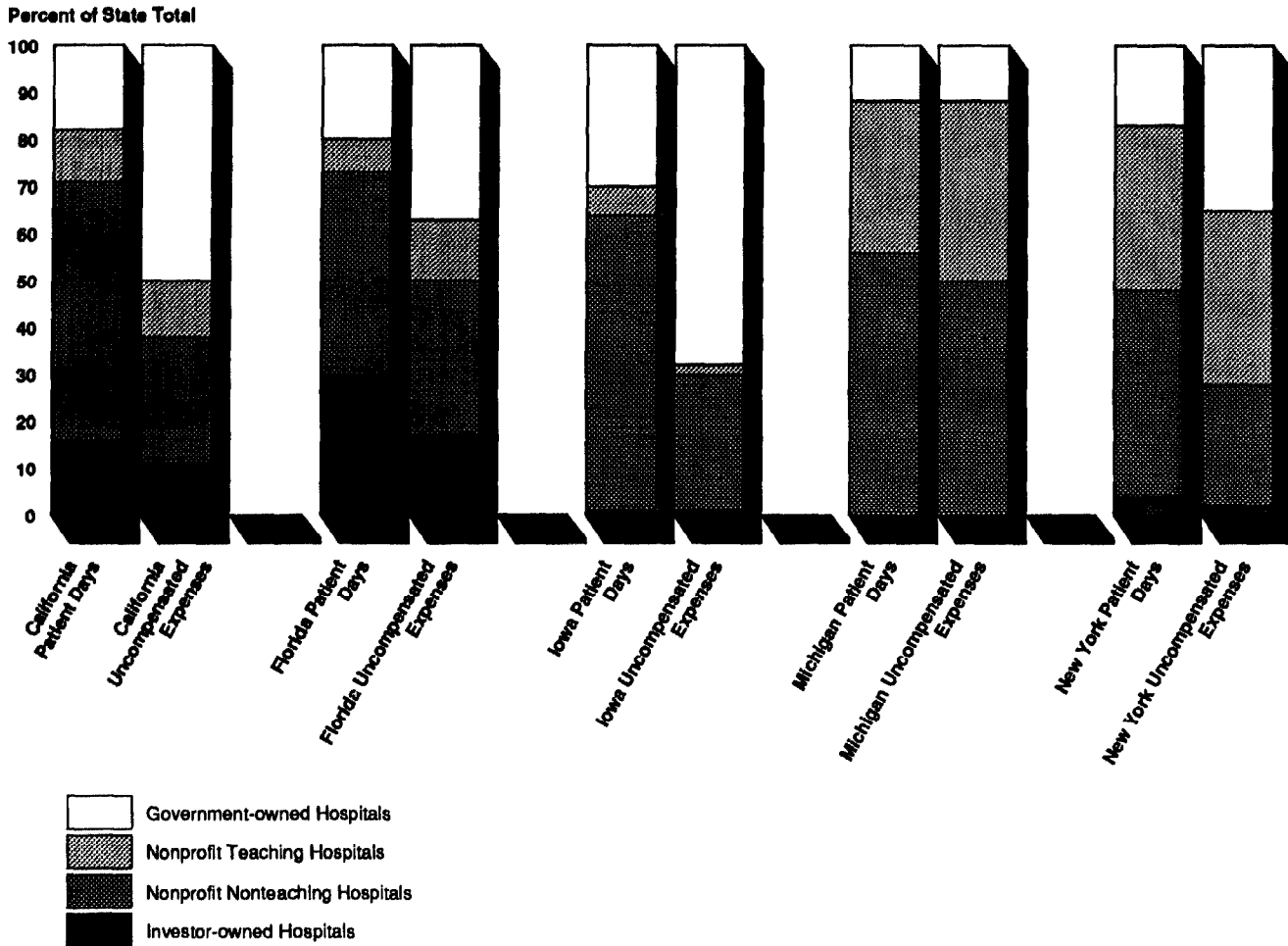
Nonprofit hospitals' rates of uncompensated care vary widely both within and between states. Hospitals with low rates of uncompensated care served fewer Medicaid patients, had higher profit margins, and, with few exceptions, were not major teaching hospitals. Hospitals with high rates of uncompensated care served more Medicaid patients and had lower profit margins. Major teaching hospitals were generally high-uncompensated-care hospitals.

## Uncompensated Care Concentrated in Relatively Few Hospitals

Generally, nonprofit hospitals as a group provided more uncompensated care than did for-profit hospitals. However, nonprofit nonteaching hospitals provide less uncompensated care than would be expected based on their share of the states' hospital market. In Florida, for example, these hospitals provide 43 percent of the total days of hospital care but only 33 percent of the state's uncompensated care expenses. In general, only nonprofit hospitals with major teaching<sup>1</sup> programs provided an amount of uncompensated care equivalent to their share of the hospital inpatient market. The distribution of uncompensated care by type of hospital ownership is shown in figure 2.1.

<sup>1</sup>We have defined major teaching hospitals as those that are members of the Council of Teaching Hospitals. Council hospitals are affiliated with colleges of medicine and participate in training residents.

Figure 2.1: Hospitals' Share of Patient Days and Uncompensated Expenses, by Ownership Type



Note: Florida data are from 1985; California data are from 1986, and the remaining data are from 1987. Iowa and Michigan have insignificant numbers of investor-owned hospitals.

In each of the states, uncompensated care expenses were concentrated in relatively few nonprofit hospitals, most of which were major teaching institutions in urban areas. Ranking the nonprofit hospitals by the dollar amount of uncompensated care provided, we found that less than 7 percent of them provided at least 26 percent of the total nonprofit contribution of uncompensated care. For example, nine major teaching hospitals in New York City accounted for 38 percent of all uncompensated care provided by nonprofit hospitals statewide, though they had only 16 percent of the state's hospital beds. Most of these hospitals belonged to the

Council of Teaching Hospitals, or were approved to participate in residency programs and were affiliated with a medical school. Table 2.1 shows the portion of the total nonprofit uncompensated care expenses borne by relatively few of each state's hospitals.

**Table 2.1: Nonprofit Hospitals With Highest Amounts of Uncompensated Care: Share of State's Uncompensated Care**

State	Number of hospitals <sup>a</sup>	Percent of nonprofit uncompensated care	Percent of nonprofit hospital beds
Iowa	4	40	28
Michigan	6	33	13
New York	9	38	16
California	10	26	11
Florida	5	31	17

<sup>a</sup>In each state, these hospitals constitute less than 7 percent of the state's hospitals.

## Rates of Uncompensated Care Vary Among States

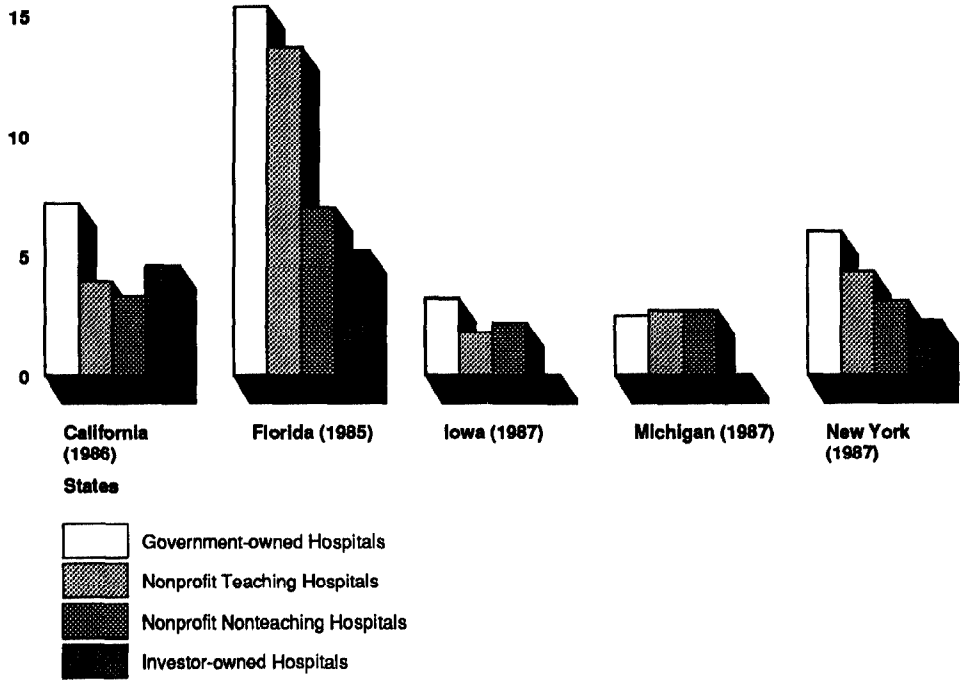
The average rate of uncompensated care for all hospitals varied substantially among the states, ranging from 2.7 percent for Iowa hospitals to 7.9 percent for Florida hospitals. This variation in rates of uncompensated care among states mirrors the interstate variation in (1) the percentages of state residents without medical insurance and (2) the extent to which the Medicaid program covers residents with incomes below the federal poverty standard. Among the states we reviewed, Florida and California have the highest rates of uninsured residents. Similarly, Florida's Medicaid program has the strictest income eligibility criteria. Accordingly, hospitals in these states have significantly higher rates of uncompensated care on average.

