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DATAWATCH

Community Benefit Spending By Tax-Exempt Hospitals Changed Little After ACA

Provisions of the Affordable Care Act (ACA) encouraged tax-exempt hospitals to invest broadly in community health benefits. Four years after the ACA's enactment, hospitals had increased their average spending for all community benefits by 0.5 percentage point, from 7.6 percent of their operating expenses in 2010 to 8.1 percent in 2014.

More than half of US hospitals are private, nonprofit organizations, virtually all of which are exempt from paying federal, state, and local taxes.[1,2] Whether these hospitals provide sufficient community benefits to justify their tax exemptions, which collectively have recently been estimated to exceed $24 billion annually,[3] has been a longstanding health policy issue.[2] Previous research, based largely on data obtained before the enactment of the Affordable Care Act (ACA) in 2010, reported that hospitals spent 7–8 percent of their operating expenses on community benefits and that most of these dollars went to unreimbursed patient care, such as charity care, rather than to broader community initiatives, such as local health improvement programs.[4,5] In this study we found that tax-exempt hospitals increased their average spending on community benefits by 0.5 percentage point from 2010 to 2014, while spending specifically on community health initiatives remained largely unchanged (exhibit 1).

The ACA was expected to have important implications for community benefit spending by tax-exempt hospitals. First, the law promoted population health by emphasizing disease prevention for local communities (sections 4001 and 4002). The ACA also required tax-exempt hospitals to conduct community health needs

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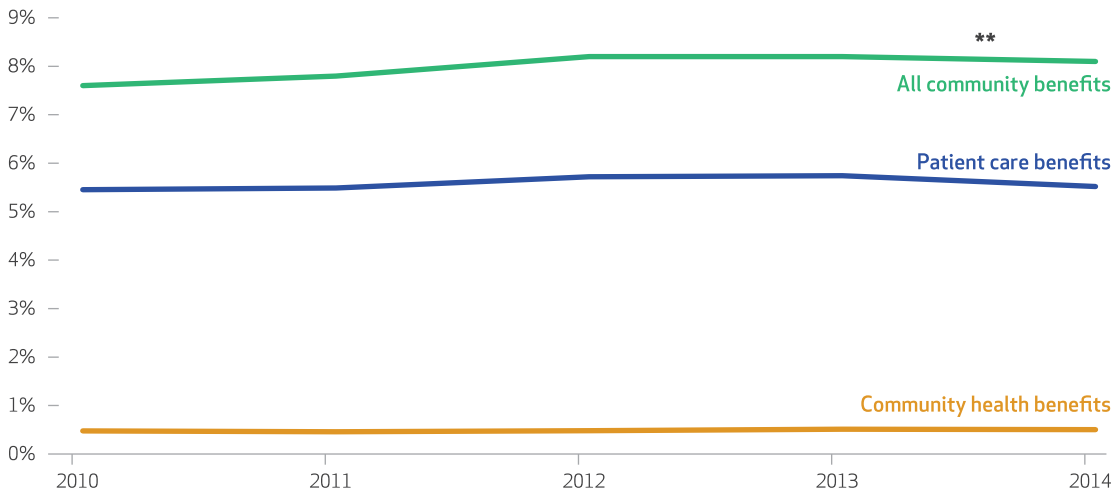
EXHIBIT 1

Tax-exempt hospital spending on community benefits as a percentage of operating expenses, 2010–14



SOURCE Authors' analysis of hospital filings from the Internal Revenue Service. **NOTES** Spending categories for hospital community benefits are defined by the IRS. There are seven types of benefits, which can be divided into "patient care benefits" (charity care, unreimbursed costs for means-tested government programs, and subsidized health services), "community health benefits" (direct spending on community health and contributions to community groups), and "other" (research and health professions education; not shown in the exhibit). Significance refers to the difference between 2010 and 2014. $^{**}p < 0.05$

assessments every three years (section 9007). Policy makers and community leaders had hoped that by conducting the assessments, hospitals would be encouraged to increase their spending on broad community health initiatives, whether this spending was in the form of hospital-directed health improvement initiatives or contributions to community groups. Second, by expanding access to health insurance, the ACA was expected to reduce over time the demand for hospital-based charity care, a key type of hospital community benefit. If hospitals experienced reduced demand for charity care, they might reallocate their community benefit dollars to other types of community benefits, including local health improvement initiatives.[6,7]

