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Does Nonprofit Hospital Community Benefit Vary by State?

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Abstract

The initial analysis of the revised Internal Revenue Service Schedule H community benefit report revealed that only about 5% of these dollars are allocated for community health improvement activities. These results have prompted suggestions for improved community health via community benefit reform, given the poor performance of the US population health system. However, if such a reform were enacted, it would have differential impacts across states due to variation in nonprofit hospitals, expenditures, and community benefit allocations. We model this variation, indicating that the range in per capita benefit across states would approximately range from \$30 to \$335. This variation should be taken into account as community benefit reform is considered.

Keywords

community benefit; health policy; hospitals; public health finance; nonprofit

The Internal Revenue Service (IRS) revised and standardized the reporting requirements of nonprofit hospitals in 2010, which verify their conditional tax-exempt status. These filings are officially Schedule H of IRS form 990, the standard annual tax filing for nonprofit organizations. Eligible nonprofit hospitals must report on efforts to improve health in their service market, known as community benefits, to receive tax-exempt status. We recently reported 2009 Wisconsin results indicating that Wisconsin hospitals reported \$1.064 billion in community benefits, or 7.52% of total average hospital expenditures,¹ although considerable variation in amount and allocation existed across individual hospitals.

A subsequent similar national analysis has shown, on average, a similar percentage (7.5%) for all non-profit hospitals in the country.² However, because the percentage of nonprofit hospitals varies by state, so too would the amount of “benefit” available to individuals in each state or in the state overall. This study identifies this variation in nonprofit hospital distribution and uses this information to project the potential amount of community benefit available in each state.

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This is important because of the growing appreciation of the impact of nonmedical care determinants of health and the current limited resource streams to support improvements.^{3,4} Many assume that community benefit allocations go primarily to charity care and community health improvement activities based on the historical intent of community benefit, but this is not the case. In the national analysis, 25% of total community dollars were reported for charity care and 5% for community health improvement. There is increasing discussion regarding greater funding of community and public health activities from community benefit allocations, as the need for charity care could decline under the Affordable Care Act due to decreases in the uninsured population.^{5,6} Community benefit could be a more robust and dependable funding stream for population health improvement, as well as foster improved relationships between public health employees and hospitals. However, the policy consequences of any such reforms would likely have different impacts in different parts of the country.

Data and Methods

We purchased data on ownership type, number of beds, revenue, and expenditures for 2012 from the American Hospital Directory, a private hospital research firm,⁷ and sorted them by state. Our focus was on general medical hospitals and thus strictly designated mental health, rehabilitative, and long-term care facilities were omitted from the results. Data complexities required limiting our analysis to Medicaid or Medicare participating hospitals with a corresponding Centers for Medicare & Medicaid Services identifier. These exclusions removed an estimated 6% of the raw data. We believe this amount to be negligible, as most general medical hospitals participate in one or both of these public insurance programs, although it might minimally underestimate the for-profit share. The total number of nonprofit hospitals examined was 2658.

The state average total community benefit percentages were graciously provided by Young and colleagues² at Northeastern University from the data set used in their national study cited earlier. These state averages excluded hospitals reporting no community benefits (66 hospitals nationally) and those with allocations greater than 45% of expenditures (6 hospitals). These state averages were then applied to each state's nonprofit hospital expenditures for 2012 to determine an estimate of the total number of community benefit dollars. Expenditures were calculated as net patient revenue minus yearly income or profit. Estimated state per capita community benefit resources were obtained by dividing this number by the state population in 2012, thus attributing the state average to all individual facilities. The national study found the interquartile range across all hospitals to be from 3.6% to 9.1%.

The IRS requires hospitals to report community benefit activities in the following categories:

- *Financial assistance at cost*, commonly referred to as charity care. This is free or reduced care provided to those financially unable to afford treatment, such as the underinsured or those not enrolled in Medicaid.

- *Unreimbursed Medicaid*, which is the “net cost” to the organization for providing these programs. It is the disparity between cost of treatment for Medicaid patients and the government reimbursement rate.
- *Other unreimbursed means tested government programs*, which is the “net cost” to the organization for providing these programs. It is the disparity between cost of treatment for these patients and the government reimbursement rate.
- *Subsidized health services* are clinical inpatient and outpatient services provided by the hospital despite a financial loss, or would be otherwise undersupplied to the community. Typically, these are services with thin or negative profit margins for the hospital, such as burn units, and meant to insulate the hospital financially for providing these services.
- *Community health improvement services* include activities or programs subsidized by the organization for the express purpose of community health improvement, documented by a community health needs assessment. Examples include immunization programs for low-income children or diabetes health education courses.
- *Health care professional education* includes the net cost associated with educating certified health care professionals.
- *Research* includes the cost of internally funded research as well as the cost of research funded by a tax-exempt or government entity.
- *Cash and in-kind contributions* include contributions, monetary or otherwise, to community benefit activities made by the organization to community groups. These activities must be marginally health related, such as partially sponsoring a local, open athletic race.