Although overall levels of uncompensated care varied among states, nonprofit hospitals without major teaching programs in California, Iowa, Michigan, and New York had similar rates of uncompensated care. In California and Florida, states with relatively high average uncompensated care rates, government-owned hospitals tended to absorb the additional burden. That is, their uncompensated care rates were much higher than in other states. The rates of uncompensated care by state and hospital type are shown in figure 2.2.



Figure 2.2: Uncompensated Expense Rates, by Hospital Ownership Type

20 Percent Uncompensated Expense to Total Expense



Note: Iowa and Michigan have insignificant numbers of investor-owned hospitals.

California and Florida have significant numbers of both investor-owned and nonprofit hospitals. In California, the average investor-owned rate of uncompensated care was slightly higher than the nonprofit rate. In Florida, the average nonprofit rate was higher than the investor-owned rate.

## Substantial Variance Between High- and Low-Uncompensated-Care Nonprofit Hospitals

We arrayed nonprofit hospitals by uncompensated care rates to identify characteristics of hospitals with significantly higher- and lower-than-average rates. By state, we compared selected characteristics of all nonprofit hospitals at or below the 25th percentile of uncompensated care rates (low-uncompensated-care hospitals) with nonprofit hospitals falling at or above the 75th percentile of uncompensated care rates (high-uncompensated-care hospitals). We found that high-uncompensated-care hospitals bore a substantially greater burden of uncompensated

care—from three to nine times greater—than low-uncompensated-care hospitals. (See p. 48.)

As well as having significantly different uncompensated care rates, low- and high-uncompensated-care hospitals were significantly distinct in at least two other respects. Compared to high-uncompensated-care hospitals, low-uncompensated-care hospitals (1) served fewer Medicaid patients and (2) had higher profit margins.

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### Low-Uncompensated-Care Hospitals Served Medicaid Patients at Lower Rates

In every state, hospitals providing low rates of uncompensated care served lower percentages of Medicaid patients than did high-uncompensated-care hospitals. (See p. 49.) The hospitals with high levels of Medicaid patients are sometimes less able to subsidize uncompensated expenses because larger percentages of Medicaid patients often mean lower percentages of privately insured patients to whom charges can be increased to help offset losses on nonpaying patients. Further, a number of states have hospital payment systems for Medicaid that result in lower payment rates than other public and private insurance programs. Both of these factors tend to exacerbate the financial burdens of hospitals' provision of uncompensated care.

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### Low-Uncompensated-Care Hospitals More Profitable

The amount of uncompensated care provided by a hospital must be evaluated in connection with the resources available to finance that care. Hospitals can finance uncompensated care with nonoperating revenue<sup>2</sup> and operating income—earned by the hospital from its patient care operations. One way to finance uncompensated care is to bill private insurers at rates exceeding actual costs and use the profits for uncompensated care. Nonprofit and investor-owned hospitals can make better use of this option than government-owned hospitals can because a larger proportion of their patients are privately insured. Nevertheless, hospitals' ability to subsidize uncompensated care through nonoperating revenue or operating income has been constrained in recent years by various health care cost-containment measures adopted by both public and private insurers.

We found that nonprofit hospitals with resources available to finance uncompensated care—either nonoperating revenue or operating

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<sup>2</sup>Nonoperating revenue consists of investment income and charitable donations, gains or losses on sales of investments, and other items that are not directly related to providing care to patients.

income<sup>3</sup> —were often the lowest volume uncompensated care hospitals. Differences in profitability between nonprofit hospitals having low- and high-uncompensated-care rates are shown on page 50.

### Rates of Uncompensated Care Vary Slightly by Location

Only in Florida were average rates of uncompensated care higher for nonprofit hospitals in rural areas than for those in urban areas. In Iowa, Michigan, and New York, rural hospitals were more likely than urban hospitals to be low-uncompensated-care hospitals. Table 2.2 shows the difference between nonprofit hospital rates of uncompensated care in urban and rural areas, by state.

**Table 2.2: Comparison of Nonprofit Uncompensated Expense Rates in Urban and Rural Areas**

State	Urban rate	Rural rate
California (1986)	3.4	3.3
Florida (1985)	7.1	10.4
Iowa (1987)	2.5	2.1
Michigan (1987)	2.8	2.4
New York (1987)	3.6	2.4

### Levels of Uncompensated Care Relative to Value of Tax Exemption

The amount of tax revenue lost as a result of excluding or exempting certain income from taxes can provide an indication of the relative cost of policies designed to achieve specified public goals. To estimate the tax revenue lost as a result of exempting nonprofit hospitals from federal and state income taxes, we applied the average effective tax rate of a sample of for-profit hospital corporations to the nonprofits' net incomes.<sup>4</sup> We did not attempt to estimate the value of nonprofit hospitals' local property tax exemption or the value of tax-exempt bond financing or charitable donations, which constitute a substantial portion of the total value of the tax expenditure.

We compared the hospitals' estimated tax exemption value to the uncompensated care they provided—one measure of hospitals' charitable activities. In the five states we reviewed, nonprofit hospitals as a group provided more uncompensated care than the estimated value of their income tax liability. (See table 2.3.)

<sup>3</sup>To measure hospitals' ability to finance uncompensated care, we examined their total margin: the percentage of revenues converted into net income.

<sup>4</sup>Net income is defined as the excess of revenues over expenses. In this calculation, we assumed that a nonprofit hospital's net income would remain the same if it were subject to tax.

**Table 2.3: Value of Nonprofit Tax Exemption vs. Uncompensated Care Costs**

Dollars in millions		
	Uncompensated care costs	Value of tax exemption <sup>a</sup>
Iowa	\$27	\$8 - \$28
Michigan	161	11 - 36
New York	457	28 - 92
California	301	84 - 278
Florida	253	35 - 117

<sup>a</sup>Because of the imprecise nature of such an estimate, the potential tax liability is presented as a range of values, rather than as a point estimate. The range represents one standard deviation around the mean.

About 15 percent of nonprofit hospitals, however, provided uncompensated care that was less than the estimated value of the tax exemption.

