



**American Hospital  
Association**

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July 24, 2013

The Honorable Max Baucus  
Chairman  
U.S. Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Baucus:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) urges you to retain certain key tax code provisions related to section 501(c)(3) hospitals as you work to reform the current tax code.

Hospitals do more to assist the poor, sick, elderly and infirm than any other entity in health care. 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 (based on 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 health and well-being. This broad array of benefits includes wellness programs, community outreach, basic research, medical education and unprofitable services such as burn intensive care, emergency department care, high-level trauma care and neonatal intensive care services.

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 access to hospital services available where needed. The current exemption for hospital services, governed and guided by 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 continues to work well for communities across the nation.

As the Committee reviews various tax reform proposals, we ask you to retain current tax code incentives for the provision of health care that effectively promote the important policy objective of providing access to the broad array of health care services provided by hospitals in communities large and small across the country.



## 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 States 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 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: (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.

### **BENEFIT TO SOCIETY**

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 the 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 represented an estimated 2.4 percent of hospital expenses in 2009 and 2.6 percent of hospital expenses in 2010 (Attachment 2, "Estimates of the federal revenue foregone from tax exemption of non-profit hospitals, 2006-2010").

Moreover, hospitals play a key role in the nation's emergency preparedness and response as part of America's health care infrastructure. In times of disaster, communities look to hospitals not only to mobilize resources to care for the ill and injured but also to provide food and shelter, and coordinate relief and recovery efforts. As part of this standby role to communities, hospitals are pivotal to disaster response activities, whether they are rural, critical access hospitals (CAHs) or Level 1 trauma centers. Emergency preparedness requires a significant investment in staff and resources. Hospitals must be prepared to provide care and, as a result, they are expected to develop and test disaster response plans, train clinical and support staff, maintain and replace disaster response equipment and supplies, ensure communication and surveillance capabilities and enable patient transport and care. Federal preparedness funding has not kept pace with the increasing demands placed on hospitals to ensure they are ready to respond to any disaster that hits their community, leaving hospitals to shoulder this expanding challenge.

### **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-comment 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 3) to ensure 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 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 reducing 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 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, TX, brought together representatives from multiple parts of the health system to help create a seamless continuum of care for 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 in Napa Valley, CA, 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.
- Part of the Alliance collaborative since 1994, Billings Clinic, a not-for-profit health care organization based in Billings, MT, serves patients in Montana, northern Wyoming and the western Dakotas. Each Alliance organization including another local hospital and the public health department developed its own community health improvement plan, which intersects a community-level plan. The organizations conducted a community health needs assessment. Billings Clinic has focused on access to care, chronic disease management, healthy weight and lifestyle for adults and children, and mental health issues. Specific initiatives include medical homes for primary care access and wellness/healthy weight programs for adults and children. The hospital’s community health improvement committee helps build knowledge and understanding for community health improvement at the board level.

## **TAX-EXEMPT FINANCING**

Meeting the health care demands of the future will require significant capital investment. Hospitals have put off major capital investments due to uncertainty about health care reform and future reimbursements. Consequently, the average age of plant for stand-alone hospitals has risen by almost a full year since 2006, to 10.5 years. Renovations, upgrades, investment in new technology and health information systems will be necessary to ensure the highest quality patient care. Raising capital at a reasonable cost is more difficult than ever for the majority of America’s hospitals. Capital markets for non-profit hospitals still have not fully recovered from the 2008 financial meltdown. Three temporary federal financing options that helped ease the credit crunch expired in 2010.

Tax-exempt bonds reduce hospitals’ borrowing costs because they normally can be sold at a lower rate of interest than can taxable debt of comparable risk and maturity. Non-profit hospital borrowers save, on average, an estimated two percentage points on their borrowing compared to taxable bonds or bank financing. Lower borrowing costs translate into lower health care costs for patients. The lower cost of tax-exempt financing also makes possible necessary upgrades and modernizations that would not be possible for hospitals with weaker balance sheets. More costly alternatives, such as taxable bonds and bank loans, are out of reach for many community hospitals.

