American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

April 15, 2013

Working Group on Charitable and Exempt Organizations
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Subject: Hospital Tax Exemption and the Community Benefit Standard

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to provide the working group its views on the importance of hospital tax-exemption to access to health care services for all Americans.

COMMUNITY BENEFIT STANDARD

Since the 1960's, Congress and the courts have examined, refined, and affirmed hospital tax exemption. Most recently, as part of the *Patient Protection and Affordable Care Act* (ACA), Congress established further refinements of the 1969 community benefit standard, the basic framework for hospital exemption. The Internal Revenue Service (IRS) is still in the process of issuing rules implementing the new law, but hospitals are required to be in compliance today.

Decades ago, the courts and Congress rejected setting a percentage of charity care as a condition for hospitals' gaining or maintaining tax-exempt status. The rejection was not based on unfulfilled hope that the Medicare and Medicaid programs would fully address concerns about the uninsured, but rather the changing nature of hospitals themselves. As the United State Supreme Court found:

> "[T]he concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the 'delivery' of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and because of increasing costs, physician specialization, shortage of general practitioners, and other factors is often compelled to turn, whenever a medical problem of import presents itself." Abbott Laboratories v. Portland Retail Druggists Ass'n., 425 U.S. 1, 11 (1976).

As hospitals assumed "a larger community character," it became increasingly clear to the courts and, apparently, to Congress that a percentage test was outdated and needed to be replaced with a standard that reflected hospitals' need to serve the entire community. The leading commentator on hospital tax-exempt status, Robert Bromberg, described it as the "humanitarian approach": "[I]n determining whether a nonprofit hospital is operated in furtherance of charitable purposes, the proper touchstone should be the more widely accepted humanitarian approach, which focuses on the hospital's delivery of health care to the community, rather than the public burden approach, which refuses to look beyond the quantum of free or below-cost care provided to the poor." In keeping with the humanitarian approach, in 1969 the IRS replaced its outdated percentage test with the community benefit standard in Revenue Ruling 69-545.

The current community benefit standard ensures that hospitals fulfill their charitable obligations through the appropriate mix of free care, financial assistance to low-income patients, subsidized health care, research, education and other community-building activities tailored to the needs of their communities. The IRS has long recognized five factors that would support a nonprofit hospital's tax-exempt status. These five factors are: (1) the operation of an emergency room open to all members of the community without regard to ability to pay; (2) a governance board composed of community members; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff with privileges available to all qualifying physicians.

The ACA created four new requirements for tax-exempt hospitals: (1) adoption of a written financial assistance policy and a policy relating to emergency medical care; (2) limitations on the amounts a hospital charges to individuals eligible for financial assistance for emergency or other medically necessary care; (3) limits on engaging in extraordinary collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance; and (4) that a community health needs assessment (CHNA) be conducted every three years. These provisions became effective for tax years beginning after March 23, 2010, except for the CHNA requirement, which is effective for tax years beginning after March 23, 2012. Failure to meet these requirements can result in fines, excise taxes or loss of tax exemption.

Among its virtues, the community benefit standard allows the community in which the hospital operates to determine the needs of its residents and the hospital to tailor its activities accordingly. That approach still works well for communities across the nation.

BENEFIT TO SOCIETY

Since 2000, hospitals of all types have provided more than $367 billion in uncompensated care to their patients. In 2011 alone, hospitals delivered more than $41.4 billion (in costs) in uncompensated care to patients and uncounted billions more in value to their communities through services, programs and other activities designed to promote and protect their health and well-being.

America's communities receive a positive return on their investment from the tax-exemption of non-profit hospitals. For two consecutive years, the AHA has collected the community benefit information that tax-exempt hospitals file with the IRS in a form called "Schedule H," and asked

Ernst & Young to analyze and report on it (Attachment 1). Schedule H forms were obtained directly from hospitals that filed them with IRS. Data from more than 900 hospitals around the nation shows that tax-exempt hospitals consistently provided benefits to the community valued at more than 11 percent of their total expenses, averaging 11.6 percent in 2010 and 11.3 percent in 2009. Direct benefits to patients, which include free care, financial assistance and spending to fill gaps in Medicaid underpayments, averaged 5.7 percent of expenses in both 2010 and 2009. In contrast, federal revenue forgone because of non-profit hospital tax-exemption represents an estimated 2.3 percent of hospital expenses in 2009.

IRS IMPLEMENTATION

As the IRS plays a more active role in oversight of hospital activities in this area, it has assumed a regulatory role. However, the IRS frequently claims that its guidance is exempt from the notice-and-hearing requirement of the *Administrative Procedures Act* (APA), and the agency has failed in the past to comply with the *Paperwork Reduction Act*. The AHA has drafted a proposal (Attachment 2) to assure hospitals have the protection of these laws, which the committee should consider as part of any tax reform effort.