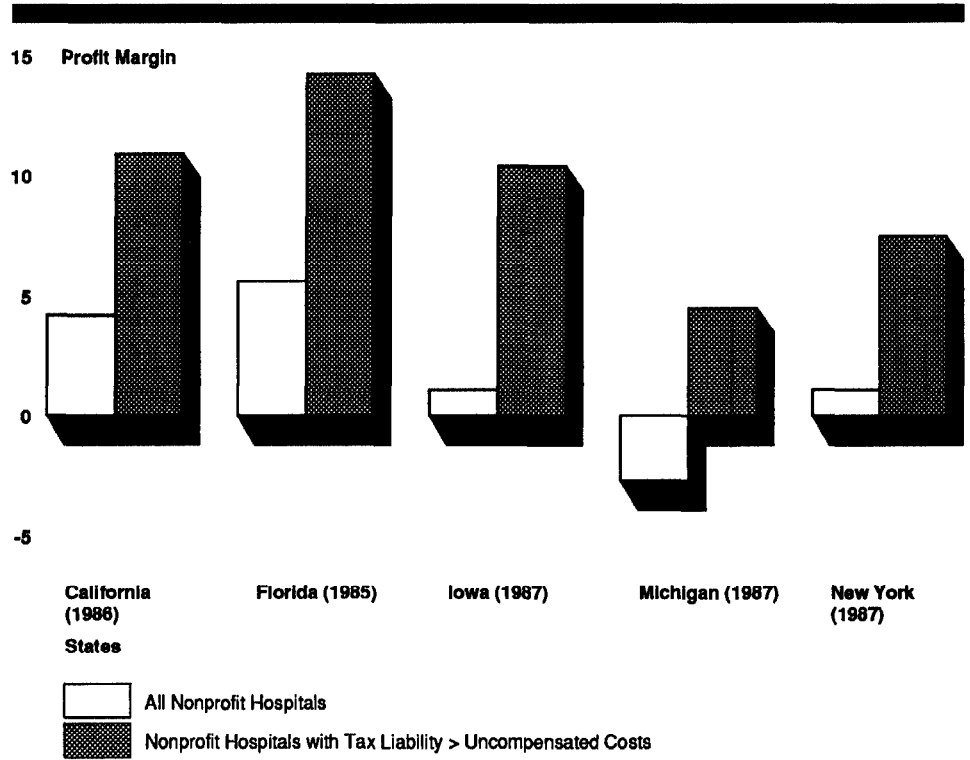
**Table 2.4: Hospitals for Which Tax Exemption Value Exceeds Uncompensated Care Costs**

Dollars in millions				
	No. of hospitals	Percent of hospitals	Uncompensated care costs	Value of tax exemption <sup>a</sup>
Iowa	14	24	\$8	\$11
Michigan	7	5	1	4
New York	23	12	5	11
California	50	24	55	92
Florida	8	9	10	13

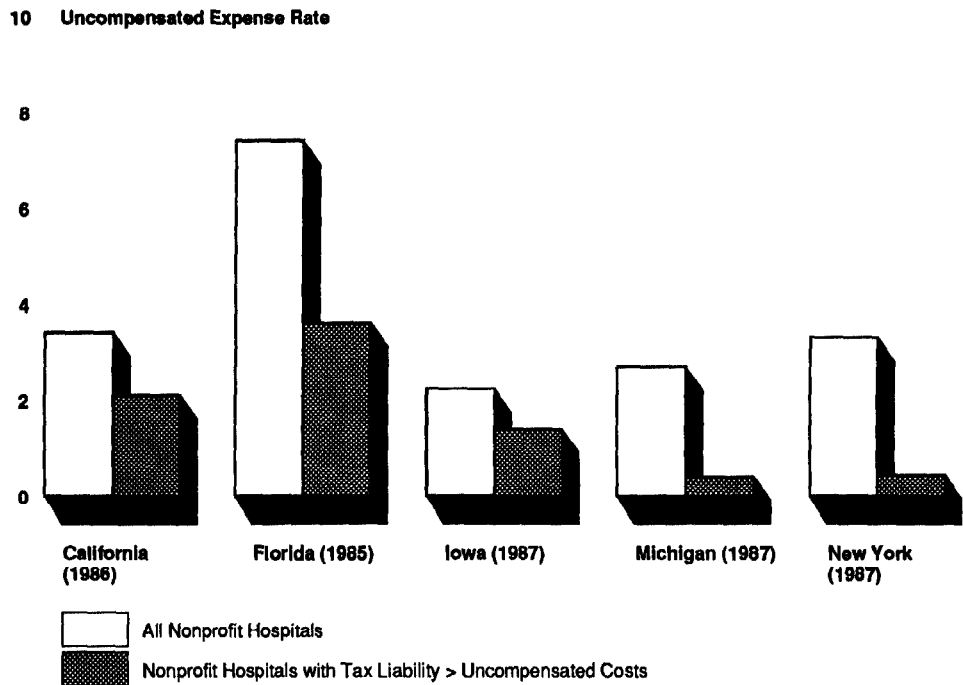
<sup>a</sup>In comparing the uncompensated care costs to the value of the tax exemption, we used the median tax exemption value.

Because their profit margins are significantly higher than those of other hospitals, these hospitals' tax liability would also be higher. Where average profit margins in the five states ranged from a loss of 2.7 percent to a profit of 5.6 percent, profit margins for these hospitals ranged from 4.5 to 14.2 percent. In addition to higher profits, these hospitals generally had uncompensated care expenses less than the average hospital in the state in which they are located. Figures 2.3 and 2.4 compare the profit margin and uncompensated care rate of the hospitals with the statewide nonprofit hospital averages.

**Figure 2.3: Profit Margins: Comparison of Nonprofit Hospitals Not Meeting Tax Threshold With All Nonprofit Hospitals**



**Figure 2.4: Uncompensated Expense Rates: Comparison of Nonprofit Hospitals Not Meeting Tax Threshold With All Nonprofit Hospitals**



When only charity care is considered, more hospitals—about 57 percent—provide care whose value is less than the value of their potential tax liability. For example, in New York and California, 43 and 71 percent of nonprofit hospitals, respectively, had an estimated potential tax liability that exceeded the amount of charity care they provided. In California, Florida, Iowa, and New York, the states we reviewed in which hospitals differentiated between charity and bad debt, charity care made up 23 percent of uncompensated care expenses. This is consistent with the conclusions of a previous analysis, which found that of the \$6.2 billion in uncompensated care provided by hospitals in 1982, only \$1.7 billion (about 27 percent) was charity care.<sup>5</sup> Because hospitals may have inconsistent methods for categorizing bad debt and charity care, however, any distinction drawn between the two is imprecise. The relative proportions reported, however, indicate that a substantial percentage of uncompensated care represents care to those expected to pay, such as unpaid deductibles of privately insured patients, rather than the medically indigent.

<sup>5</sup>Sloan, and others. *Uncompensated Hospital Care, Rights and Responsibilities*.

# Factors Affecting Distribution of Indigent Care Within Communities

Factors that can influence the distribution of indigent care among hospitals include the hospitals' admissions and staffing policies and practices, their services, and their locations. To better understand the factors influencing the amount and distribution of uncompensated care and Medicaid patient care among hospitals, we conducted case studies of hospitals in five communities—one in each of the states we reviewed.

In each community, some nonprofit hospitals' policies—such as those governing patient admissions and transfers, physician staffing, and the setting of strategic goals—discouraged the provision of nonemergency care to those unable to pay for it. Most care for the medically indigent was provided by hospitals that historically have provided such care—that is, government-owned or university-affiliated nonprofit teaching hospitals.

In the communities with adequate funding and capacity to treat the communities' indigent, nonprofit hospitals' uncompensated-care rates were relatively low and not perceived as a significant problem. In the communities where the numbers of medically indigent people in need of services outstripped the capacity or willingness of the nonprofit teaching hospitals to meet the demand, the amount and distribution of uncompensated care was a significant issue among hospital administrators. In these communities, some hospitals were undertaking actions to reduce the amount of treatment provided to those who could not pay.

## Causes of Indigent Care Distribution Examined Through Case Studies

Available research demonstrates a large and increasing indigent care burden on government-owned hospitals, especially in large cities. For our case studies, we selected four communities in which there was no government-owned hospital so that we could examine the factors affecting the distribution of indigent care among hospitals in the absence of a government-owned hospital. We also selected a community in a predominantly rural state. In California and Florida, the two states with significant numbers of both for-profit and nonprofit hospitals, the hospitals we visited included a mix of both types. In the three other states, the communities contained government-owned and nonprofit hospitals only. Table 3.1 shows the hospitals visited in each community, by ownership type.