For many communities, tax-exempt financing has been the key to maintaining vital hospital services. Governments would otherwise be called upon to provide these necessary services. If that were the only alternative, the resulting increased borrowing cost to state and local governments would be borne by taxpayers and ratepayers in every local jurisdiction through the imposition of increased taxes and fees (e.g., *ad valorem* property taxes, special assessments, sales taxes, toll charges and utility rates) or through service cuts. These taxes or fees, including especially sales taxes, tolls or user fees, would fall disproportionately on lower- and middle-income households, as would service cuts.

If hospital access to tax-exempt financing is limited or eliminated entirely, the result could be devastating for both patients and their communities. The financial unraveling of a hospital has the potential to impact a community more profoundly than the unplanned closure of nearly any other institution. Patients will suffer as hospitals struggle to survive and slowly deteriorate. Prices will rise, equipment will wear down without being replaced, and physicians will leave. Ultimately, the health of the community will suffer. Furthermore, closure may result in reduced specialty services and overcrowding in hospital emergency departments, while patients may delay treatment if services are not readily available.

#### **HOSPITAL FINANCIAL CONDITION**

Moody's Investors Service is maintaining its negative outlook for the U.S. not-for-profit health care sector for 2013. The negative outlook reflects Moody's view that revenue growth will remain positive, but will continue to decelerate as a result of federal cuts to Medicare and Medicaid spending, and limited reimbursement increases from commercial health insurers. Moody's outlook has been negative since 2008, as the recession has left a lasting impact on hospital financial viability. The sector faces heightened pressure from all levels of government, as well as businesses, to lower the cost of health care services.

Since 2010, hospitals have faced \$250 billion in cuts to federal health programs, including more than \$14 billion in reductions included in the recent *American Taxpayer Relief Act*. These cuts are increasing the gap between Medicare payment to hospitals and the cost of delivering services to beneficiaries, as well as threatening the overall financial health of hospitals. In its March 2013 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) indicated that hospital Medicare margins fell to negative 4.0 percent for inpatient services, negative 11.0 percent for outpatient services, and negative 5.8 percent for overall Medicare services in 2011.

Even under this financial pressure, hospitals continue to be an economic mainstay for their communities. Hospitals directly employed nearly 5.5 million people in 2011 and are the second-largest source of private-sector jobs. The \$702 billion in goods and services hospitals purchased in 2011 from other businesses created additional economic value for their communities.

A hospital's ability to finance projects through tax-exempt bonds depends primarily on its credit rating, which is shorthand for its ability to access capital and the price at which it can borrow. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on the bonds. Even the slightest drop in bond rating – resulting in a slightly higher interest rate – may cost a hospital significantly more over the lifetime of a bond issue.

In 2009, 88 percent of hospitals reported that it was “more difficult or impossible to access capital from tax-exempt bonds” since the 2008 recession. Without capital expenditures, hospitals are unable to invest in new technology and equipment that benefits patients. They also may find it more difficult to recruit top physicians and other staff.

### **HEALTH CARE DELIVERY AND DEMOGRAPHICS**

Aging baby boomers and an increasingly diverse population create demand for new and different services. The ACA’s promise of expanded health insurance coverage will add to demand. Clinical procedures continue to evolve, as do diagnostic techniques and communication technologies.

Americans rely heavily on hospitals to provide 24/7 access to care for all types of patients, to serve as a safety-net provider for vulnerable populations and to have the resources and skills needed to respond to disasters. Emergency department visit volume has increased by nearly 26 percent since 2000, and will continue to grow.

Over the past 15 years, market, economic and regulatory forces have led hospitals and physicians to explore new ways to better align their interests and achieve greater integration in order to both reduce costs and improve the quality of care. With an eye on the future, hospitals across the country are in a constant state of renovation and improvement in order to provide the latest treatments and services to meet the increasing and changing needs of their communities.

Not only should access to tax-exempt financing be preserved, but present rules governing the use of tax-exempt proceeds should be updated to remove barriers to hospital compliance with new law in areas outside the tax code. Significant changes in the way in which government and private insurance companies reimburse hospitals (focusing on achieving prescribed quality measures) promote the alignment of interests between physicians and hospitals. These changes are intended to further the important public policy goals of more effective and affordable patient care. Major hurdles have arisen, however, in these attempts to implement innovative new hospital-physician arrangements as a result of limitations imposed on the use of tax-exempt bond financed facilities under Rev. Proc. 97-13. Modifications to Rev. Proc. 97-13 are necessary if the goals of better integration and alignment of interests between hospitals and physicians are to be accomplished in light of the significant number of governmental and 501(c)(3) health care facilities that have been financed with tax exempt bonds.