COMMUNITY BENEFIT STANDARD IN PRACTICE

Today, hospitals of all kinds — urban and rural, large and small — are making their communities healthier in ways that are as diverse as the needs of each community. The men and women who work in hospitals are not just mending bodies. Their work extends far beyond the literal and figurative four walls of the hospital to where free clinics, job training efforts, smoking cessation classes, back-to-school immunizations, literacy programs and so many others. Below is just a sampling of the unique and innovative ways hospitals are improving the long-term health of their communities:

- Fletcher Allen Health Care in Burlington, VT, developed an outreach program that puts mental health clinicians "on the street" in downtown Burlington to provide access to services for those individuals dealing with substance abuse, homelessness and other unmet social service needs. Through this outreach program, the hospital works with the police department to respond to social service needs city-wide and has had succeeded in reducing disruptive behaviors and referrals to the court system. The program is now being replicated in other cities.
- Sparrow Health System in Lansing, MI, has committed to reduce childhood obesity and helping the children of their community become healthier. The Fitness Initiative Targeting Kids (FITKids) program was developed to reduce the problems and illnesses associated with excess weight by teaching at-risk children and families how to improve nutrition and physical activity by maintaining a healthier lifestyle. FITKids leadership and staff work with middle school teachers to create fun, interactive activities that strive to increase intake of fruits and vegetables; decrease intake of sugar- based drinks; and balance caloric intake with calories expended through physical activity.
- Jewish Hospital & St. Mary's Health Care in Louisville, KY, work together to offer the Jewish Diabetes Care Education and Screenings program. The program provides free nutrition and diabetes care weekly to patients at a rural clinic that serves the uninsured – including a growing number of Hispanic migrant workers and their families.

- Overlook Medical Center in Summit, NJ, developed the Breast Health Outreach to Minority Women program to help reduce racial and cultural disparities in the early detection of breast cancer through culturally sensitive outreach education with teen and adult women. Interactive discussions and educational materials are employed in a variety of settings, making it possible for outreach workers to reach more than 5,653 women a year. Patient navigator services guide these women through needed clinical breast examinations, mammography screening, and follow-up medical care.
- Cook Children's Health Care System in Fort Worth, Texas, brought together representatives from multiple parts of the health system to help create a seamless continuum of care for the children living in one of three local homeless shelters and to make health care easily accessible. The hospital provides financial support for an RN case manager, a social worker and other expenses for this initiative.
- St. Helena Hospital Napa Valley provides a series of medical screenings – for conditions including hypertension, diabetes and high cholesterol for their community, specifically farmers.
- San Francisco General Hospital's Mobile Eye Service (Eye Van) is staffed by a residency-trained optometrist and an ophthalmic technician and provides comprehensive eye exams that include screenings for glaucoma and diabetic eye disease. Without this service, these patients would not be able to get the ophthalmic care they need.
- Olean General Hospital in Olean, NY, established the Gundlah Dental Center to provide regular and timely dental care to the poor and underserved in the community. It offers affordable cleanings, fillings and simple extractions, as well as accommodating most dental emergencies.

CONCLUSION

As the Committee debates tax reform, we ask you to consider that current tax code incentives for the provision of health care have worked to provide access to hospital services in communities large and small across the country. The ability to obtain tax-exempt financing and to accept tax-deductible charitable contributions are two key benefits of hospital tax-exemption that work to make hospital services available where needed. The current community benefit standard for hospital tax exemption allows the community in which the hospital operates to determine the needs of its residents and the hospital to tailor its activities accordingly. That approach still works well for communities across the nation.

Attachment 1

Results from 2009 & 2010 Tax-Exempt Hospitals' Schedule H Community Benefit Reporting

April 2013

Prepared by Ernst & Young LLP

for the American Hospital Association

ERNST & YOUNG
Quality In Everything We Do

Introduction

Hospitals provide benefits to their communities in a multitude of ways. They not only provide financial assistance and absorb underpayments from means-tested government programs such as Medicaid, but also incur losses due to unreimbursed Medicare expenses and bad debt expenses that are attributable to charity care. In addition, they offer programs and activities to:

- improve community health,
- underwrite medical research and health professions education, and
- subsidize high cost health services.

Ernst & Young LLP (EY) assisted the American Hospital Association (AHA) in reviewing over 900 member hospitals' Form 990 Schedule Hs from tax years 2009 and 2010. In 2010, the hospitals and systems' reported total community benefits of 11.6 percent of their total hospital expenses, 5.7 percentage points of which resulted from expenditures for charity care and absorbing losses from Medicaid and other means-tested programs.[1] In 2009, total community benefits were reported as 11.3 percent of total hospital expenses, 5.7 percentage points of which resulted from expenditures for charity care and absorbing losses from Medicaid and other means-tested programs.

