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### Commentary: Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems

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## Commentary: Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems

### Abstract

In *Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems*, Rosenbaum *et al* describe the numerous variations between current state law in 24 states and federal requirements regarding nonprofit hospitals' community benefit activities. The potential for nonprofit hospitals to help shape community health is great, and how states choose to address requirements regarding community benefit, and potentially reinforce the new federal requirements to incentivize hospital participation in addressing root causes of poor health, should be of significant interest to the public, policy makers and public and population health experts, given the large percentage of hospitals in the US that are nonprofit. Criteria that states may wish to examine when determining whether to add or retain separate reporting requirements include: 1) Is there a state policy interest in listing or further defining additional examples of community benefit investments beyond federal requirements, for instance specific public health activities or in mandating statutory percentages/ minimums for community benefit overall and also among specific sub-categories of benefits, such as the percentage for uncompensated care versus community-building activities, and, 2) Is there a state policy interest in continuing to include 'bad debt' as a part of 'charity care' even after implementation of health care reform? For the 24 states that address community benefit reporting in state policy, and the other 26 that do not, key policy debates will include how nonprofit hospitals can continue to meet divergent state and federal reporting and activity requirements, what fundamental values are articulated by Schedule H that could be replicated by states to serve their own tax and other policy needs, how state action may reinforce federal requirements and encourage nonprofit hospital engagement in addressing community health, and whether states may have unique or additional policy interests beyond federal requirements that should be included in separate reporting requirements. Rosenbaum's analysis provides a helpful start to acknowledging the varying state and federal interests at play.

### Keywords

Schedule H, nonprofit hospitals, community benefit, social determinants of health

## **Editorial Comment**

In *Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems*, Rosenbaum *et al* describe the numerous variations between current state law in 24 states and federal requirements regarding nonprofit hospitals' community benefit activities. Recent federal changes include addition of Schedule H to the annual IRS 990 reporting form<sup>i</sup> for charitable organizations (typically known as 501c3 organizations), and clarification both in the Patient Protection and Affordable Care Act<sup>ii</sup> and IRS guidance. These federal changes address a specific menu of benefits among which nonprofit hospitals may choose to provide to the community as a reportable charitable purpose, how they must assess community needs, and how they must report their activities. In 2010, 2,904 nonprofit community hospitals (or approximately three-quarters of all hospitals) served millions of Americans in the United States, according to an American Hospital Association survey. The potential for nonprofit hospitals to help shape community health is great, and how states choose to address requirements regarding community benefit, and potentially reinforce the new federal requirements to incentivize hospital participation in addressing root causes of poor health, should be of significant interest to the public, policy makers and public and population health experts.

Key points raised by Rosenbaum in her comparison of state level policy to IRS Schedule H requirements include the variation around three core issues - 1) Public reporting of hospital activities, 2) Clear, consistent terminology and definition of community benefit, and 3) Reporting requirements regarding community health improvement and community building. Of these, perhaps the most important variations are in the areas of definitions of community benefit (including whether 'bad debt' is included as part of financial assistance or charity care), and

requirements to report on community health improvement and community building.

Only 24 states currently have reporting requirements according to Rosenbaum. Her analysis raises the question for these states as to whether state policy could permit Schedule H to satisfy state filing requirements<sup>iii</sup>, or replicate the requirements of Schedule H, in lieu of maintaining distinct state reporting frameworks for their nonprofit hospitals (many states provide state tax exemptions to nonprofit hospitals and the article's analysis of different state laws also shows that some states require community benefits and reporting as a condition of hospital licensure). While states may take either of these actions, they may also wish to retain their own reporting requirements as a condition of state policy, as Rosenbaum notes. Ultimately, the issue for all states moving forward is whether or not there may be a compelling state interest to have separate reporting requirements for purposes of nonprofit hospital state tax exemptions or other state policy reasons.