Yet even with these increasing demands, the growth in spending on hospital care is at historic lows. This leveling of growth is evident across Medicare, Medicaid and private payers. The Congressional Budget Office recently revised its future projection of Medicare spending downward by \$169 billion for the next decade. Growth in premium levels for employee health benefits are half of what they were in 2011, as new benefit care models begin to take hold.

### **DIRECT PAY BONDS**

A variety of proposals have been made to restrict or alter tax-exempt financing mechanisms. One example is direct pay bonds, such as Build America Bonds (BABs). While these bonds were not available to nonprofits, some hospitals issued BABs when they were available. While the detail of

any new proposals would need review, the AHA generally supports direct pay programs if they are designed with subsidies adequate to result in a financial instrument whose total costs are comparable with a tax-exempt bond. Should BABs be reinstated, eligibility should be expanded to private 501(c)(3) institutions. However, if continuity of federal subsidy payments is unreliable, as demonstrated under the recent sequestration order, direct pay bonds will not be a dependable budget and planning tool to lower borrowing costs. The Committee should consider direct pay bonds and other proposals as complements, and not alternatives, to tax-exempt bonds.

#### **TAX-EXEMPT FINANCING SHOULD BE MAINTAINED**

At a time when hospital revenues are already strained, hospitals must respond to rapidly changing market and government forces, including: (1) reimbursement reductions and changes; (2) an increasing necessity to provide access to a broad range of health services to a growing population; and (3) limited access to capital. These market forces are driving an urgent need for hospitals to make significant capital investments while reducing costs, both of which require continued access to low-cost capital through tax-exempt financing. The AHA strongly recommends retention of the current law exemption from income for tax-exempt bond interest.

#### **DEDUCTIBILITY OF CHARITABLE CONTRIBUTIONS**

Hospitals recognize the responsibilities that come with tax-exemption and fully appreciate its benefits. One important benefit is the ability to attract community investment through tax-deductible giving. Hospitals are the backbone of the communities they serve, and people in those communities recognize their importance through generous philanthropic giving. In FY 2011, philanthropic support for nonprofit hospitals and health care organizations reached \$8.9 billion, according to the Association of Healthcare Philanthropy (AHP). Needed construction and renovation projects receive almost a quarter of philanthropic dollars, but many hospitals rely on funds raised from community partners simply to meet operating expenses, allocating on average more than 15 percent of the funds they raise to general operations.

Philanthropic giving is also increasingly important as a source of capital financing as hospitals change to meet the health care needs of the future. Hospitals that are under significant financial strain — not profitable, not liquid and with a significant debt burden — often are shut out of traditional capital markets. They have a limited number of capital sources and incur higher costs than hospitals with a brighter financial picture. For these hospitals, philanthropy is essential to finance the necessary facility upgrades and investments in information technology required if they are to continue to provide high-quality health care services in their communities.

Community support for hospitals is strong, but incentives are necessary to retain this critical support. The AHA is concerned that, in an environment where hospitals rely increasingly on charitable giving, limiting or eliminating the current charitable contribution deduction would reduce the availability of resources that are critical to fund hospital operations. The most recent AHP survey of hospital and health care development professionals found that nine out of 10 agreed that proposed limits on charitable deductions would result in significant reductions in giving to their organizations. About 40 percent estimate that giving would decrease between 10 and 30 percent if significant changes are made to the current tax incentives for charitable

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donations, which conservatively could amount to a decrease of more than a \$1.07 billion in total annual giving to nonprofit hospitals and health care providers, based on AHP's FY 2009 giving statistics.

We urge you to continue to encourage private giving by excluding charitable giving from any limitations on deductions and maintaining the existing federal tax charitable deduction.

## CONCLUSION

America's hospitals are always open, serving their communities 24 hours a day, seven days a week, 365 days a year. As hospitals face new challenges to maintaining access to high-quality care to everyone who needs it, they need the support they find from generous members of the communities they serve now more than ever. As the Committee engages in the important work of reforming the nation's tax code, we urge you to retain current tax code incentives for the provision of health care that continue to work to provide access to hospital services in communities large and small across the country.