Table 1. Charity Care and Community Benefit as Percent of Total Hospital Expense, 2009 and 2010

Type of Benefit	2010	2009
Charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs	5.7	5.7
Total Benefits to the Community	11.6	11.3

This summary and comparison of the 2009 and 2010 Schedule Hs reports the financial costs incurred by hospitals in providing these community benefits, but doesn't measure the overall tangible and intangible benefits of improving their communities' health and economic well-being. Hospitals provided the Internal Revenue Service (IRS) with detailed descriptions of their community benefit programs as part of their filing. These descriptions often tell the hospitals' story beyond what can be found from the financial information alone.

Background

Beginning in January of 2011, AHA requested that their members provide EY with a copy of their filed 2009 Schedule H. In 2012, AHA repeated this request to their members for their filed 2010 Schedule H. In addition, EY invited its clients to submit their Schedule H forms.

As part of the Form 990 filing requirement, tax-exempt hospitals complete the Schedule H form. The form reports hospitals' benefit to the community through questions on free or discounted care; Medicaid underpayments, health research, education, bad debt expense attributable to patients eligible for financial assistance, and Medicare shortfalls; and other community benefits and building activities.[2]

Methodology

Data was collected and tabulated for the following sections of the Schedule H form:

- Part I on charity care and certain other community benefits
- Part II on community building activities
- Part III on bad debts and Medicare.

Based on the participating hospitals, the results are presented by the following segments of respondents:

- **Systems**[3] (A Schedule H with more than one licensed hospital)
- **Single Hospitals** (Schedule H with a single licensed hospital)
    - **Size** – *based on total hospital expense*[4]
        - Small – *less than $100M of total hospital expense*
        - Medium – *$100M to $299M of total hospital expense*
        - Large – *$300M or more of total hospital expense*
    - **Location** – *based on hospital zip code*
        - Urban and Suburban
        - Rural
    - **Hospital Type** – *based on facility response*
        - General Medical and Surgical
        - Children's
        - Teaching
        - Critical Access

Parts I, II, and III responses are reported as a percent of hospitals' or systems' total annual expenses.

- Average responses were calculated for all hospital systems, as well as for individual hospitals by their size, location, and type.
- Calculations made are simple averages of the Schedule Hs received. No weighting was applied for size of the hospitals.[5]
- Overall averages represent the average of results from both hospital systems (multiple hospitals responding on a consolidated basis on a single Schedule H) and individual hospitals.

Results

524 Schedule H's were received for fiscal year 2010 representing 972 hospitals or one-third of the hospitals required to file a Schedule H in 2010. [6] In the previous year, 571 Schedule Hs were received, representing nearly 900 hospitals or 30 percent of the hospitals required to file Schedule H.

Table 2 below shows the number of respondent hospitals' Schedule Hs based on size, location, and type categories.

Table 2. Responding Hospitals by Size, Location, and Type

Size	2010	2009
Small	188	172
Medium	121	185
Large	97	120
System	118	94
Location[7]		
Urban/Suburban	258	298
Rural	148	159
Type[8]		
General Medical	374	375
Children's	25	26
Teaching	97	107
Critical Access	91	85

Details of the breakout for each category are included below, along with a comparison of the respondents to the field using the American Hospital Association's 2009 and 2010 Survey of Hospitals.

Size

There were 524 individual hospitals and hospital systems in 2010 and 571 individual hospitals and hospital systems in 2009 that reported enough information to estimate total annual expense, and were therefore included in all the tabulations. "System" respondents were Schedule Hs that included more than one hospital reporting on a consolidated basis. System respondents were not included in other size calculations, as their response may include a mix of hospitals of different sizes.

Location

Individual hospitals were divided into urban/suburban and rural locations by matching zip codes to Census Bureau data on metropolitan areas. If a hospital chose not to include its zip code in its submission, the hospital was excluded from the tabulations by location. System respondents were not included in these calculations, as their response may contain both urban and rural locations.

Type

Individual hospitals identified up to three hospital types under which to classify themselves. For example, a hospital could indicate they qualify as general medical, teaching, and critical access categories, and therefore be included in results for each of the three types. Again, system respondents were not included, as they might include a mix of hospital types on their Schedule H.