Chapter 3  
**Factors Affecting Distribution of Indigent  
 Care Within Communities**

**Table 3.1: Hospitals Visited in Selected Communities, by Ownership Type**

<b>Community hospitals</b>	<b>Number of beds</b>	<b>Nonfederal government- owned</b>	<b>Member of Council of Teaching Hospitals</b>	<b>Other nonprofit</b>	<b>Investor-owned</b>
<b>Central San Diego, California</b>					
University of California at San Diego	406		X	X	
Mercy	411			X	
Paradise Valley	210			X	
Harbor View	176				X
Physicians/Surgeons	69				X
<b>Orlando, Florida</b>					
Orlando Regional Medical Center	733		X		
Florida	964			X	
Winterpark Memorial	301			X	
Humana	267				X
AMI	153			X	
<b>Des Moines, Iowa</b>					
Broadlawns	294	X			
Des Moines General	231			X	
Iowa Lutheran	347			X	
Iowa Methodist	680			X	
Mercy	500			X	
<b>Washtenaw County, Michigan</b>					
University of Michigan	799		X		
St. Joseph Mercy	511			X	
Saline Community	63			X	
Chelsea Community	137			X	
Beyer Memorial	148			X	
<b>Capital District, New York*</b>					
Albany Medical Center	654		X		
St. Peters	437			X	
Memorial	233			X	
Ellis	413			X	
St. Clare's	227			X	

Notes: Number of beds available for use as of September 30, 1987. Data are from American Hospital Association Guide to the Health Care Field, 1988 edition. We did not review federal hospitals, such as Department of Veterans Affairs hospitals.

\*Includes selected hospitals in Albany and Schenectady.



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## Some Hospitals Lack Proactive Goals or Policies for Nonemergency Indigent Care

Across communities, we found that some nonprofit hospitals' admissions, transfer, and physician staffing policies generally discouraged the provision of nonemergency care to those unable to pay for treatment. The lack of proactive policies for the indigent results in a distribution of uncompensated care largely based on historic treatment patterns or geographic area.

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## Many Hospitals' Admissions and Transfer Policies Limit Elective Care for Those Unable to Pay

The admissions policies of many hospitals we visited—both nonprofit and investor-owned—limited a majority of charity care to that initiated in the emergency room. Nonprofit hospitals in Des Moines, for example, referred patients needing elective care to the publicly financed hospitals. Among hospitals we visited, few had admissions or physician staffing policies that facilitated elective admissions for those who could not pay. In the communities we visited with a mix of hospital ownership types, we found similar admissions and physician staffing policies at nonprofit nonteaching and investor-owned hospitals. Teaching hospitals' physician staffing policies, however, were different in that medical residents could assist in treating the indigent.

Both nonprofit and investor-owned hospitals participating in Medicare are required by law to provide necessary medical examinations to individuals with emergency medical conditions and women in active labor. In certain circumstances, the hospital may provide for an appropriate transfer to another facility. Four of the states in our review have similar statutes or administrative regulations to assure that all patients are stabilized in emergencies, regardless of whether they can pay their bills.

In contrast, hospitals are not required to provide nonemergency care to those unable to pay. Policies of both nonprofit and investor-owned hospitals we reviewed generally limit the nonemergency care they provide to those who have insurance or have a physician to treat them.

In Albany, three of the hospitals still had Hill-Burton obligations to provide charity care. These hospitals used Hill-Burton criteria to determine eligibility for charity care. The other two hospitals had satisfied prior Hill-Burton obligations and did not have specific criteria for charity care. Officials at these two hospitals told us that uncompensated care is usually the result of bad debt rather than charity care.

In Ann Arbor, another community without a nonfederal government-owned hospital, hospitals we visited had similar policies regarding admissions. To receive outpatient services or to be admitted other than from the emergency room, the patient generally must make financial arrangements before services are rendered. A hospital official told us, however, that indigent patients generally sought services through the emergency room. If a patient is ineligible for Medicaid or another state-subsidized program for indigent care, the hospitals attempt to negotiate a financial arrangement with the patient. Hospitals generally billed all patients and made efforts to collect the amounts owed. Only two of the hospitals have written charity care policies. The policies of both hospitals allowed for the elective admissions of persons regardless of their ability to pay.

In the two communities with a mix of nonprofit and investor-owned hospitals, admissions policies of the two types of hospitals were similar. In Orlando, both nonprofit and investor-owned hospitals sought to determine whether patients were able to pay before admitting them for non-emergency treatment. Two of the three nonprofit hospitals in this community generally referred patients unable to pay to state and county clinics for elective care. Similarly, in San Diego, hospital officials told us that most uncompensated care stemmed from mandatory treatment provided in emergencies, not from nonemergency care. For elective admissions, the hospital administrators of both nonprofit and for-profit hospitals generally made a decision in each case whether to admit patients after determining that they could not pay. For example, one hospital's policy was to admit such patients only if they were employed.

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### Some Hospital Staffing Policies Allow Emergency Care but Not Elective Treatment for Indigents

The willingness of physicians to treat Medicaid patients or other patients unable to pay for treatment can affect the amount of nonemergency indigent care a hospital can provide. Although the hospitals we visited allowed the medically indigent to receive care in the emergency room, subsequent admission to the hospital depended on physicians' willingness to provide treatment without reimbursement.

At the teaching hospitals we reviewed, officials told us that indigent patients can be treated by supervised residents, helping to facilitate residents' experience in treating different kinds of problems. Nonteaching hospitals we visited, however, rely on the medical staff to voluntarily treat indigent patients who need to be admitted to the hospital. The

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“on-call” duty was generally made a condition of maintaining staff privileges. Generally, physicians providing treatment were not paid by the hospital, but billed patients directly for the services they provided.

In the communities with relatively high numbers of medically indigent, hospital administrators told us that it was often difficult to obtain physicians to treat the indigent. In addition to receiving little or no payment from indigent patients, physicians often have to interrupt their regular practice to treat indigents. Some hospital administrators feared that if they increased the on-call duties of physicians practicing at their hospital, some would eventually move their practices to hospitals without many indigent patients.

Physician practice patterns can also affect a hospital’s proportion of Medicaid patients. In Orlando, for example, officials from one nonprofit hospital told us that because few of the physicians admitting patients to the hospital participated in the Medicaid program, they admitted few Medicaid patients to the hospital.

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### Hospitals Did Not Generally Have Strategic Goals Designed to Expand or Improve Indigent Access to Care

The hospitals we visited provided us information on their strategic goals<sup>1</sup> and, in some cases, recent minutes of meetings of hospitals’ boards of directors. We used this information to determine the types of goals being set and issues being addressed by the boards. From these sources, we identified goals related to provision of charity care or community health services.

A majority of goals concerned maintaining the hospitals’ financial viability, improving their competitive positions, expanding services and facilities, or developing employee skills and personnel practices. Although the hospitals set numerous goals related to expanding medical services due to increased patient demand or to increase their market share, generally no goals were directed at serving low-income community residents.

Of the 24 private nonprofit and investor-owned hospitals we visited, 7 had strategic goals related to provision of care to the medically indigent: 3 in Washtenaw County, Michigan; 2 in Albany, New York; and 2 in Des Moines, Iowa. Some of these goals were not specific to the needs of the community and were not linked to dollar amounts or other quantifiable

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<sup>1</sup>The Joint Commission on Accreditation of Healthcare Organizations requires for certification that hospitals develop and maintain a set of strategic goals and a 5-year strategic plan.

targets, such as numbers of people to be served. As a result, they were ambiguous. For example, two hospital goals were to (1) ensure continued financial commitment to health care of the poor while strengthening financial viability and (2) develop an analysis and policy regarding care for the medically indigent.

## Uneven Distribution of Indigent Care a Problem in Some Communities

The absence of proactive policies among nonprofit hospitals can cause problems in delivering services to the indigent and could eventually cause gaps in services for entire communities. Delivering services to the indigent was a greater problem in some communities we visited than in others.

In three communities—Des Moines, Ann Arbor, and Albany—most uncompensated care was provided by either a government-owned or a major teaching nonprofit facility. Although teaching hospitals provided the largest share of uncompensated care, their uncompensated care rates were not substantially higher than the average rate of uncompensated care provided by other hospitals in the state.

In Des Moines, a nonfederal government-owned hospital financed through local tax revenues provided most indigent care, resulting in relatively low and stable indigent expenses for the community's private nonprofit hospitals. Similarly, in both Ann Arbor and Albany, a large teaching nonprofit hospital provided a majority of indigent care. Uncompensated care did not represent a large expense relative to total expenses for any of these communities' other hospitals.