Total community benefit is the total amount of dollars reported across the categories. There are no standards for either the total amount or allocation within categories. In the national study, 45% was reported for unreimbursed Medicaid and 15% for subsidized clinical services.

Results

Overall, a total of 4708 hospitals were examined, with a distribution of approximately 56% nonprofit, 23% governmental, and 20% for-profit. The Table shows that the nonprofit percentage of hospitals varied from a low in Alabama at 22.4% to a high in Delaware, Rhode Island, and Vermont at 100%. Governmental hospitals had a lesser range with a low of 40% (North Dakota, New Hampshire, Delaware, Rhode Island, and Vermont) to 52% (Hawaii). For-profit hospitals ranged from 0% (Vermont, Delaware, Minnesota, Rhode Island, and Vermont) to 45% (New Mexico), respectively (data not shown). The second column displays hospital expenditure for the 2012 financial year, which totaled \$489 billion for the 2658 hospitals examined. Column 3 is from the Northeastern data set, which displays 2009 state average community benefit percentage. Nationally, 7.5% of total nonprofit hospital expenditures were spent on community benefit activities. Three states—Wyoming,

Colorado, and Vermont—all had averages greater than 11%, with Wyoming having the highest statewide average of 11.92%. The lowest state average was observed in North Dakota at 3.76% of expenditures. This was the only observation below 4%, but 5 states had state averages in the 4% range.

The last 2 columns of the Table show our projections of community benefit resources in total and per capita that may be available in each state. For the entire country, given our assumptions, this amount would be more than \$36.7 billion in 2012, with great variation across the states in relation to the relative number of nonprofit facilities, beds, and revenues. This figure was calculated by summing the individual state projection totals. The last column of the Table divides the state expenditure number by the state population to arrive at a projection of the per capita amount of community benefit allocation that would have been made, given our assumptions. The national average would be approximately \$119 per person annually, but with a range from \$30 in Alabama to \$335 in Vermont.

The results for national distribution of nonprofit hospital and community benefit dollars per capita are displayed geographically in Figures 1 and 2, respectively. In both figures, the states were organized into 5 equal-size groupings, with roughly 10 states in each. These hospitals tend to, although not exclusively, cluster in the Northeast and Midwest. Figure 2 exhibits potential per capita community benefit dollars on the basis of our projection. The distribution across the country is generally similar to that shown for the distribution of hospitals as would be expected; however, states such as Virginia, Kentucky, Tennessee appear to have more per capita dollars than states with similar community benefit totals, and the opposite was observed in Oregon and Arkansas. The Spearman's rank correlation between percent of non-profit hospital share and projected per capita dollars was 0.402. Hawaii, not pictured, fell into the second smallest range on both maps. Alaska, also not pictured fell into the second and third smallest range, respectively.

Discussion

These findings are currently relevant because of the need for more robust and dependable revenue streams for nonmedical public and population health investments. While there exists other potential public and private sources, hospital community benefit offers a starting point since it is a legal requirement already. However, any successful attempt to increase the resources devoted to community health improvement from this source would have differential impact across states. We believe that this is the first report to attempt to characterize the potential quantitative variation in community benefits available across states. The range is, not surprisingly, correlated with the share of nonprofit hospitals at a state level, although we believe that both of these variations are not widely appreciated.

We are not certain that a per capita state measure is the best way to represent this variation, although fundamentally necessary to control for state population size. There are several limitations to this approach. First, the percentages applied to each state were averages from 2009 applied to 2012 expenditures, because they are the only years for which they are available. We expect that there will be a year-to-year variation in total allocation, so future

projections should use the current state community benefit figures as they become available from future analysis of Schedule H data.

Second, using the entire state population to project a per capita amount implies that these benefits are equally distributed across the state, which is certainly not the case for several reasons. Nonprofit hospitals vary in their geographic distribution within states, as well as across the country. Third, individual hospitals' community benefit allocations and community health commitments vary by philosophical and policy differences. Finally, hospital services and community benefit spending often cross state borders.

Since there is no guidance from the IRS to hospitals on either the total amount reported or how to allocate among the 8 categories, the specific benefit to any individual in a state will also vary widely on a hospital-to-hospital basis. For example, the largest allocation category is unreimbursed Medicaid, which, by definition, reaches a limited subset of the state population and varies widely in generosity of benefits across states.

Unreimbursed costs of medical education could also be a large contributor to the total community benefit in states with large teaching hospitals. These benefits would be unevenly distributed across the state on the basis of locations of large teaching hospitals. In addition, charity care is likely most available to patients geographically close to an individual institution, as are likely community health improvement and community building activities. Some of these limitations could be addressed in part with substate-, regional, or community-level analysis, which has yet to be performed.