Comparison to AHA Survey of Hospitals

Table 3. Responding Individual Hospitals Compared to AHA Survey of Hospitals, 2010

Hospital Type	Sch H Participants	AHA Hospital Survey
General Medical	92%	94%
Children's	6%	2%
Teaching	24%	26%
Critical Access	22%	33%
Location	**Sch H Participants**	**AHA Hospital Survey**
Urban/ Suburban	64%	53%
Rural	37%	47%
Bed Size Category	**Sch H Participants**	**AHA Hospital Survey**
99 or less	38%	54%
100-199	21%	18%
200-299	13%	11%
300 or more	28%	17%

Source: American Hospital Association 2011 Annual Survey of Hospitals and EY calculations

Based on a comparison with AHA's 2011 Annual Survey of Hospitals, the responding hospitals are representative of the field. The participants included tax-exempt hospitals located in thirty-five states throughout the country. Hospital types were compared to the 2011 AHA Hospital Survey. Individual responding hospitals are 14 percent of total hospitals in the field, while responding systems make up 20 percent of total hospitals in the field.

Hospitals' benefits to the community

In 2010, participating hospitals and systems reported an average of 11.6 percent of their total annual expense as providing benefits to the community. In 2009, participating hospitals and systems reported 11.3 percent of their total annual expense as providing benefits to the community.

Benefits to the community include charity care, Medicaid underpayments, community health improvement programs, health research and education, subsidized services, bad debt expense attributable to charity care, Medicare shortfall, and other community benefits and building activities. These are the financial costs incurred by hospitals in providing these community benefits, but do not include all the tangible and intangible benefits of improving their communities' health and well-being

Table 4 shows the average percent of total expense broken down to correspond to Parts I, II and III of the Schedule H form:

- Part I on charity care and certain other community benefits
- Part II on community building activities
- Part III on bad debts and Medicare.

Table 4. Hospitals' Benefit to the Community, by Type of Benefit
Average percent of total expense.

Hospital Category	Total Charity Care, Unreimbursed Means-Tested Government Programs and Other Benefits		Community Building Activities		Medicare Shortfall**		Bad Debt Expense Attributable to Charity Care		Total Benefits to the Community	
	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009
Overall*	8.2	8.4	0.1	0.1	2.8	2.4	0.5	0.4	11.6	11.3
System	8.1	9.3	0.1	0.1	2.9	3.8	0.5	0.5	11.6	13.7
Individual Hospitals: Size										
Small	7.3	7.3	0.1	0.1	2.9	2.0	0.8	0.5	11.1	9.9
Medium	7.5	8.0	0.1	0.2	2.6	3.6	0.5	0.5	10.8	12.3
Large	9.2	9.8	0.1	0.2	2.6	2.6	0.3	0.3	12.2	12.8
Individual Hospitals: Location										
Urban/ Suburban	8.2	8.3	0.1	0.2	2.9	3.0	0.6	0.4	11.7	11.9
Rural	7.2	8.1	0.1	0.2	2.6	2.7	0.6	0.5	10.5	11.5
Individual Hospitals: Type										
General Medical	7.7	7.9	0.1	0.2	2.9	3.2	0.6	0.4	11.3	11.7
Children's	12.6	14.1	0.1	0.4	2.1	0.5	0.2	0.2	15.0	15.2
Teaching	9.7	10.1	0.1	0.2	1.7	1.8	0.4	0.3	12.0	12.4
Critical Access	8.1	8.3	0.1	0.1	0.6	1.0	0.8	0.5	9.7	10.0

*Overall averages include hospital system and individual hospital results.

**Net shortfall (gross shortfall less surplus).

Charity care, means-tested programs, and other benefits

In addition to providing charity care and subsidizing Medicaid underpayments, hospitals fund community health improvement programs, underwrite health professions education, conduct medical research, subsidize certain health services, and make cash and in-kind contributions to community groups.

Table 5 shows the overall average for hospital systems and individual hospitals' charity care and unreimbursed means-tested government programs for 2009 and 2010, as well as other benefits to the community. In 2009 and 2010, charity care and unreimbursed costs from Medicaid and means-tested government programs were 5.7 percent of total hospital expenses. Adding this amount to expenditures for health professions education, medical research, cash and in-kind contribution and other benefits amounts to 8.2 percent of expenses in 2010 and 8.4 percent of expenses in 2009.

Table 5. Charity care, means-tested programs, and other benefits

Average percent of total expense.