Study Data And Methods

Our study period was 2010–14. The primary data source was Schedule H of IRS Form 990, which tax-exempt hospitals have been required to submit since 2009. On this form, hospitals report net expenditures (costs minus any offsetting revenues) for seven types of community benefits, which are listed in online appendix exhibit 1.[8] We standardized each measure by dividing a hospital's reported net expenditures by its reported total operating expenses.

The study population consisted of a little more than two-thirds of all tax-exempt general hospitals during the study period. The remaining tax-exempt hospitals did not file a Schedule H because they were members of hospital systems that submitted consolidated filings for their member hospitals. Many hospital systems, however, did not submit consolidated filings, and their member hospitals did file their own forms. The final sample consisted of 1,786 hospitals in 2010 and 1,501 hospitals in 2014. (For descriptive characteristics of hospitals, see appendix exhibit 2.)[8]

We computed descriptive statistics for the community benefit measures for each year of the study period and examined changes over time. We compared trends for spending on patient care benefits (in the form of charity care, unreimbursed costs for means-tested government programs, and subsidized health services) versus spending on community health benefits (direct spending on community health improvement and contributions to community groups for health improvement initiatives). To examine hospital variation in total community benefit spending, we sorted hospitals into quartiles and deciles based on the magnitude of community benefit spending. In addition, we used regression analysis to identify hospital-level institutional and community characteristics associated with community benefit spending. (Definitions of these characteristics and details on our regression procedures are in appendix exhibit 3.)[8]

Approximately 43 percent of the study hospitals had 2014 tax years that did not cover at least ten months of the 2014 calendar year. As a sensitivity analysis, we conducted all analyses for only the study hospitals with tax years that covered at least ten months of that calendar year. These results did not differ materially from those presented below.

Study Results

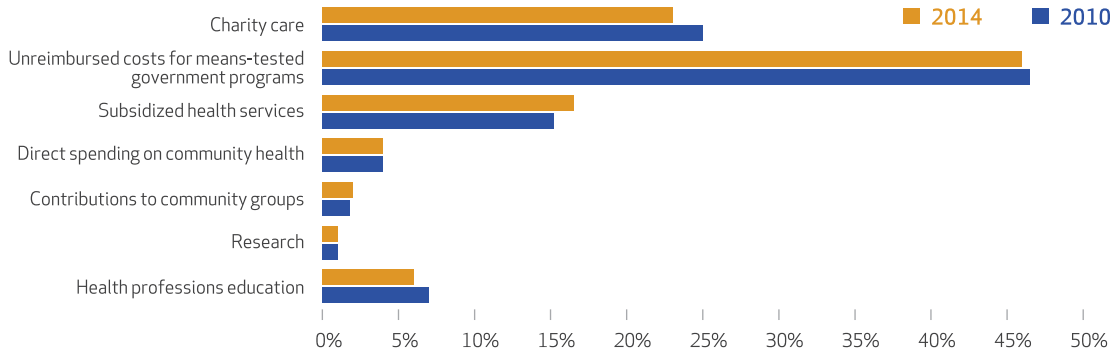
Tax-exempt hospitals' average spending for all seven types of community benefits increased from 7.6 percent of operating expenses in 2010 to 8.1 percent in 2014 (exhibit 1), a significant change. All of this increase occurred by 2012 and was driven largely by spending on patient care benefits, which also rose from 2010 to 2012—although the change for the entire study period was not significant. Spending on community health benefits remained essentially flat throughout the study period, as did spending on the other types of community benefits (the data for which are available in appendix exhibit 1).[8] Overall, the pattern of tax-exempt hospitals' spending for all seven types of community benefit remained largely unchanged during the study period (exhibit 2).