In two of the communities we visited, the uncompensated care costs were relatively high and the nonprofit hospitals providing the largest share of such care were seeking ways to reduce these costs. Hospital administrators in these communities were most concerned about controlling the costs of emergency and obstetrical services to the indigent.

In 1986, the hospital that traditionally served the indigent in Orlando adopted several policies to stem its indigent care costs, including

- refusing to treat patients unable to pay except those needing urgent medical treatment and those residing in the hospital's catchment area,
- encouraging indigent patients to go to a hospital in the area covered by the zip code of their residence, and
- rotating their medical residents to a military hospital, rather than the adjacent county clinic, for obstetrical training.

Other hospitals in the community opposed these policies. Because of the absence of a nonfederal government-owned hospital, several hospitals, including an investor-owned hospital, were inundated with obstetrical patients. In response, a local health council devised an allocation method to redistribute indigent obstetrical patients more evenly among the community's hospitals. Although participating hospital administrators believe that the allocation system lessened the problem, disagreements remain. For example, officials at the hospital traditionally serving indigents are concerned that other hospitals' requests to transfer women having a high risk of complications during labor are based on the patients' financial, not medical, condition. Conversely, some of the area's hospital administrators expressed concern that the hospital traditionally serving indigents is not accepting transfers of all patients who are at high risk.

Similarly, hospitals in San Diego were attempting to restrict their indigent care expenses in response to reductions in state and county indigent care funding as well as to increases in the numbers of undocumented aliens lacking means to pay. Administrators' concern focused on emergency services. The administrator of an investor-owned hospital located adjacent to a low-income section of the community estimated that 75 percent of 3,000 emergency visits monthly involved people with no insurance or inadequate insurance. To reduce its losses, the hospital corporation planned to close the emergency room, potentially causing a domino effect throughout the community. In response, officials from a nonprofit hospital were considering donating money to the investor-owned hospital to keep its emergency room open. To avoid financial stresses, another investor-owned hospital closed its emergency room to ambulance traffic by downgrading it to an urgent care center. In addition, it chose not to contract with the state to provide inpatient services for Medicaid patients and did not contract with the county to provide emergency services to county-sponsored indigent patients.

Nonprofit hospitals were also beginning to take actions to reduce the effect of expenses associated with treating the indigent. At the time of our visit, the hospital traditionally treating indigents was investing in a new facility in a suburb to increase its market share of patients able to pay. Another nonprofit hospital in the area planned to downgrade its emergency room, closing it to ambulance traffic.

# Community Services Provided by Hospitals

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In addition to providing care to those unable to pay, nonprofit hospitals also sponsor research or provide education and various types of health screening services for their communities.

Our nationwide survey of hospital administrators showed that overall, a high percentage of nongovernmental hospitals, regardless of ownership type, provide community services. Nonprofit hospitals were more likely than investor-owned hospitals, however, to provide such services.

Although relatively few services were targeted to low-income residents, nonprofit hospitals were more likely to target than investor-owned hospitals. A majority of nonprofit and investor-owned hospitals offered some community services at no charge. When they did charge a fee, few hospitals of either ownership type reported that the revenues collected for a particular service covered its costs.

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## Issues Addressed by Survey

We undertook a nationwide survey of hospitals to ascertain the types and extent of activities that they perceive as providing community benefits. Providing acute medical services to people unable to pay is only one measure of the extent to which communities benefit from the presence of a hospital. For example, some hospitals, though not reporting high amounts of uncompensated care, may serve their communities' low-income residents through clinics that offer services or low-cost or free screening to all community residents. Data are not collected on the extent of such community services provided, and the associated costs are frequently not reported in uncompensated expense statistics.

Our survey questionnaire asked hospital officials whether they had offered various broad categories of community services during their most recent fiscal year. It also asked them more detailed questions regarding the characteristics of the services they offered and their costs. The categories of community services we asked about included

- health screening, such as cancer or cholesterol screening;
- health education, such as clinics to help people stop smoking or classes to help prevent the spread of AIDS;
- clinic services, such as ambulatory clinics or clinics targeted to specific groups in the community, such as glaucoma clinics for the elderly;
- immunizations, such as flu shots for the elderly;
- housing, usually provided to family members of patients;
- transportation services for patients;
- food and clothing drives sponsored for the poor; and
- basic science or clinical research subsidies.

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## Some Distinctions Between Community Services Delivered by Nonprofit and Investor-Owned Hospitals

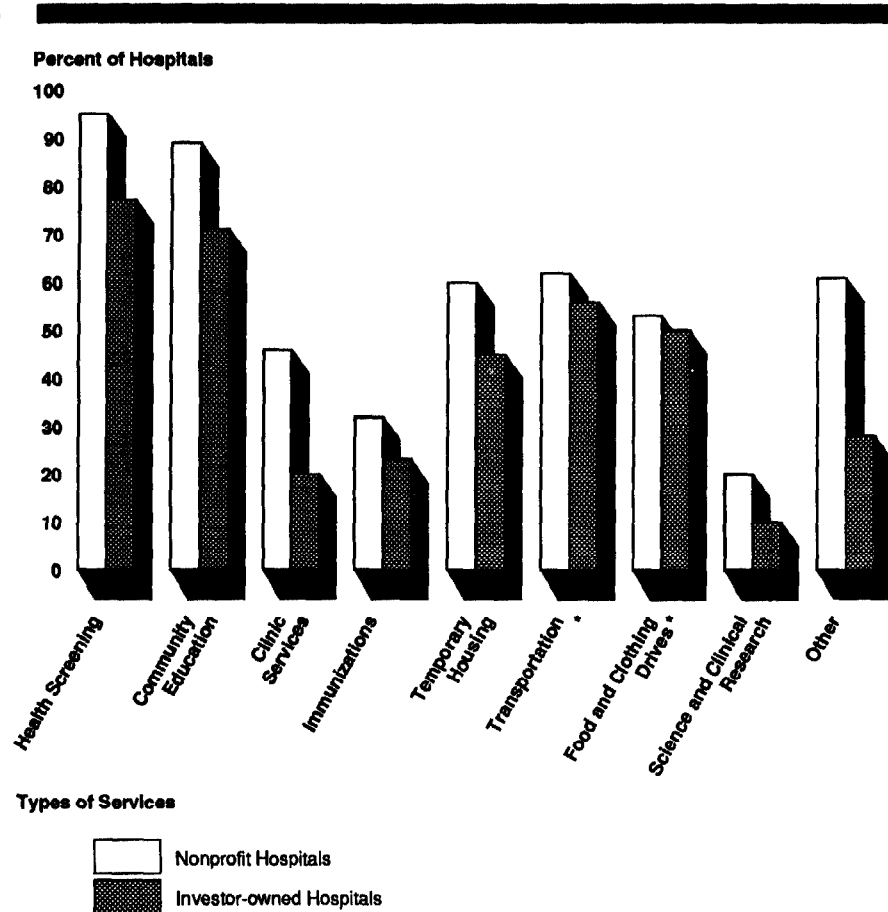
One way we assessed the delivery of community services by nonprofit hospitals was by comparing the types of services and method of delivery they used with those offered by investor-owned hospitals responding to our survey. Though a majority of both types of hospitals offered a wide range of community services, a higher percentage of nonprofit than investor-owned hospitals offered such services and provided them to more people. A majority of services provided by nongovernmental hospitals were not targeted to low-income persons. Nonprofit hospitals were more likely to target than investor-owned hospitals, however. Nonprofit and investor-owned hospitals were equally likely to charge a fee for community services, but nonprofit hospitals were more likely to cover the costs of providing the services.

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## Types of Services Offered

We estimate that nonprofit hospitals provided community services to at least 54 million people, while investor-owned hospitals served at least 5 million. On average, a nonprofit hospital served about twice as many people as an investor-owned hospital of the same size. Figure 4.1 shows the percentage of responding nonprofit and investor-owned hospitals reporting that they provided various types of community services during 1988.

Figure 4.1: Types of Community Services Offered, by Hospital Ownership Type



Note: These estimates have confidence intervals of no greater than plus or minus 8 percentage points.