Sincerely,

A handwritten signature in black ink that reads "Rick Pollack". The signature is fluid and cursive, with the first name "Rick" being more prominent than the last name "Pollack".

Rick Pollack  
Executive Vice President

Attachments

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

## 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.<sup>1</sup> 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
<b>Total Benefits to the Community</b>	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.<sup>2</sup>

## 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<sup>3</sup>** (A Schedule H with more than one licensed hospital)
- **Single Hospitals** (Schedule H with a single licensed hospital)
  - **Size** – *based on total hospital expense<sup>4</sup>*
    - 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.<sup>5</sup>
- 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. <sup>6</sup> 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**

<b>Size</b>	<b>2010</b>	<b>2009</b>
Small	188	172
Medium	121	185
Large	97	120
System	118	94
<b>Location<sup>7</sup></b>		
Urban/Suburban	258	298
Rural	148	159
<b>Type<sup>8</sup></b>		
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**

<b>Hospital Type</b>	<b>Sch H Participants</b>	<b>AHA Hospital Survey</b>
General Medical	92%	94%
Children's	6%	2%
Teaching	24%	26%
Critical Access	22%	33%
<b>Location</b>	<b>Sch H Participants</b>	<b>AHA Hospital Survey</b>
Urban/ Suburban	64%	53%
Rural	37%	47%
<b>Bed Size Category</b>	<b>Sch H Participants</b>	<b>AHA Hospital Survey</b>
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
<b>Overall*</b>	8.2	8.4	0.1	0.1	2.8	2.4	0.5	0.4	11.6	11.3
<b>System</b>	8.1	9.3	0.1	0.1	2.9	3.8	0.5	0.5	11.6	13.7
<b>Individual Hospitals: Size</b>										
<b>Small</b>	7.3	7.3	0.1	0.1	2.9	2.0	0.8	0.5	11.1	9.9
<b>Medium</b>	7.5	8.0	0.1	0.2	2.6	3.6	0.5	0.5	10.8	12.3
<b>Large</b>	9.2	9.8	0.1	0.2	2.6	2.6	0.3	0.3	12.2	12.8
<b>Individual Hospitals: Location</b>										
<b>Urban/ Suburban</b>	8.2	8.3	0.1	0.2	2.9	3.0	0.6	0.4	11.7	11.9
<b>Rural</b>	7.2	8.1	0.1	0.2	2.6	2.7	0.6	0.5	10.5	11.5
<b>Individual Hospitals: Type</b>										
<b>General Medical</b>	7.7	7.9	0.1	0.2	2.9	3.2	0.6	0.4	11.3	11.7
<b>Children's</b>	12.6	14.1	0.1	0.4	2.1	0.5	0.2	0.2	15.0	15.2
<b>Teaching</b>	9.7	10.1	0.1	0.2	1.7	1.8	0.4	0.3	12.0	12.4
<b>Critical Access</b>	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
<b>Overall</b>	5.7	5.7	0.9	0.8	0.6	0.3	0.3	0.3	1.0	0.8	8.2	8.4
<b>System</b>	5.2	5.8	1.1	1.2	0.2	0.5	0.5	0.6	1.0	0.7	8.1	9.3
<b>Individual Hospitals: Size</b>												
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
<b>Individual Hospitals: Location</b>												
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
<b>Individual Hospitals: Type</b>												
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.<sup>9</sup>

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		Size				Location			Type			
Use FPG for:	Overall	Small	Medium	Large	System	Urban/	Suburban	Rural	General Medical	Children's	Teaching	Critical Access
Free Care	98%	98%	98%	100%	97%				99%	100%	98%	98%
Discounted Care	90%	87%	91%	94%	89%				90%	92%	91%	92%
2009		Size				Location			Type			
Use FPG for:	Overall	Small	Medium	Large	System	Urban/	Suburban	Rural	General Medical	Children's	Teaching	Critical Access
Free Care	97%	98%	96%	99%	98%				97%	100%	98%	96%
Discounted Care	92%	88%	92%	97%	91%				94%	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
<b>2010</b>											
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%
<b>2009</b>											
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
<b>2010</b>											
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%
<b>2009</b>											
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.<sup>10</sup>
- 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

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<sup>1</sup> The percentages are based on the hospitals' actual reported costs, not charges.