Criteria that states may wish to examine when determining whether to add or retain separate reporting requirements include: 1) Is there a state policy interest in listing or further defining additional examples of community benefit investments beyond federal requirements, for instance specific public health activities<sup>iv</sup> or in mandating statutory percentages/minimums for community benefit overall and also among specific sub-categories of benefits, such as the percentage for uncompensated care versus community-building activities, and, 2) Is there a state policy interest in continuing to include 'bad debt' as a part of 'charity care' even after implementation of health care reform? Only 4 of the studied states define community benefits similarly to Schedule H. Rosenbaum also finds that the 24 states' definitions of community benefit (whether or not that precise term is used)

do not fully articulate the distinction between hospital investments in charity care as uncompensated care versus bad debt, as the IRS form does.<sup>v</sup>

In order to understand specific policy interest in the degree and type of investment that nonprofit hospitals make, it is worth understanding both the overall investments in community benefit and how they are allocated by categories. A 2009 study, conducted by the American Hospital Association, for instance, showed that of 571 nonprofit hospitals surveyed, only 0.1 of total expenses were for community benefits (defined then, prior to the recent changes, as programs and activities to improve community health, underwrite medical research and health professions education).<sup>vi</sup> And, even with the Schedule H changes, only two reporting areas -- “Community Health Improvement Services” (Part I Section 7) and “Community Building Activities” (Part II) potentially address ‘upstream’ causes of poor health or ‘social determinants of health.’ With the IRS requirements, hospitals may opt to invest the entirety of their resources for community benefit in uncompensated care or research (provided that their community health needs assessment calls out those issues), yet this laudable effort still leaves out the more difficult work of investing in the root causes of poor health, necessary ultimately to address the triple aims of health care reform.<sup>vii</sup>

The ACA requirements and Schedule H appear to provide a more comprehensive and clear set of definitions for what constitutes a community benefit, including uncompensated care, and community building, in exchange for federal tax-exempt status for nonprofit hospitals than current state policy does in most instances, yet states may choose to go further in their own policies. For the 24 states that address community benefit reporting in state policy, and the other 26 that do not, key policy debates will include how nonprofit hospitals can continue to meet divergent state and federal reporting and activity requirements, what fundamental values are articulated by Schedule H that could be replicated by states to serve

their own tax and other policy needs, how state action may reinforce federal requirements and encourage nonprofit hospital engagement in addressing community health, and whether states may have unique or additional policy interests beyond federal requirements that should be included in separate reporting requirements. Future areas of study could monitor state policy changes, and ultimately seek to understand the relationship between variable reporting requirements and community impact that community benefit work is intended to accomplish. Rosenbaum's analysis provides a helpful start to acknowledging the varying state and federal interests at play.



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<sup>i</sup> Internal Revenue Service, Schedule H (Form 990) 2011: Hospitals (Revised 2012), accessed December 15, 2012, <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>

<sup>ii</sup> Patient Protection and Affordable Care Act, Public Law No. 111-148, §9007, 124 Stat. 855, (March 2010): 737-741.

<sup>iii</sup> Some states analyzed already use Schedule H to satisfy their reporting requirements.

<sup>iv</sup> See Rosenbaum's excerpt of Oregon's community benefit definition, which includes threshold criteria, as well as a list of benefits. Oregon Administrative Rules §409-023-0100.

<sup>v</sup> This distinction is significant, because as the article notes, as more people are insured under the reforms of the ACA, whether through public, subsidized or market-rate insurance, fewer individuals are expected to need true charity care due to lack of insurance. This narrow interpretation of uncompensated care could allow more nonprofit hospital attention to and investment in other community benefits, as identified by the community health needs assessment. Other differences between state law and Schedule H include how Medicaid participation and costs associated with Medicare are treated, as well as how 'community building investments' are defined.

<sup>vi</sup> Results of the 2009 Schedule H Project, Ernst and Young, January, 2012, accessed December 15, 2012. <http://www.aha.org/content/12/09-sche-h-benchmark.pdf>

<sup>vii</sup> Medical research spending is estimated to be \$140 billion annually. Public health research is estimated to be no more than \$1 billion annually. States may have a compelling interest in increasing investment by nonprofit hospitals in public health research.