Hospital Category	Charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs		Health professions education		Medical research		Cash and in-kind contributions to community groups		Other benefits		Total charity care, means-tested government programs, and other benefits*	
	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009
Overall	5.7	5.7	0.9	0.8	0.6	0.3	0.3	0.3	1.0	0.8	8.2	8.4
System	5.2	5.8	1.1	1.2	0.2	0.5	0.5	0.6	1.0	0.7	8.1	9.3
Individual Hospitals: Size												
Small	5.9	5.7	0.1	0.2	0.0	0.0	0.2	0.1	1.1	1.0	7.3	7.3
Medium	5.5	5.8	0.4	0.6	0.0	0.1	0.3	0.2	1.3	0.9	7.5	8.0
Large	5.5	5.7	1.6	1.6	1.1	0.9	0.2	0.4	0.9	0.7	9.2	9.8
Individual Hospitals: Location												
Urban/ Suburban	5.7	5.5	0.8	0.9	0.4	0.4	0.2	0.2	1.1	0.7	8.2	8.3
Rural	5.6	6.1	0.2	0.2	0.0	0.0	0.1	0.1	1.2	1.2	7.2	8.1
Individual Hospitals: Type												
General Medical	5.7	5.7	0.6	0.6	0.2	0.1	0.2	0.2	1.0	0.8	7.7	7.9
Children's	6.7	6.7	1.8	2.0	1.8	2.4	0.2	0.8	2.1	1.2	12.6	14.1
Teaching	5.7	5.9	1.7	1.9	1.1	0.7	0.1	0.2	1.1	1.1	9.7	10.1
Critical Access	6.5	6.1	0.3	0.3	0.0	0.0	0.1	0.1	1.1	1.4	8.1	8.3

*Does not include Medicare shortfall, bad debt expense attributable to charity care, or community building activities

Federal Poverty Guidelines to Determine Free and Discounted Care

Hospitals generally use Federal Poverty Guidelines (FPG) to determine free and discounted care to patients. The Department of Health and Human Services issues FPG annually. The FPG is based on the Census Bureau's federal poverty threshold, the income level at which an individual or family unit is considered to be poor. The Schedule H form asks hospitals about their use of FPG to determine eligibility for free or discounted care.

The 2009 and 2010 Schedule H provided checkboxes for free care in the amounts of 100%, 150%, 200% of FPG and an open field for "Other %".

- In 2010, more than 97 percent of hospitals in each of the size and location categories use FPG to determine eligibility for free care while more than 96 percent used FPG to determine eligibility in 2009.[9]

The Schedule H also provided checkboxes for discounted care in the amounts of 200%, 250%, 300%, 350%, 400% of FPG, and an open field for "Other %".

- In 2009 and 2010, more than 87 percent of hospitals in each of the size and location categories use FPG to determine eligibility for discounted care.
- In 2010, 87 percent of small hospitals use FPG for discounted care eligibility compared to 89 percent of systems, 91 percent of medium-sized hospitals, and 94 percent of large hospitals. 90 percent of urban/suburban and 89 percent of rural hospitals use FPG for discounted care eligibility.
- In 2009, 88 percent of small hospitals use FPG for discounted care eligibility compared to 91 percent of systems, 92 percent of medium-sized hospitals, and 97 percent of large hospitals. 94 percent of urban/suburban and 87 percent of rural hospitals use FPG for discounted care eligibility.

Amounts listed as greater than 200% for free care and greater than 400% for discounted care were based on open field ("Other %") responses.

Table 6 details the percentage of respondents who indicated they used the Federal Poverty Guidelines for free or discounted care.

Table 6. Percent of Respondents Using Federal Poverty Guidelines to Determine Free and Discounted Care

2010	Overall	Size				Location			Type				
Use FPG for:		Small	Medium	Large	System	Urban/	Suburban	Rural	General Medical	Children's	Teaching	Critical Access	
Free Care	98%	98%	98%	100%	97%	99%	97%		99%	100%	98%	98%	
Discounted Care	90%	87%	91%	94%	89%	90%	89%		90%	92%	91%	92%	
2009	**Overall**	**Size**				**Location**			**Type**				
Use FPG for:		**Small**	**Medium**	**Large**	**System**	**Urban/**	**Suburban**	**Rural**	**General Medical**	**Children's**	**Teaching**	**Critical Access**	
Free Care	97%	98%	96%	99%	98%	97%	97%		97%	100%	98%	96%	
Discounted Care	92%	88%	92%	97%	91%	94%	87%		92%	96%	94%	93%	

Table 7 shows the percent of FPG used by those hospitals to determine free and discounted care, with breakouts by hospital size and location. In 2010, 100 percent of hospitals provided free care for those below 100 percent of FPG, while 91 percent of hospitals provided discounted care for those below 200 percent of FPG.