<sup>2</sup> Links to the Form 990 Schedule H for 2009 and 2010 are included on the last page.

<sup>3</sup> 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.

<sup>4</sup> Total hospital expense is reduced by bad debt expense for Schedule H calculations.

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Location does not include system respondents, as system responses may contain both urban and rural locations.

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> IRS Notice 2011-20

Attachment 2

# **Estimates of the federal revenue foregone from tax exemption of non-profit hospitals, 2006-2010**

Prepared for the American Hospital Association

July 2013



Building a better  
working world

## Estimates of the federal revenue foregone from tax exemption of non-profit hospitals

This analysis estimates the federal revenue foregone due to the tax exemption of non-profit hospitals between 2006 and 2010. The analysis calculates the value of tax exemption of non-profit hospitals based on Medicare hospital cost report information from 2006-2010 for approximately 3,000 non-profit general hospitals. This analysis does not account for other non-profit specialty hospitals, such as psychiatric or long-term acute care.<sup>1</sup>

### Three tax provisions affecting federal tax exemption of non-profit hospitals

Previous studies of the value of tax exemption<sup>2</sup> include different tax provisions and estimate the value in different ways. This study analyzes the federal revenue foregone from three federal tax provisions:

- 1) Federal corporate income tax;
- 2) Tax-exempt bond financing; and
- 3) Federal unemployment tax.

The analysis does not include the deductibility of charitable contributions to non-profit hospitals. It is likely that the federal revenue foregone from donations to non-profit hospitals would be replaced by revenue foregone from increased donations to other charities or foundations affiliated with hospitals, if deductions for donations to hospitals were not available.

If federal tax exemption were changed, then the assumption is that state and local tax exemptions would also change, thereby increasing state and local taxes on non-profit hospitals which would reduce federal corporate taxable income. Thus, the analysis incorporates an estimate of the current state and local revenue foregone due to tax exemption.

### The federal revenue foregone from tax-exempt non-profit hospitals in 2006-2010

Based on the data and methodology described below, the value of the federal revenue foregone from tax exemption of non-profit hospitals between 2006 and 2010 is estimated to average \$7.1 billion per year. It ranges from \$5.5 billion in 2008 to \$8.9 billion in 2010. This estimate is an upper bound (i.e., the most it could be) on the potential value of the federal tax exemption because: some hospitals may be exempt due to their educational or religious nature, rather than their charitable nature; the inability to include all features of the federal tax code due to lack of necessary information, such as potential tax credits and accelerated depreciation; and the change in incentives taxation would cause.

**Table 1. Federal revenue foregone from tax exempt non-profit hospitals, 2006-2010**

	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
<i>Dollars in billions</i>					
Federal income tax exemption	4.4	4.2	2.7	5.1	6.2
Tax-exempt bond financing	1.8	2.2	2.5	2.4	2.4
Federal unemployment tax	0.2	0.2	0.2	0.2	0.2
<b>Total federal revenue foregone</b>	<b>6.5</b>	<b>6.6</b>	<b>5.5</b>	<b>7.8</b>	<b>8.9</b>

Source: EY calculations

Note: Numbers may not add due to rounding

A Congressional Budget Office analysis of the currently untaxed business sectors, including non-profit hospitals, noted that “Taxation of these entities might not generate as much revenue as initially anticipated. Taxation would bolster managers’ incentives to reduce or eliminate entities’ tax liabilities by using more of any surplus to cut prices, boost costs, or both. As a consequence of being taxed, however, those entities would retain fewer funds for expansion.”<sup>3</sup>

Total federal revenue foregone is shown as a percentage of total hospital expenses in Table 2. Federal revenue foregone as a percentage of total hospital expenses averaged 2.3 percent, ranging from 1.8 percent in 2008 to 2.6 percent in 2010.