\*Not statistically significant at the 95-percent confidence level.

The community services reported were generally diagnostic or preventive tests or lectures. In comparing nonprofit and investor-owned hospitals that reported providing one of these types of services, we found that both types of hospitals were likely to provide similar services. For example, both nonprofit and investor-owned hospitals identified blood pressure tests, cholesterol tests, and various types of cancer screening as their major health screening services. The most frequently reported services under each community service category are shown in appendix III.



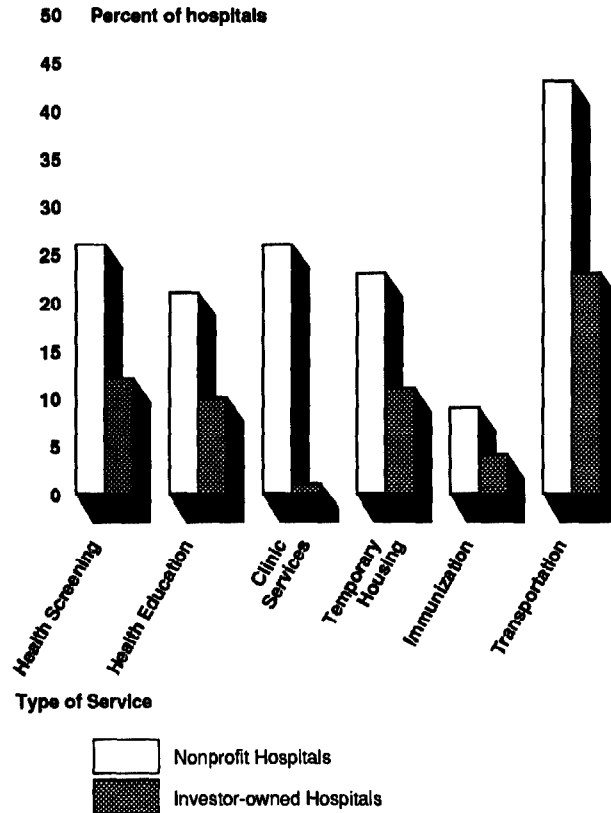
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## Nonprofit Hospitals More Likely to Target Services to Low-Income People

Community services often reflect the character of the neighborhood in which the hospital is located. A hospital in a relatively high-income neighborhood may offer types of services designed to attract paying patients or increase its market share, such as free childbirth classes to women who plan to use the hospital's birthing center. In contrast, a hospital in a poor urban area may offer prenatal care as a service to women who would otherwise not receive treatment.

In our survey, hospital administrators reported that a majority of services were not targeted to a low-income population. Nonprofit hospitals were more likely than investor-owned hospitals to target services to low-income people. Sixty-eight percent of nonprofit hospitals and 39 percent of investor-owned hospitals reported that they targeted at least one program. Figure 4.2 compares the extent to which nonprofit and investor-owned hospitals targeted each type of community service to low-income people.

**Figure 4.2: Percent of Hospitals That Target Each Community Service to Low-Income People**

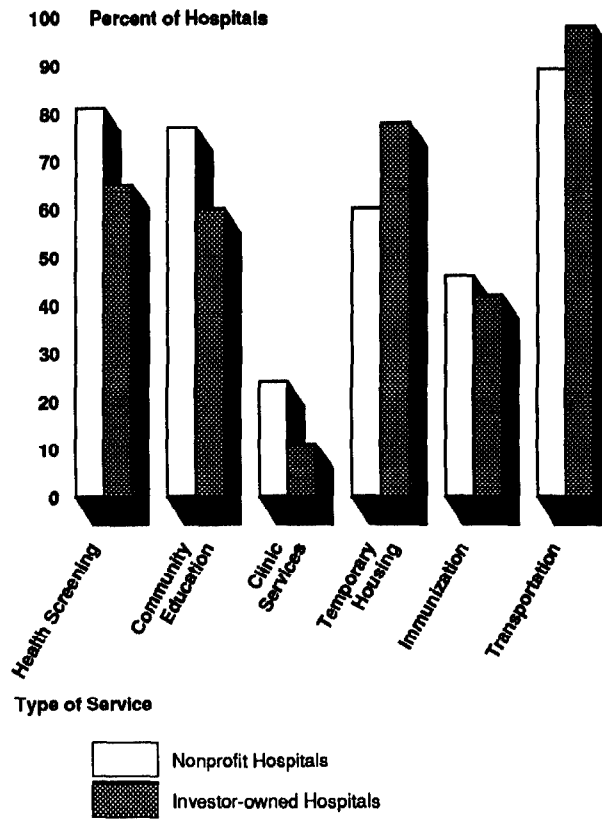


Note: These estimates have confidence intervals of no greater than plus or minus 11 percentage points.

**Nonprofit and Investor-Owned Hospitals Were Equally Likely to Offer Community Services at No Charge**

Another way to differentiate between community services is to distinguish services that were offered free from those that were generally offered at a fee. Most private hospitals offered some community services at no charge. Although philanthropic grants may subsidize the provision of these services in nonprofit hospitals, these hospitals were no more likely to provide some community services at no charge than were investor-owned hospitals. Figure 4.3 shows the extent to which some services were provided to the community at no charge.

**Figure 4.3: Percent of Hospitals That Offer Each Community Service at No Charge, by Hospital Ownership Type**

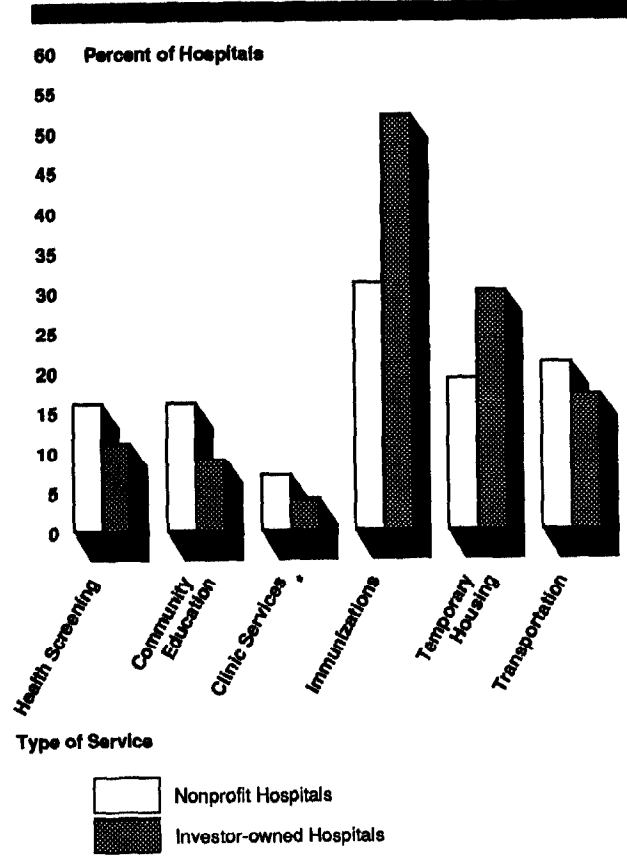


Note: These estimates have confidence intervals of no greater than plus or minus 10 percentage points.

### Nonprofit Hospitals More Likely to Cover Costs of Providing Service

Both nonprofit and investor-owned hospitals did not generally recover the costs of providing community services by charging fees to recipients. Nonprofit hospitals were more likely than investor-owned hospitals to recover the costs of delivering particular community services. Figure 4.4 shows the extent to which the costs of some community services exceeded or equaled the revenues generated.

Figure 4.4: Percent of Hospitals That Reported Community Services for Which Revenues Covered Costs, by Hospital Ownership Type



Note: These estimates have confidence intervals of no greater than plus or minus 5 percentage points.

\*Not statistically significant at the 95-percent confidence level.

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# Conclusions and Matters for Congressional Consideration

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## Conclusions

As reflected in IRS rulings implementing the tax code, federal policy regards most nonprofit hospitals as charitable institutions. Although IRS formerly specified that tax-exempt hospitals provide charity care commensurate with their financial ability, it eliminated this criterion in the late 1960s.