Table 7. Use of Federal Poverty Guidelines to Determine Free and Discounted Care

Free Care Threshold	Overall	Size				Location		Type			
		Small	Medium	Large	System	Urban/ Suburban	Rural	General Medical	Children's	Teaching	Critical Access
2010											
Less than 100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
100-200%	91%	96%	91%	83%	89%	88%	97%	91%	88%	85%	95%
More than 200%	9%	4%	9%	17%	11%	12%	3%	9%	12%	15%	5%
2009											
Less than 100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
100-200%	81%	92%	82%	69%	75%	78%	91%	84%	50%	77%	91%
More than 200%	19%	8%	18%	31%	25%	22%	9%	16%	50%	23%	9%

Discounted Care Threshold	Overall	Size				Location		Type			
		Small	Medium	Large	System	Urban/ Suburban	Rural	General Medical	Children's	Teaching	Critical Access
2010											
200%and lower	10%	13%	10%	8%	6%	5%	21%	10%	9%	8%	21%
201-300%	31%	35%	33%	30%	22%	33%	34%	33%	26%	30%	32%
301-400%	47%	44%	46%	45%	54%	50%	36%	46%	57%	51%	40%
More than 400%	13%	9%	10%	17%	18%	13%	9%	12%	9%	11%	7%
2009											
200%and lower	14%	23%	16%	6%	5%	10%	29%	15%	0%	5%	25%
201-300%	28%	33%	27%	25%	29%	25%	36%	29%	21%	24%	39%
301-400%	42%	35%	42%	42%	52%	44%	28%	42%	71%	52%	28%
More than 400%	16%	9%	16%	28%	14%	21%	8%	14%	8%	19%	7%

Bad debt expense

In 2010, more than 80% of the 524 responding hospitals and systems reported bad debt expense attributable to charity care on their Schedule H submissions. For 2009, approximately 70% of the 571 respondents had bad debt attributable to charity care. Although the IRS provides minimal instruction on how to calculate this amount, the average bad debt expense attributable to charity care reported was 0.5 percent of total expenses in 2010 and 0.4 percent in 2009, or an average $1.8 million and $1.6 million per respondent respectively. Some patients unable to pay for their medical care do not complete hospitals' financial assistance processes. Consequently, hospitals classify unreimbursed care for those patients as bad debt expense. Most hospitals and systems report that some portion of their bad debt expense would qualify as a benefit to the community as charity care due to the low income of the patients.

One of the respondents, who indicated that about 5% of their bad debt expense would be attributable to charity care, provided the following explanation to the Schedule H question about the rationale for including bad debts amounts in community benefit:

> The Hospital provides an allowance for doubtful accounts based upon a review of outstanding receivables, historical collection information and existing economic conditions.... The Hospital believes that this cost is a community benefit because patients, who would likely qualify for assistance under the Hospital's Charity Care policy, do not or are unwilling to provide documentation of their eligibility for charity care, and are therefore classified as bad debt. The Hospital is very willing to work out payment arrangements and discounted fees: however, those patients who do not respond to repeated offers of assistance are categorized as bad debt expense. Had information been made available to make a determination of their eligibility, the Hospital believes that many of the patients classified as bad debt, would qualify for charity care. This judgment is based on the economic conditions of our area and specific knowledge of the patients involved.

Medicare surplus and shortfall

In 2010, 74 percent of participating hospitals and systems reported having Medicare shortfalls, which compares with 75 percent in 2009. Medicare reimbursement shortfalls occur when the Federal government reimburses the hospitals less than their costs for treating Medicare patients.

Most hospitals described why their Medicare shortfall should be treated as community benefit:

- They explained on their Schedule H forms that non-negotiable Medicare rates are sometimes out-of-line with the true costs of treating Medicare patients.
- By continuing to treat patients eligible for Medicare, hospitals alleviate the federal government's burden for directly providing medical services. The IRS recently acknowledged that lessening the government burden associated with providing Medicare benefits is a charitable purpose.[10]
- Additionally, many hospitals pointed to IRS Rev. Rul. 69-545 in their explanation of Medicare shortfall as a community benefit. IRS Rev. Rul. 69-545 states that if a hospital serves patients with government health benefits, including Medicare, then this is an indication that the hospital operates to promote the health of the community.

Community Building Activities

For 2009 and 2010, hospital systems and individual hospitals spent on average 0.1 percent of their total expenses on community building activities. Children's hospitals report the largest spending at 0.4 percent. Community building activities take many forms:

- Hospital employees report participating on the state Board of Health, in regional health departments and neighborhood community relations committees, and with university and other school partnerships.
- Many hospitals donate cash or in-kind to programs that address health problems in their surrounding communities.

These activities often promote regional health by offering direct and indirect support to communities with unmet health needs. These include patients who are indigent, uninsured, underprovided for, or geographically isolated from healthcare facilities.

Conclusion

Hospitals provide benefits to the communities in a multitude of ways. They not only provide charity care and make up for underpayments by Medicaid and other means-tested government programs, but also cover for losses due to unreimbursed Medicare and bad debt expense attributable to charity care. In addition, they offer programs and activities to improve community health, underwrite medical research and health professions education, and subsidize high cost health services.

