LDI Issue Brief

Volume 6, Number 4
December 2000/January 2001

Leonard Davis Institute of Health Economics

Sean Nicholson, PhD
LDI Senior Fellow,
Assistant Professor of Health Care Systems
University of Pennsylvania

Mark V. Pauly, PhD
LDI Senior Fellow,
Bendheim Professor of Health Care Systems
University of Pennsylvania

Community Benefits: How Do For-Profit and Nonprofit Hospitals Measure Up?

Editor's Note: The rise of the for-profit hospital industry has opened a debate about the level of community benefits provided by non-profit hospitals. Do nonprofits provide enough community benefits to justify the community's commitment of resources to them, and the tax-exempt status they receive? If nonprofit hospitals convert to for-profit entities, would community benefits be lost in the transaction? This debate has highlighted the need to define and measure community benefits more clearly. In this Issue Brief, the authors develop a new method of identifying activities that qualify as community benefits, and propose a benchmark for the amount of benefit a nonprofit hospital should provide.

States are enhancing and clarifying federal community benefit standards

About 14% of U.S. community hospitals are for-profit, although they are not evenly distributed in all areas. In the Northeast, for example, for-profits have fewer than 3% of all hospital beds; in some southern states, they control more than 30% of beds. In many markets, nonprofit hospitals compete directly with for-profits, leading some to question whether nonprofits should retain their tax-exempt status.

- On one hand, for-profit hospitals argue that they provide a level of community benefits similar to their nonprofit counterparts, and view tax exemption as providing unfair competitive advantage; on the other hand, nonprofit hospitals maintain that they provide special benefits to the communities they serve, ones that may be lost when nonprofit hospitals convert to for-profit entities.
- The Internal Revenue Service has a broad definition of the community benefits required for exemption from federal income taxes. States and communities have shown an interest in refining this definition to protect the yield from their investment in nonprofit hospitals.
- According to the General Accounting Office, at least 24 states have enacted legislation regarding nonprofit hospital conversions to for-profit entities. Generally, these laws include provisions for public disclosure of the transaction, fair valuation of the charitable assets of the hospital, and assurances that the proceeds of the transactions will continue to be used to provide community benefits.
- Since 1990, at least 8 states have enacted requirements expanding upon the federal community benefit standard. Five of these states have taken a process-oriented approach, with community benefit planning and reporting provisions, while the others have taken a more prescriptive approach, imposing minimum charity care or community benefit expenditures on tax-exempt hospitals.

Defining community benefits as "public-good" services

Nicholson and colleagues used the economic concept of a "public good" as the basis for defining a useful and valid measure of community benefits. A public good generates benefits for people other than the direct user by increasing the well-being of non-users. While most medical services are private goods, some, such as those that prevent contagious disease, have important public-good dimensions. Using this framework, the authors developed a set of activities that they believe constitute community benefits. They include:

- Uncompensated care. Uncompensated indigent care is a public good because everyone in the community presumably values knowing that high-risk and poor persons are receiving proper care. Uncompensated care includes charity care (free care provided to those who qualify based on financial eligibility), and bad debt (care for which the patient was billed, but the hospital was unable to collect the entire bill).
- Other public-good, money-losing services. Hospitals provide other services for the public good, although those services often do not generate a bill. Examples include AIDS prevention clinics, health screenings, and pregnancy education classes. They may also provide critical facilities that may not be as profitable as others, such as a trauma unit or an emergency room.
- Medical research. Hospitals that subsidize medical research activities provide a public good because all patients benefit from the research discovery.
- Taxes. Property taxes, sales taxes on supplies, and income taxes on profits can be considered a public good. A community that taxes a for-profit hospital benefits because it will be able to lower its tax rates for everyone, or increase the level of public services it provides with the additional tax revenue.

Other services that might qualify as community benefits

The authors identified other services that might fit into an inclusive definition of community benefits. However, they felt that the rationale for including them was weaker than the first four activities. These more debatable activities include:

- Medicare and Medicaid shortfalls. Such shortfalls occur when government payments are lower that the hospital's treatment costs. Proponents of treating shortfalls as community benefits argue that a hospital relieves the government of a financial burden when it provides care to publicly insured patients. But others believe that these payments reflect voters' preferences for the amounts of resources they wish to devote to these patients, and should not be considered a community benefit.
- Price discounts to privately insured patients. If a hospital charges less than it "could" to maximize profits, it could be reducing health plan expenditures and premiums for consumers in the community. However, such "underpricing" transfers money from some members of society to others, rather than creating a benefit to the entire community.
- Losses on medical education. Losses occur when medical education expenses exceed the sum of tuition and government payments for medical education. This can be interpreted as a community benefit only if one believes that subsidies are required to ensure a sufficient number or quality of physicians.

New benchmark for community benefits based on financial performance of for-profit hospitals

Conventional wisdom suggests that a nonprofit hospital should provide community benefits that are at least as large as the taxes it would pay if it were for-profit. But in competitive markets, nonprofit and for-profit hospitals are subject to the same business conditions, and might be expected to yield similar returns on their assets. The authors propose a new benchmark for nonprofits based on the financial performance of similar for-profits.