There are significant disparities in the level of charity care that nonprofit hospitals provide. Typically, in the states we reviewed, large urban teaching and public hospitals provide a disproportionate share of charity care. Further, our review of several communities indicates that it is not uncommon for nonprofit hospitals' strategic goals to resemble those of investor-owned institutions in that they relate to increasing market share, rather than targeting underserved populations or addressing particular health problems of their communities. Finally, many nonprofit hospitals' community service activities do not distinguish them from investor-owned hospitals.

Clearly, the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak for many nonprofit hospitals. To the extent that one of the goals of the tax exemption is to recognize the charitable role of the hospital and encourage hospitals to continue or expand current levels of charity care and other services to the poor in an increasingly competitive hospital environment, changes in tax policy may be needed. One option would be to reestablish the link between tax exemption and the level of charity care provided by hospitals. In this way, the tax exemption would be retained by nonprofit hospitals providing a valuable community service. On the other hand, those that do not provide a reasonable level of charity care or other services to the poor would have their tax exemption withdrawn.

Although IRS could revise the standard for charitable hospitals without a legislative mandate, given the important implications for health and tax policy, it would be preferable to have congressional direction for such a policy change.

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## Matters for Consideration by the Congress

Currently, there are no requirements relating hospitals' charitable activities for the poor to tax-exempt status. If the Congress wishes to encourage nonprofit hospitals to provide charity care to the poor and underserved and other community services, it should consider revising the criteria for tax exemption. Criteria for exemption could be directly linked to a certain level of (1) care provided to Medicaid patients, (2)

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free care provided to the poor, or (3) efforts to improve the health status of underserved portions of the community.

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# Legal Basis for Hospital Tax Exemption

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Unlike some other activities, such as education, hospital activities are not specifically exempt in the tax code. However, IRS has long interpreted qualifying hospitals to be charitable organizations, which are specifically exempt. Charitable activities include those that relieve the poor, distressed, or underprivileged; those that lessen the burdens of government; and those that promote social welfare.

Unlike some types of tax-exempt organizations, which rely more on donations and endowments and less on fees, most tax-exempt hospitals principally provide services for fees, produce income, and appear in many respects like taxable, investor-owned businesses.

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## Tax-Exempt Law and Theory Focuses on Organizations, Not Operations

Before 1969 IRS interpreted the status of nonprofit hospitals as charitable organizations to require that they provide care to those unable to pay in order to qualify for a continued tax exemption. Since 1969, however, IRS has not specifically required such care, so long as the hospital provides benefits to the community in other ways. Treating patients receiving public assistance, allowing physicians from the community to have privileges to admit patients, and using surplus funds to make hospital improvements are indications of public benefit that IRS has most recently deemed sufficient to qualify a hospital for the income tax exemption.

Nonprofit organizations can be profitable; however, the profits cannot be paid out to owners or anyone else associated with the organization. Instead, they must be devoted to the organization's tax-exempt purpose.<sup>1</sup> In exchange for the above restrictions, the organization is exempted from federal income tax and receives a number of subsidies and advantages, such as access to tax-exempt bond financing and enhanced access to individual philanthropy.

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## Historical Basis for Tax Exemption

Earlier in this century, when hospitals customarily provided a great deal of care to nonpaying patients, they could easily be categorized as charities. As the percentage of paying patients in hospitals increased due to the growth of health insurance and the creation of public medical assistance, IRS identified other criteria that might indicate that a hospital was organized and operated exclusively for charitable purposes and not for the benefit of private interests.

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<sup>1</sup>Burton Weisbrod. The Nonprofit Economy, Harvard University Press, 1988.

In 1956, IRS issued a revenue ruling establishing criteria to be met by hospitals in order to qualify for the income tax exemption contained in section 501(c)(3). Relying upon a 1934 Supreme Court decision directing that section 501(c)(3) not be narrowly construed, IRS determined that the term "charitable" in that section "contemplates an implied public trust constituted for some public benefit, the income or beneficial interest of which may not inure to the benefit of any private shareholder or individual." The ruling set forth four criteria to be met by a hospital requesting the tax exemption: (1) that it be organized as a nonprofit organization for the care of the sick, (2) that it operate to the extent of its financial ability for those not able to pay for the services rendered, (3) that its facilities not be restricted to a particular group of physicians, and (4) that earnings not inure directly or indirectly to the benefit of any private shareholder or individual.

In 1969, IRS expressly modified its earlier ruling to remove requirements relating to caring for patients without charge or at rates below cost. IRS also held that in considering whether a nonprofit hospital claiming exemption is operated to serve a private benefit, it would weigh all of the relevant facts and circumstances in each case. IRS indicated that the absence of particular factors or the presence of others will not necessarily be determinative. The hospital described in the ruling provided care to indigents only in its emergency room. <sup>2</sup>

In a 1983 revenue ruling, IRS decided to extend the tax exemption to a hospital that did not operate an emergency room, because a state health planning agency determined that an emergency room would provide unnecessary and duplicative services. IRS held that several aspects of the facility indicated that the hospital operated exclusively to benefit the community. For example: (1) the board of directors was drawn from the community; (2) the hospital established an open medical staff policy allowing physicians from the community to practice; (3) the hospital treated persons paying their bills with the aid of public programs like Medicare and Medicaid; and (4) surplus funds were used to improve facilities, equipment, patient care, medical training, education, and research. The hospital did not provide care to indigent patients.

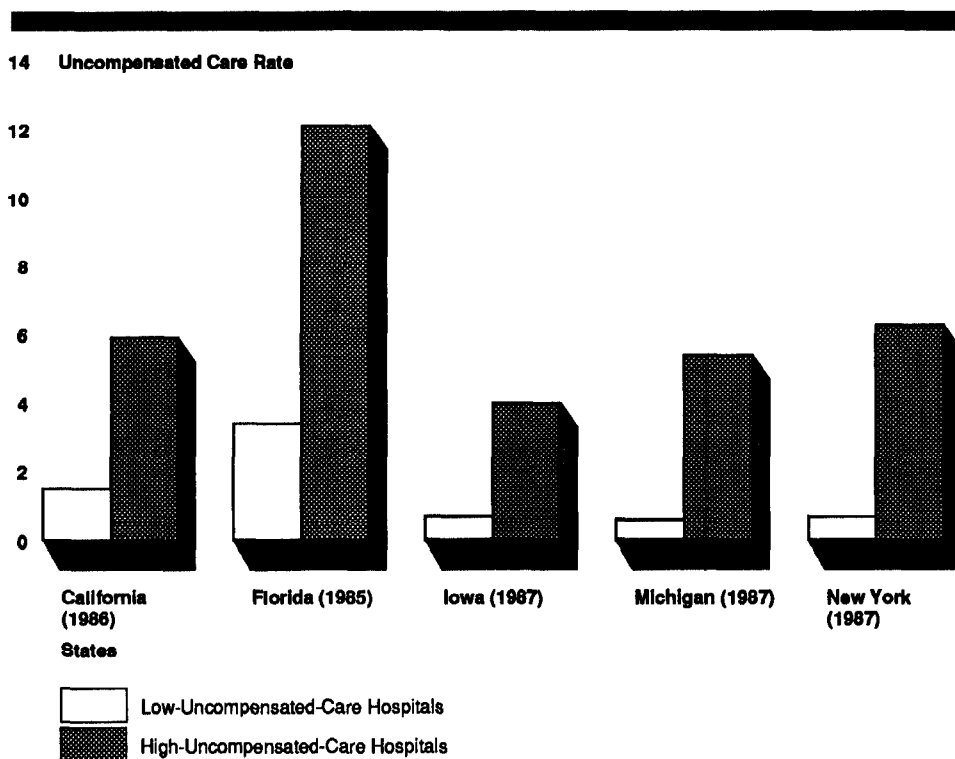
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<sup>2</sup>Groups representing indigent patients challenged the 1969 revenue ruling in federal court, asserting that the ruling encouraged hospitals to deny services to indigents and constituted an erroneous interpretation of section 501(c)(3). The case was dismissed on other grounds. The Supreme Court ruled that the groups failed to establish their standing to bring the suit. Simon v. Eastern Kentucky Welfare Rights Organization, 426 U.S. 26 (1976).