Follow-up

Questions about this report can be addressed to:

- Howard Levenson (Ernst & Young) 202.327.8811
- Kathy Pitts (Ernst & Young) 205.254.1608
- Ken Nagle (Ernst & Young) 202.327.6409
- Ambar La Forgia (Ernst & Young) 202.327.6299

A copy of the tax year 2009 and 2010 Schedule H form is available online at <http://www.irs.gov/pub/irs-prior/f990sh--2009.pdf>

<http://www.irs.gov/pub/irs-prior/f990sh--2010.pdf>

Endnotes

[1] The percentages are based on the hospitals' actual reported costs, not charges.
[2] Links to the Form 990 Schedule H for 2009 and 2010 are included on the last page.
[3] For purposes of this study, "System" is used to identify Schedule Hs with more than one hospital filing on a combined tax return. Systems filing separately for each hospital are reported by individual hospital.
[4] Total hospital expense is reduced by bad debt expense for Schedule H calculations.
[5] The responses reported are simple averages of the 524 Schedule Hs received in 2010. A large system's Schedule H has the same weight as a small individual hospital's Schedule H. When the overall responses were weighted by total hospital expense, the average total benefit to the community was 12.2 percent, compared to 11.6 percent for the simple average in 2010.
[6] The 118 systems for 2010 represent 565 individual hospitals. The 94 system responses for 2009 represent 400 individual hospitals. In 2010, two hospitals of all responding hospitals and systems reported insufficient information on their Schedule H forms to estimate total annual expenses. In 2009, eight hospitals had insufficient information. These hospitals and systems are excluded from the tabulations in this report.
[7] Location does not include system respondents, as system responses may contain both urban and rural locations.

[8] Hospital type is provided only for individual hospital responses. Hospitals could identify up to three different categories that applied to their hospital. For example, a hospital could identify itself as both a children's and teaching hospital. Hospital type does not include system respondents, as system responses may contain a mix of hospital types.
[9] Of the hospitals that indicated they did not use FPG to determine free or discounted care, most used low income housing guidelines from the Department of Housing and Urban Development. One indicated they also used an asset test, one used their state's food stamp eligibility guidelines, one used an internally developed "ability-to-pay" model, and two did not provide additional details to their response.
[10] IRS Notice 2011-20

ATTACHMENT 2

PROPOSAL: REQUIRE INTERNAL REVENUE SERVICE ADHERENCE TO THE ADMINISTRATIVE PROCEDURE ACT

ISSUE

Under the current provisions of the Internal Revenue Code (the "Code") related to the collection of information from tax-exempt organizations, the Internal Revenue Service (the "IRS") may issue and materially amend the forms and instructions it uses to collect information from tax-exempt organizations without any notice to or comment from affected organizations, even if the forms and instructions impose new and burdensome requirements.

RECOMMENDATION

Require the IRS to follow the applicable provisions of the Administrative Procedure Act ("APA") when issuing forms and instructions.

BACKGROUND

The following is a summary of the events that have precipitated this action:

- In 2010 Congress enacted the Patient Protection and Affordable Care Act ("ACA"), which imposed four additional requirements on tax-exempt hospitals that must be met in order for tax-exempt hospitals to maintain their exempt status: (1) a community health needs assessment ("CHNA") to be conducted every 3 years; (2) adoption of a written financial assistance policy; (3) limitations on the amounts a hospital charges to individuals eligible for financial assistance; and (4) limits on engaging in certain collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance. The additional requirements were included in a new

section 501(r) of the Code and all except one requirement were effective immediately upon enactment, (March 23, 2010). The requirement for hospitals to conduct a CHNA was effective for tax years beginning after March 23, 2012.

- The new section 501(r) mandates the Department of the Treasury and the IRS to issue regulations and guidance as may be necessary to carry out the provisions of section 501(r).

- Without issuing proposed or temporary regulations or any other guidance, on February 23, 2011, the IRS amended the 2010 Schedule H, *Hospitals*, to Form 990, *Return of Organizations Exempt from Income Tax*, and instructions accompanying Schedule H. The revised Schedule H and instructions impose onerous reporting requirements on tax-exempt hospitals that exceed the scope of Section 501(r). Schedule H and instructions were materially amended without the IRS providing any meaningful notice to the tax-exempt hospital community or opportunity for comment. Furthermore, when issuing the revised form and instructions, the IRS neglected to follow the collection of information requirements contained in the Paperwork Reduction Act ("PRA") or the notice and comment process under the APA.

- After receiving numerous concerned responses to the revised Schedule H from the tax-exempt hospital community, on June 9, 2011, the IRS issued Notice 2011-37 advising tax-exempt hospitals that the revised portions of Schedule H related to the new section 501(r) requirements were optional for tax year 2010.