- Because nonprofit hospitals do not need to generate a profit to satisfy shareholders, they should be expected to provide community benefits equal to the amount that for-profit hospitals spend on community benefits, plus the for-profit hospital's after-tax profit.
- The for-profit hospital's profit can be calculated as its return on assets (ROA, net income divided by the book value of its assets) or return on equity (ROE, net income divided by its assets after subtracting its outstanding debts.) The benchmark amount would adjust for differences in the amount of assets or equity at each hospital.
- If a nonprofit hospital spends less on community benefits than this benchmark amount, it could be using its assets for purposes that the community does not value (or for purposes the community does value but are not measured), or it could be accumulating profit to provide community benefits in the future.

Study compares actual and expected spending on community benefits using new benchmark

The authors compare estimates of the current level of community benefits by nonprofit hospitals with estimates based on their new benchmark. They used financial data from 1996-1998 to calculate return on assets and return on equity for the three largest U.S. for-profit systems—Columbia/HCA, Tenet and Universal Health Services. With currently available data, they were able to estimate only two of the four clear community benefits: taxes and uncompensated care.

- According to the American Hospital Association, in 1995 for-profit hospitals provided uncompensated care equal to 4.1% of their total operating costs, on average. If the three largest for-profit systems exhibit similar behavior, they would provide $1.2 billion of uncompensated care per year.
- The systems paid an estimated $810 million in income taxes, $165 million in sales taxes, and $263 million in property taxes, for a total of $1.2 billion in taxes per year.
- Thus, the three systems spent an estimated $2.4 billion per year on uncompensated care and taxes. On average, the systems earned an annual net income of close to $1 billion. Combining the community benefits and profit, the benchmark for average return on equity and return on assets would have been 30.1% and 10.3%, respectively.

Nonprofits appear to fall far short of benchmark

The benchmark rate of return can be applied to the equity and assets of a particular nonprofit hospital to determine its expected level of community benefit spending. The authors applied the benchmark to 1995 data on 3,646 private, nonprofit general acute care hospitals.

- With the benchmark rates of return of 10.3% on assets or 30.1% on equity, the average nonprofit hospital would be expected to spend $9.1 million or $13.2 million on community benefits.
- American Hospital Association data indicate that nonprofit hospitals spend 4.6% of their operating costs on uncompensated care. This translates into average uncompensated care costs of $3.3 million per hospital in the study, or about 25%-36% of expected community benefit spending. There remains a $5.8-$9.9 million gap between expected and actual services.
- It is possible that some of this gap is due to other community benefits that the authors could not measure, for example, subsidies of medical research and price discounts. Even with generous assumptions for these amounts, it appears that actual community benefit spending is still only 83% of the return-on-assets benchmark, and 58% of the return-on-equity benchmark.

POLICY IMPLICATIONS

These results suggest that nonprofit hospitals are not using their funds to generate as large a volume of identifiable community benefits as they could. The reasons for this gap remain unclear, but could relate to differences in the quality of care, to unmeasured benefits, or to inefficiencies in community-led institutions.

- It is likely that nonprofit hospitals are delivering care that is of higher quality, but the market contains inadequate measures for either identifying higher quality or compensating hospitals that deliver higher quality care. This possibility highlights the need for additional research on objective and practical measures of quality.
- This model is useful for identifying situations in which nonprofit hospitals might be providing fewer community benefits than expected—situations in which other benefits are not measured or are not well justified. Once the unmeasured activities are identified, these hospitals can be asked to describe and justify them.
- This model may also be useful to regulators in identifying and protecting the charitable assets of nonprofit hospitals converting to for-profit entities, and for tracking the status of community benefits after conversion.

This Issue Brief is based on the following article: S. Nicholson, M.V. Pauly, L.R. Burns, A. Baumritter, D. A. Asch. Measuring community benefits provided by for-profit and nonprofit hospitals. Health Affairs, November/December 2000, vol. 19, pp. 168-177.

Published by the Leonard Davis Institute of Health Economics, University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104-6218, 215-898-5611.
Janet Weiner, MPH, Associate Director for Health Policy, Editor
David A. Asch, MD, MBA, Executive Director

Visit us on the web at **www.upenn.edu/ldi**

Issue Briefs synthesize the results of research by LDI's Senior Fellows, a consortium of Penn scholars studying medical, economic, and social and ethical issues that influence how health care is organized, financed, managed, and delivered in the United States and internationally. The LDI is a cooperative venture among Penn schools including Dental Medicine, Medicine, Nursing and Wharton. For additional information on this or other Issue Briefs, contact Janet Weiner (e-mail: weinerja@mail.med.upenn.edu; 215-573-9374).

ADDRESS CORRECTION REQUESTED
fax 215.898.0229
215.898.5611
Philadelphia, PA 19104-6218
3641 Locust Walk

University of Pennsylvania
Leonard Davis Institute
of Health Economics
Published by the

Issue Brief

Nonprofit Organization
U.S. Postage
PAID
Permit No. 2563
Philadelphia, PA 19104