**Table 2. Federal revenue foregone compared to hospital community benefits as percentage of total hospital expenses, 2006-2010**

	2006	2007	2008	2009	2010
<i>Percentage of total hospital expenses</i>					
Federal revenue foregone	2.4	2.3	1.8	2.4	2.6
Charity care and government assistance <sup>4</sup>				5.7	5.7
Total charity care, government assistance and other benefits <sup>5</sup>				8.4	8.2
Total benefits to the community <sup>6</sup>				11.3	11.6

Source: EY calculations; Community benefits from 'Schedule H Project Benchmark Report', Ernst & Young LLP

Table 2 also offers a comparison of the federal tax revenue foregone to hospital-provided charity care and other community benefits. Charity care, government assistance, and total community benefits are calculated using financial assistance and certain other community benefits at cost for private not-for-profit hospitals from the Form 990 Schedule H.<sup>7</sup> An estimate of the charity care and community benefit was based on the EY/AHA surveys of over five hundred Form 990 Schedule H’s in 2009 and 2010 respectively. Charity care and government assistance encompasses financial assistance at cost, unreimbursed Medicaid, and other unreimbursed costs.

Charity care and government assistance accounted for 5.7 percent of total hospital expenses in 2009 and 2010. Total charity care, government assistance and other benefits includes charity care and government assistance defined above as well as the following benefits: the community health improvement services and community benefit operations; health professions education; subsidized health services; research; and cash and in-kind contributions. Total benefit to the community includes the above, as well as Medicare shortfall and bad debt attributable to charity care. These benefits accounted for 11.3 percent of total hospital expenses in 2009 and 11.6 percent of total hospital expenses in 2010.

**The methodology for estimating the federal revenue foregone**

This analysis calculates an estimate of the federal revenue foregone as a result of three federal tax provisions, relying on data from the Medicare hospital cost reports filed by hospitals that receive Medicare reimbursements. The hospital cost reports are not audited financial reports, but are filed with the federal government. Between 2006 and 2010 – the years of analysis – an average 2,955 private, not-for-profit, general hospitals filed Medicare hospital cost reports.<sup>8</sup> The methodology applies the general federal tax rules to the reported level of activity of the non-profit hospitals. Not all aspects of the

detailed federal tax rules can be applied in this analysis to the available financial data in the hospital cost reports.

Estimate of revenue foregone from corporate income tax exemption. For purposes of this estimate, the analysis of corporate taxable income starts with the positive net income of each hospital as reported in the Medicare hospital cost reports, before adjustments. The cost reports, similar to financial reports, do not include the entire income and expense detail equivalent to a corporate income tax return. Adjustments for positive and negative differences between book and tax accounting are not made due to insufficient detail in the Medicare hospital cost reports. For example, the provision for bad debts is likely to result in financial net income being lower than taxable income, while accelerated tax depreciation is likely to result in financial net income being greater than taxable income.

In 2008, 2009 and 2010, federal tax law allowed bonus depreciation which provided additional first-year tax write-offs of capital investments as part of fiscal stimulus. Bonus depreciation applied to only certain qualifying property and some state tax systems did not piggyback on the federal change, so bonus depreciation's effect could not be effectively modeled. Incorporating bonus depreciation would have significantly reduced the federal corporate income tax foregone in 2008 through 2010.

The analysis assumes that non-profit hospitals would take advantage of the tax consolidation rules with affiliated hospitals if they were subject to tax. Thus, a hospital with a taxable loss could offset positive taxable income of a consolidated hospital in the current year.<sup>9</sup> Using an affiliation listing provided by the American Hospital Association, consolidated taxable income of all non-profit hospitals can be estimated, which reduces positive net taxable income below the positive taxable income of unconsolidated hospitals in all years analyzed.

The analysis reduces hospitals' taxable income by the amount of contributions received. If contributions constitute gifts for federal income tax purposes, such gifts are not included in taxable income, but may be subject to gift tax. Restricted gifts used for capital improvements may not be included in taxable income if certain conditions are met, in which case they would reduce the taxable basis of the capital improvements. Further, if donors could not receive a tax deduction for their contributions to the hospital, most donors would choose to donate to other charitable organizations. For these reasons, the contributions are excluded from the estimate of corporate taxable income.

There are additional adjustments made for increased costs that would result if non-profit hospitals were subject to federal and state tax. For example, hospitals using tax-exempt bond financing would pay a higher interest expense without their tax exemption. Many hospitals would automatically pay higher state and local taxes if federal tax exemption was eliminated. Thus estimates on a state-by-state basis of the potential sales tax on business inputs and of potential property taxes on non-profit hospitals were incorporated in the federal tax calculations.<sup>10</sup> State corporate income taxes would also be deductible against federal taxable income. All of these adjustments reduce industry federal taxable income in all years analyzed.