In addition, substantial variation existed among hospitals in the level of total community benefit spending throughout the study period. For each year of the study, a more than fivefold difference existed with respect to mean spending on total community benefits between hospitals in the lowest and highest spending quartiles (14.65 percent versus 2.58 percent of total operating budget in 2014), and a nearly twentyfold difference existed between hospitals in the highest and lowest deciles (18.28 percent versus 0.96 percent of total operating budget in 2014) (data not shown). Among the 1,501 hospitals that were in operation each year of the study period, approximately 44 percent of those in the top quartile at the beginning of the period remained in that quartile throughout, and approximately 48 percent of those in the bottom quartile at the beginning remained there throughout (data not shown).

The regression analyses yielded information regarding hospital-level institutional and community characteristics that underlie some of the observed variation in community benefit spending. We conducted two separate analyses: one for a hospital's total community benefit spending, and the other for whether a hospital

EXHIBIT 2

Percentages of tax-exempt hospital spending on community benefits, by type of benefit, 2010 and 2014



SOURCE Authors' analysis of hospital filings from the Internal Revenue Service.

was consistently in the top or bottom quartile of spending during each year of the study period. The same characteristics that were significantly associated with higher total community benefit spending were for the most part also associated with hospitals' being consistently at the high end of the spending distribution. For institutional characteristics, this was teaching status and disproportionate-share hospital status. For community characteristics, this was state-level community benefit reporting requirements, per capita income, and proportion of uninsured residents. (The complete results from the regression analyses are in appendix exhibit 3.)[8]

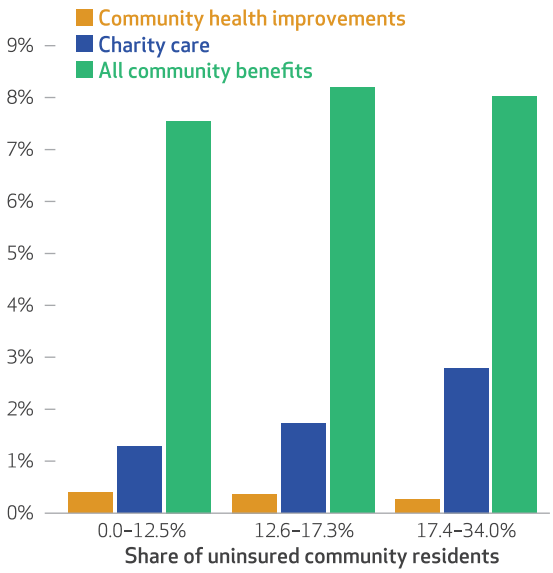
As the regression results pointed to the influence of local socioeconomic characteristics, we further compared levels and patterns of hospitals' community benefit spending according to these characteristics. In particular, we divided hospitals into three groups based on the share of uninsured residents in their communities. Although the data in exhibit 3 are from 2014, the pattern was the same for each year. For total community benefit spending, differences among the three groups of hospitals were modest and not significant. Significant differences did exist among the groups for spending on charity care and community health improvement. Hospitals in the top tercile spent approximately 11.0 times as much on charity care as they did on community health improvement. Hospitals in the middle and bottom terciles spent approximately 4.7 times and 3.2 times as much, respectively. We also compared hospitals' spending relative to the other types of community benefits but found no significant differences.