Despite these limitations, we believe that this analysis is a valuable initial step in beginning to understand the variation of community benefit across the country and should be useful to policy makers as they consider further reform of community benefit policy. Such projections will become increasingly important as the need for charity care may be reduced under the Patient Protection and Affordable Care Act and since the Affordable Care Act now requires hospitals to draft community health needs assessments once every 3 years.⁵ These assessments must define the community the hospital is serving, identify particular needs of that community, and have a plan to address these established needs.^{1,5} In those states with a substantial number of nonprofit hospitals, community benefit can be an important source of the broader population health investments that are required for improving overall health outcomes and reducing disparities.^{8,9}

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Figure 1.
Nonprofit Hospital Percent Distribution by State, 2012

Figure 2.
Estimated Community Benefit Dollars Per Capita by State

TABLE

State Nonprofit Hospital and Community Benefit Data and Projections, 2012

State	Nonprofit Hospitals (% of State Total Hospitals)	State Total Hospital Expenditures, Billions	State Average Community Benefit (% of 335 Hospital Expenditures)	Community Benefit Dollars by State, Millions	Community Benefit Dollars Per Capita
Total	2658 (56.5)	\$489.1	7.5%	\$36,709	\$119
AK	8 (50.0)	\$0.9	8.68%	\$81	\$114
AL	22 (22.4)	\$2.9	4.79%	\$141	\$30
AR	44 (56.4)	\$3.7	6.24%	\$233	\$80
AZ	41 (61.2)	\$9.0	9.28%	\$831	\$130
CA	165 (51.7)	\$44.7	9.11%	\$4,069	\$109
CO	39 (52.7)	\$6.4	11.15%	\$712	\$142
CT	26 (89.7)	\$8.9	7.23%	\$642	\$180
DC	6 (75.0)	\$2.7	5.88%	\$157	\$262
DE	6 (100)	\$2.2	7.66%	\$167	\$186
FL	70 (37.8)	\$21.2	8.53%	\$1,811	\$96
GA	51 (35.7)	\$8.5	7.14%	\$609	\$63
HI	9 (42.9)	\$1.5	7.85%	\$121	\$89
IA	57 (49.1)	\$4.5	4.65%	\$207	\$68
ID	13 (33.3)	\$2.0	5.14%	\$101	\$65
IL	142 (78.9)	\$25.6	8.60%	\$2,203	\$172
IN	67 (57.3)	\$10.9	9.46%	\$1,029	\$159
KS	44 (32.1)	\$3.4	6.29%	\$213	\$75
KY	65 (69.1)	\$9.1	8.30%	\$755	\$174
LA	29 (22.8)	\$4.7	4.84%	\$230	\$50
MA	52 (75.4)	\$16.1	6.75%	\$1,088	\$166
MD	42 (93.3)	\$11.5	6.33%	\$727	\$126
ME	30 (88.2)	\$3.9	7.63%	\$299	\$225
MI	101 (77.1)	\$19.7	6.31%	\$1,243	\$126
MN	95 (73.1)	\$12.3	7.90%	\$971	\$183
MO	65 (56.5)	\$13.3	6.22%	\$828	\$138
MS	24 (25.3)	\$2.5	4.71%	\$118	\$40

State	Nonprofit Hospitals (% of State Total Hospitals)	State Total Hospital Expenditures, Billions	State Average Community Benefit (% of 335 Hospital Expenditures)	Community Benefit Dollars by State, Millions	Community Benefit Dollars Per Capita
MT	50 (86.2)	\$2.7	5.58%	\$150	\$152
NC	63 (57.3)	\$12.2	6.62%	\$810	\$85
ND	40 (95.2)	\$2.0	3.76%	\$75	\$112
NE	45 (50.6)	\$3.9	4.44%	\$171	\$94
NH	24 (92.3)	\$3.6	9.40%	\$342	\$260
NJ	58 (84.1)	\$17.2	6.90%	\$1,186	\$135
NM	11 (33.3)	\$1.8	10.03%	\$176	\$86
NV	12(35.3)	\$1.8	4.76%	\$84	\$31
NY	160 (85.6)	\$43.3	6.75%	\$2,924	\$151
OH	130(73.4)	\$28.2	8.07%	\$2,273	\$197
OK	36 (30.5)	\$3.4	6.43%	\$218	\$58
OR	43 (75.4)	\$6.4	8.50%	\$542	\$141
PA	135 (81.8)	\$28.9	7.00%	\$2,023	\$159
RI	11 (100)	\$2.9	8.67%	\$249	\$236
SC	21 (35.0)	\$4.0	8.17%	\$329	\$71
SD	44 (80.0)	\$2.1	5.90%	\$122	\$150
TN	45(39.1)	\$8.7	10.10%	\$876	\$138
TX	121 (30.6)	\$21.5	6.92%	\$1,486	\$59
UT	23 (53.5)	\$2.7	7.72%	\$211	\$77
VA	62(72.1)	\$11.4	7.07%	\$804	\$291
VT	14(100)	\$1.8	11.67%	\$209	\$335
WA	38 (42.7)	\$9.8	5.81%	\$571	\$85
WI	116(92.8)	\$12.7	7.56%	\$962	\$169
WV	30 (60.0)	\$3.6	7.47%	\$267	\$144
WY	13(50.0)	\$0.5	11.92%	\$64	\$113