Finally, the federal corporate income tax does not tax businesses only on their net positive income in each year, but instead allows for taxable net operating losses to offset taxable income in certain prior years and for any remaining tax loss to be carried forward offsetting positive taxable income in future years.<sup>11</sup> The analysis incorporates a one year net operating loss carry back with any remaining tax loss carried forward against future

taxable income. Thus, a tax net operating loss in 2008 was carried back against positive taxable income in 2007, and if any tax loss remained was offset against positive taxable income in 2009 and/or 2010. The tax loss carryover rules, similar to the tax consolidation rules, result in taxable income being lower than positive financial net income in all years analyzed, as shown in Table 3.

Applying the corporate tax rate structure to the estimated taxable income, Table 3 shows the estimated revenue foregone from federal corporate income tax on non-profit hospitals at \$4.4 billion in 2006; \$4.2 billion in 2007; \$2.7 billion in 2008; \$5.1 billion in 2009; and \$6.2 billion in 2010. The fluctuations over time reflect the economic recession in 2008 and the initial recovery.

**Table 3. Estimated corporate taxable income and federal corporate tax foregone, 2006-2010**

	2006	2007	2008	2009	2010
<i>Dollars in billions</i>					
Medicare cost report net income	16.4	16.5	(2.0)	21.5	23.1
Medicare cost report positive net income	19.6	21.0	12.7	25.0	26.8
Estimated corporate taxable income	12.5	12.0	7.8	14.5	17.6
Estimated federal corporate tax foregone	4.4	4.2	2.7	5.1	6.2

Source: EY calculations based on data from Medicare cost reports

The actual federal revenue foregone is likely to be less than the estimate above for the following reasons:

- Potential federal tax credits, such as enterprise zone and work opportunity tax credits, and special deductions, such as accelerated depreciation, are not included due to lack of necessary information.
- Non-profit hospitals likely would change their behavior to reduce future taxable income by reducing prices, increasing services and related expenses, or both.
- Legal tax planning could also result in hospitals retaining fewer earnings and thus earning less future investment income.
- Tax net operating losses arising in these five years that remained at the end of 2010 could be used by some hospitals to offset future taxable income.
- Some non-profit hospitals pay unrelated business income tax already on certain of their revenue generating activity.<sup>12</sup> These amounts are not reflected in these estimates.

Estimate of federal revenue foregone from tax exempt bond financing. The analysis calculates the revenue foregone from tax-exempt bond financing to non-profit hospitals. The estimate assumes the total amount of notes payable and other long-term liabilities outstanding as reported in the Medicare cost reports were issued as federally tax-exempt bonds. The analysis assumes that the average marginal tax rate applicable to investors due to an increase in tax-exempt bonds is roughly 30 percent. Applying this tax rate to the ten-year average taxable yields of Aaa and Baa corporate bonds and tax-exempt debt outstanding in each of the years, the revenue foregone from tax-exempt bonds of non-profit hospitals averaged \$2.3 billion per year between 2006 and 2010. To the extent that non-profit hospitals are using short-term financing with lower yields, the revenue foregone would be lower. It should be noted that the value of tax exemption to the hospital issuer is smaller than the federal revenue foregone, since investors in tax-exempt bonds need to be compensated for risks associated with tax-exempt bonds.

Estimate of the revenue foregone from federal unemployment tax. The value of the revenue foregone from the federal unemployment tax is calculated assuming a federal effective unemployment tax rate of 0.8 percent and a maximum wage base of \$7,000 per employee. Based on the 4.3 million employees of private non-profit hospitals, the value of the exemption from federal unemployment tax is estimated to average \$240 million per year between 2006 and 2010.<sup>13</sup>

## Estimates of the federal revenue foregone from tax exemption of non-profit hospitals, 2006-2010

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<sup>1</sup> AHA's 2010 Annual Hospital Statistics Survey indicates there are 5,724 registered hospitals in the US. This includes community, federal government, psychiatric, long term care, and other hospitals. There are 4,973 community hospitals, which include non-governmental not-for-profit (2,903 hospitals), investor-owned for-profit (1,025 hospitals), and state and local government (1,045 hospitals). The remaining 821 hospitals are made up of the federal government, psychiatric, long-term care, and other hospitals (e.g., prison hospitals).