- In the meantime, the tax-exempt hospital community continued to submit comments to the IRS and offered and attempted to collaborate with the IRS to craft a more streamlined version of Schedule H that would reduce reporting burdens while, at the same time, achieving the underlying section 501(r) purposes of accountability and transparency.

- On October 14, 2011, and again on December 15, 2011, the IRS published draft 2011 Schedule H to Form 990 and instructions. The 2011 Schedule and instructions remained largely and substantively unchanged from the 2010 Schedule and instructions. Although the IRS permitted comments to be submitted with respect to the 2011 draft Schedule H and instructions, the IRS did not follow the procedure prescribed by the PRA for an agency's collection of information.

- On January 23, 2012, the IRS published the 2011 draft Schedule H and instruction in final. The Schedule and instructions were identical to the draft versions. The IRS issued final Schedule H and instructions without following the PRA-mandated process. The 2011 Schedule H and instructions did not reflect the comments that were submitted to the IRS by the tax-exempt hospital community.

- On May 9, 2012, almost four months after final Schedule H and instructions were released, the IRS published a notice in the Federal Register pursuant to the PRA requesting comments on the collection of information contained in Schedule H and instructions.

- On June 22, 2012 the IRS released a notice of proposed rulemaking ("NPRM") for three of the four requirements in section 501(r). The NPRM requested public comments and scheduled a public hearing on the proposed regulations. The NPRM followed the requirement of the PRA for collection of information. However, the NPRM stated that the APA does not apply to the proposed regulations. The proposed regulations generally reflected the content of the revised Schedule H and instructions.

- On December 5, 2012, the IRS held a public hearing on the proposed section 501(r) regulations.

- In January 2013, the IRS published 2012 Schedule H and instructions, which included modest revisions to the 2011 versions but largely ignored the comments that were submitted by the regulated community generally and in response to the notice published on May 9, 2012, and to the NPRM.

- On April 3, 2013 the IRS released a notice of proposed rulemaking ("NPRM") for the fourth requirement in section 501(r), the CHNA. The NPRM requested public comments on the proposed regulations. The NPRM followed the requirement of the PRA for collection of information. However, the NPRM stated that the APA does not apply to the proposed regulations. The proposed regulation generally reflected the content of prior informal guidance on CHNA issued in 2011 (Notice 2011-52). The NPRM also included a proposed regulation on the consequences of failing to satisfy any of the Section 501(r) requirements.

PROPOSED AMENDMENT TO IRC

The following amendment to IRC section 6033 would rectify the IRS's lapse in process for issuing informal guidance that binds tax-exempt organizations without any formal opportunity for input from them, such as in the example outlined above. Additionally, the amendment would ensure public participation and transparency in the IRS's process for issuing new or materially amended forms to collect information from tax-exempt organizations.

Section 6033(a) is currently divided into three paragraphs. Paragraph (1), which grants the Secretary expansive authority to issue new forms, provides:

> (1) Except as provided in paragraph (3)**,** every organization exempt from taxation under section 501(a) shall file an annual return, stating specifically the items of gross income, receipts, and disbursements, and such other information for the purpose of carrying out the internal revenue laws as the Secretary may by forms or regulations prescribe, and shall keep such records, render under oath such statements, make such other returns, and comply with such rules and regulations as the Secretary may from time to time prescribe; except that, in the discretion of the Secretary, any organization described in section 401(a) may be relieved from stating in its return any information which is reported in returns filed by the employer which established such organization.

We would recommend revising the text of paragraph (1), adding a new paragraph (2), and renumbering the remaining paragraphs. The amended section 6033(a) would read:

> (1) ~~(1)~~ Except as provided in paragraph (~~3~~4)**,** every organization exempt from taxation under section 501(a) shall file an annual return, stating specifically the items of gross income, receipts, and disbursements, and such other information for the purpose of carrying out the internal revenue laws as the Secretary may by forms or regulations prescribe consistent with the requirements of paragraph (2), and shall keep such records, render under oath such statements, make such other returns, and comply with such rules and regulations as the Secretary may from time to time prescribe consistent with the requirements of paragraph (2); except that, in the discretion of the

Secretary, any organization described in section 401(a) may be relieved from stating in its return any information which is reported in returns filed by the employer which established such organization.

(2) Notwithstanding any other provision of law, the Secretary shall comply with the provisions of sections 553 through 557 (other than subparagraphs (A) and (B) of section 553(b)) and section 706 of title 5 when prescribing forms, regulations, and rules under paragraph (1).

(3) [former paragraph (2)]

(4) [former paragraph (3)]

(b) Every organization described in section 501(c)(3) which is subject to the requirements of subsection (a) shall furnish annually information, at such time and in such manner as the Secretary may by forms or regulations prescribe, consistent with the requirements of paragraph (a)(2), setting forth-- . . . .