# Differences Between Low- and High-Uncompensated-Care Hospitals

**Figure II.1: Uncompensated Care Rates for Low- and High-Uncompensated-Care Hospitals**

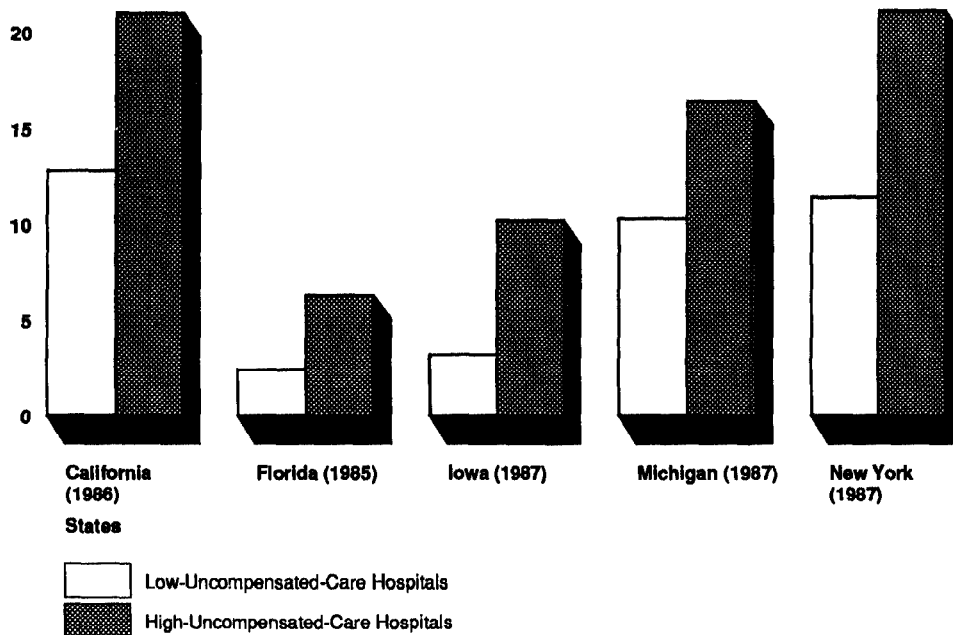


Note: We ranked the nonprofit hospitals by their rates of uncompensated care from lowest to highest. Low-uncompensated-care hospitals were below the 25th percentile, while high-uncompensated-care hospitals were above the 75th percentile.

**Appendix II  
Differences Between Low- and High-  
Uncompensated-Care Hospitals**

**Figure II.2: Medicaid Patient Mix of  
Low- and High-Uncompensated-Care  
Nonprofit Hospitals**

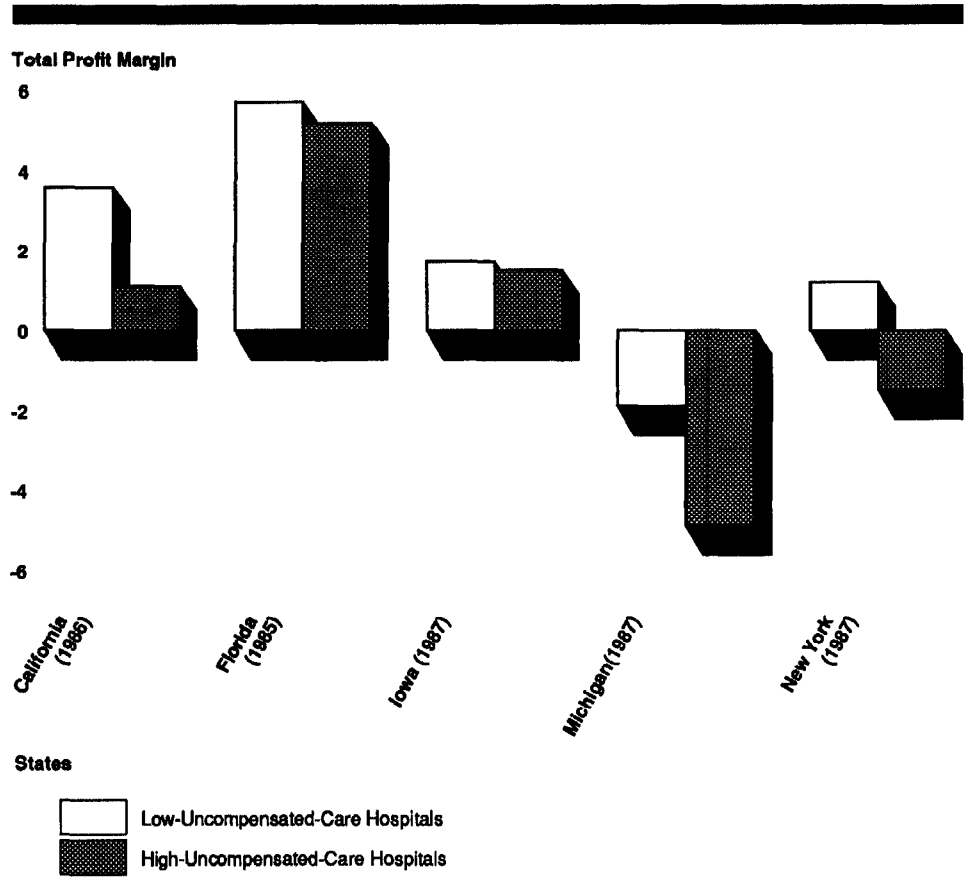
25 Medicaid as a Percent of Total Patient Days



Note: We ranked the nonprofit hospitals by their rates of uncompensated care from lowest to highest. Low-uncompensated-care hospitals were below the 25th percentile, while high-uncompensated-care hospitals were above the 75th percentile.

**Appendix II  
Differences Between Low- and High-  
Uncompensated-Care Hospitals**

**Figure II.3: Total Profit Margins of  
Low- and High-Uncompensated-Care  
Nonprofit Hospitals**



Notes: Total profit margin is the difference between total net revenue and total expense, divided by total net revenue.

We ranked the nonprofit hospitals by their rates of uncompensated care from lowest to highest. Low-uncompensated-care hospitals were below the 25th percentile, while high-uncompensated-care hospitals were above the 75th percentile.

# Most Frequently Reported Community Services, by Ownership Type, for Each Service Category

<b>Nonprofit hospitals</b>	<b>Investor-owned hospitals</b>
<b>Health Screening Services:</b>	
Cholesterol (67)	Cholesterol (73)
Cancer (62)	Blood pressure (63)
Blood pressure (62)	Glucose (43)
Health fairs/promotions (45)	Cancer (40)
Glucose (40)	Health fairs/promotions (36)
Glaucoma (17)	Lung (20)
Lung (14)	Glaucoma (9)
<b>Health Services Education:</b>	
Obsterical/gynecological (51)	Heart disease (34)
Diabetes (39)	Diabetes (33)
Heart disease (28)	Obsterical/gynecological (28)
Cancer (28)	Cancer (25)
Emergency procedures (27)	Emergency procedures (23)
AIDS (21)	Smoking cessation (20)
Lectures (21)	Hypertension (15)
Health fairs/promotions (19)	Health fairs/promotions (14)
Smoking cessation (19)	Stress management (14)
Cholesterol (14)	Nutrition (13)
Nutrition (12)	Cholesterol (12)
Drug/alcohol (11)	AIDS (11)
Weight control (11)	Weight Control (10)
<b>Clinic Services:</b>	
Women and children (64)	General walk-in (36)
General walk-in (42)	Eye, ear, nose, and throat (23)
Eye, ear, nose, and throat (17)	Senior citizens (16)
Specific diseases (16)	Women and children (14)
Cancer (12)	Specific diseases (7)
Mental health (9)	Cancer (5)
<b>Other Community Services:</b>	
Meeting rooms (29)	Meeting rooms (25)
Senior citizens' programs (23)	Holiday drives (24)
Health information services (13)	Fitness programs (19)
Meals (13)	Senior citizens' programs (18)
Lifelines (10)	Meals (11)

Note: Percentage of hospitals offering the services is in parentheses.

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