<sup>2</sup> William M. Gentry and John R. Penrod, "The Tax Benefits of Non-Profit Hospitals," NBER Working Paper #6435, February 1998, and Nancy M. Kane and William H. Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Tax Exemption," *The Milbank Quarterly*, Vol. 78, No. 2, 2000. Institute for Health and Socio-Economic Policy, "Benefit of Tax Exemption for California Non-Profit Hospitals," August 2012.

<sup>3</sup> Testimony of Douglas Holtz-Eakin, Director, Congressional Budget Office on the Untaxed Business Sector before the U.S. House of Representatives Committee on Ways and Means, April 20, 2005.

<sup>4</sup> Charity care summarizes financial assistance and means tested government programs, including unreimbursed Medicaid and other unreimbursed costs from means-tested government programs (Part I, line 7d of the Schedule H Form 990).

<sup>5</sup> Total charity care, government assistance and other benefits summarizes financial assistance and means tested government programs and other benefits (Part I, line 7k of the Schedule H Form 990).

<sup>6</sup> Total benefit to the community summarizes financial assistance and means tested government programs and other benefits (Part I, line 7k of the Schedule H Form 990), Medicare shortfall (Part III, line 7 of the Schedule H Form 990), and bed debt attributable to charity care (Part III, line 3 of the Schedule H Form 990). Calculations were made to translate Medicare shortfall and bed debt attributable to charity care into a percentage of total hospital expense.

<sup>7</sup> Community Benefit from 'Schedule H Project Benchmark Report' Ernst & Young LLP, Jan 2012 and April 2013.

<sup>8</sup> Hospitals were identified based on AHA's 2010 Annual Hospital Statistics Survey. The Survey defines a general medical hospital as follows: "Provides acute care to patients in medical and surgical units on the basis of physicians' orders and approved nursing care plans." In terms of the hospitals used for this analysis, there were 2,885 hospitals in the 2006 Medicare hospital cost reports; 2,943 hospitals in 2007; 2,903 hospitals in 2008; 2,968 hospitals in 2009; and 3,075 hospitals in 2010.

<sup>9</sup> For example, two independent hospitals, one with a net operating loss (NOL) of \$10M and one with a taxable income of \$10M, have an aggregate taxable income of \$10M in that year, since the hospital with the NOL has a taxable income of zero, with a potential carryover of the loss against the hospital's future taxable income. If these two hospitals joined together into a system that files a federal consolidated return, the net operating loss from the first hospital would offset the taxable income of the second, leading to a consolidated taxable income of \$0, \$10M less than if the two hospitals were separate.

<sup>10</sup> Council on State Taxation, Total State and Local Business Taxes: Nationally 1980-2004 and by State 2000-2004, April 12, 2005. The methodology used by Ernst & Young in this study was used for the state-by-state hospital estimates of sales tax on business inputs and property taxes.

<sup>11</sup> For 2010, a taxpayer could carry back net operating losses two prior years and could carry forward up to twenty years. Net operating loss carry back and carry forward rules vary by state.

<sup>12</sup> In 2009, there were 373 tax returns that paid a total of \$45 million in unrelated business income classified as "Healthcare and social assistance". This may not account for all unrelated business income taxes paid by hospitals, as taxes paid may have been classified under a different category, such as "retail trade" for gift shop sales. Internal Revenue Service Statistics of Income Tax Stats – Exempt Organizations' Unrelated Business Income (UBI) Tax Statistics, October 2012.

<sup>13</sup> The U.S. Census Bureau *Survey of Services* reports approximately 4.3 million employees for all "not-for-profit hospitals" for the periods above. This definition of not-for-profit hospitals includes public facilities. Another Census Bureau program, the *Census of Governments*, reports approximately 984 thousand employees for public hospitals for the same periods. The number of employees of private, not-for-profit hospitals is calculated as total not-for-profit employment less government hospital employment.

### **ATTACHMENT 3**

#### **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)~~, 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-- . . . .