Discussion

The ACA promotes population health as a concept and requires tax-exempt hospitals to conduct community health needs assessments. We found that several years after the ACA was enacted, tax-exempt hospitals exhibited a modest increase in total community benefit spending and essentially no change in direct spending on community health. The most obvious explanation for this finding is that more time is needed before hospitals can be expected to make a noticeable shift in community benefit spending. In

EXHIBIT 3

Mean percentages of tax-exempt hospital spending on community benefits, by share of uninsured community residents, 2014



SOURCES Authors' analysis of hospital filings from the Internal Revenue Service and data from the Area Health Resources File of the Health Resources and Services Administration. **NOTES** The categories of benefits are explained in the notes to exhibit 1. Differences among the three groups of communities by share of uninsured residents were significant for community health improvement and charity care ($p < 0.05$).

this vein, it is important to note that the provision of the ACA related to the assessments did not become effective for most hospitals until 2012, and the law's health insurance expansion provisions did not begin until 2014. Indeed, there is research indicating that hospitals located in states that expanded Medicaid eligibility in 2014 experienced declines in uncompensated care costs, which includes charity care.[9] Whether these and other ACA initiatives, if they remain in place, will eventually lead to changes in the level and pattern of community benefit spending among tax-exempt hospitals is an important question for future research.

In addition, our study shows that hospitals facing relatively high demand for charity care spend substantially less on community health initiatives than do other hospitals. This result points to a paradox of sorts, in that hospitals located in communities with substantial socioeconomic challenges may lack the financial resources to invest in community health initiatives as a result of strong and ongoing demand for charity care.

Finally, we note that during the entire study period, much variation existed among hospitals in terms of spending on community benefits relative to their operating expenses. Much of this variation was systematic: Many of the same hospitals were at the high and low ends of the spending distribution year after year. This substantial and persistent variation in community benefit spending among hospitals will likely continue to be a source of concern among policy makers and community leaders.

Conclusion

Certainly, more time is needed to see whether hospitals' spending on community benefits begins to move in a direction that is in line with key US health policy goals. However, even if ACA-related expansions of health insurance do help free up financial resources for hospitals to invest in community health, many hospitals may lack the infrastructure and competencies necessary for effectively engaging in community health initiatives. A recent study reported that many hospitals have made limited progress in achieving key objectives of the provision about community health needs assessments—specifically, developing stronger collaborations with community stakeholders such as local public health departments.[10] Accordingly, policy makers may need to consider other approaches for promoting hospitals' investment in community health, such as providing technical support and training to help hospitals develop and implement community health initiatives. ■

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NOTES

1 American Hospital Association. Fast facts on US hospitals [Internet]. Chicago (IL): AHA; [updated 2016 Jan; cited 2017 Nov 16]. Available from: http://www.aha.org/research/rc/stat-studies/fast-facts2016.shtml

2 Rubin DB, Singh SR, Young GJ. Tax-exempt hospitals and community benefit: new directions in policy and practice. Annu Rev Public Health. 2015;36:545–57.

3 Rosenbaum S, Kindig DA, Bao J, Byrnes MK, O'Laughlin C. The value of the nonprofit hospital tax exemption was $24.6 billion in 2011. Health Aff (Millwood). 2015;34(7):1225–33.

4 Young GJ, Chou CH, Alexander J, Lee SY, Raver E. Provision of community benefits by tax-exempt U.S. hospitals. N Engl J Med. 2013;368(16):1519–27.

5 Leider JP, Tung GJ, Lindrooth RC, Johnson EK, Hardy R, Castrucci BC. Establishing a baseline: community benefit spending by not-for-profit hospitals prior to implementation of the Affordable Care Act. J Public Health Manag Pract. 2017;23(6):e1–9.

6 James J. Health policy brief: nonprofit hospitals' community benefit requirements [serial on the Internet]. 2016 Feb 25 [cited 2017 Nov 16]. Available from: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_153.pdf

7 Somerville MH, Seeff L, Hale D, O'Brien DJ. Hospitals, collaboration, and community health improvement. J Law Med Ethics. 2015;43(Suppl 1):56–9.

8 To access the appendix, click on the Details tab of the article online.

9 Dranove D, Garthwaite C, Ody C. Uncompensated care decreased at hospitals in Medicaid expansion states but not at hospitals in non-expansion states. Health Aff (Millwood). 2016;35(8):1471–9.

10 Cramer GR, Singh SR, Flaherty S, Young GJ. The progress of US hospitals in addressing community health needs. Am J Public Health. 2017;107(2):255–61.