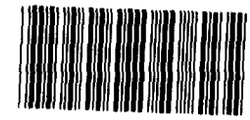
United States General Accounting Office 144334

GAO Testimony



For Release
on Delivery
Expected at
10:00 a.m.
Wednesday
July 10, 1991

NONPROFIT HOSPITALS: Better Standards Needed for Tax Exemption

Statement of
Mark V. Nadel, Associate Director,
National and Public Health Issues

Before the
Committee on Ways and Means
House of Representatives

GAO/T-HRD-91-43

051850/144334

GAO Form 160 (12/87)

SUMMARY

In the wake of increasing pressure on hospitals to contain costs, there are concerns that some hospitals are reducing their provision of indigent care and other charitable activities. Changes in the market affect all types of hospitals, but nonprofit hospitals are under more scrutiny because of their treatment as charities under the tax code.

Last year, GAO issued a report, Nonprofit Hospitals: Better Standards Needed for Tax Exemption, (GAO/HRD-90-84, May 30, 1990) assessing the role played by these hospitals in providing charitable services to the indigent population of their communities. GAO found that the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak for many nonprofit hospitals. Typically, in the states GAO reviewed large urban teaching and public hospitals provided a disproportionate share of charity and other unreimbursed care. The nonprofit hospitals providing the lowest levels of such care served the fewest Medicaid patients and often had the highest profits. These were among the hospitals most financially able to provide additional care to the medically indigent, and also the hospitals that profited most from their tax exemptions.

Furthermore, in the communities we reviewed it was not uncommon for nonprofit hospitals' strategic goals to resemble those of for-profit institutions. For example, both focus on increasing market share, rather than targeting underserved populations or addressing particular health problems of this segment of their communities. For the most part, the nonprofits' admission policies effectively limit charity care to emergency room and admissions resulting from emergencies.

In addition to providing care to those unable to pay, nonprofit hospitals provide such community services as health education and screening, clinic services, and immunizations. However, these activities do not distinguish nonprofits from for-profit hospitals. Nonprofit hospitals were just as likely as for-profits to charge a fee for these services and more likely to recover the costs of providing them.

Currently, the Internal Revenue Service has no requirements relating hospitals' tax-exempt status to the charitable activities they provide to the poor or underserved residents of their communities. If the Congress wishes to encourage nonprofit hospitals to provide charity care to the poor and underserved and other community services, it should consider revising the criteria for tax exemption.

Mr. Chairman and Members of the Committee,

I am pleased to be here today to discuss the role played by nonprofit hospitals in providing charitable services to the indigent population of their communities. My testimony will be based on the report we issued last year, Nonprofit Hospitals: Better Standards Needed for Tax Exemption.[1] In this report, we analyzed the distribution of uncompensated care (which includes both charity care and bad debt expense) among hospitals in five states--California, Florida, Iowa, Michigan, and New York. Where available, we focused on data concerning charity care. In addition, we conducted case studies in five communities and surveyed a nationwide sample of hospital administrators in which we obtained 522 responses as to the types of community services they provided.

For many nonprofit hospitals, we found the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak. Currently, the Internal Revenue Service (IRS) has no requirements relating hospitals' charitable activities for the poor to their tax-exempt status. If the Congress wishes to encourage nonprofit hospitals to provide charity care and other community services that benefit the poor, it should consider revising the criteria for tax exemption.

---

[1]GAO/HRD-90-84, May 30, 1990.

BACKGROUND

Nonprofit hospitals that meet certain tests established by the IRS are exempt from federal taxation; they generally are also exempt from state and local taxes. Between 1956 and 1969, IRS's test for tax-exempt status included specific reference to providing--to the extent the hospital's finances allowed--services to individuals not able to pay. Since 1969, however, IRS has not required such care so long as the hospital provides benefits to the community in other ways. Presently, the major distinction between for-profit and nonprofit hospitals is that the nonprofit hospitals' surplus earnings (or profits) cannot be paid out to owners or anyone else associated with the organization. Instead, they must be devoted to the hospitals' tax-exempt purposes.

In light of significant changes in the hospital sector, IRS is beginning to explore its tax policies. During the 1980s, changes in the way hospitals are reimbursed raised concerns about the extent to which hospitals would be able to provide care to those who cannot pay. Increased competition between hospitals for patients and attempts by government, employers, and insurers to contain costs make hospitals less able or willing to subsidize care.

There are some indications that access by the medically indigent to hospital care in this cost-containment environment is

declining. Poor people without public or private insurance gain access to nonemergency hospital services only if the hospital is willing to admit them with little expectation of payment. By treating patients who are uninsured or underinsured, hospitals give residents access to care that might otherwise be unavailable.

UNEVEN DISTRIBUTION OF UNCOMPENSATED CARE

In the five states we reviewed, government-owned hospitals provided a disproportionate amount of the uncompensated care. Both nonprofit and for-profit hospitals provided a smaller share of the states' uncompensated care than they provided of general hospital services. For example, in California, nonprofit hospitals provided 66 percent of the total days of hospital care but only 39 percent of the state's uncompensated care expenses.

Moreover, the burden of uncompensated care was not distributed equally among the nonprofit hospitals in these five states. Large, urban teaching hospitals often bore a disproportionate share of the uncompensated care expenses incurred by the nonprofit hospital sector than did other nonprofit hospitals. For example, nine major teaching hospitals in New York City accounted for 38 percent of all uncompensated care provided by nonprofit hospitals statewide, though they had only 16 percent of the state's nonprofit hospital beds.

Nonprofit hospitals that had the highest rates of uncompensated care served more Medicaid patients and had lower profit margins. Conversely, those with the lowest rates of uncompensated care served fewer Medicaid patients and had higher profit margins. Because of their higher profits, nonprofit hospitals with the lowest uncompensated care rates received the greatest benefit from their tax exemption. Consequently, these hospitals were generally more financially able than other nonprofit hospitals to increase services to their communities' indigent population.

SOME HOSPITALS' POTENTIAL TAX LIABILITY EXCEEDS CHARITY CARE PROVIDED

One way of gauging the reasonableness of the levels of care provided by nonprofit hospitals to those who cannot pay is to compare the value of that care to the value of the hospitals' tax exemptions. To estimate the tax revenue lost as a result of exempting nonprofit hospitals from federal and state income taxes, we applied the average effective tax rate of a sample of for-profit hospital corporations to the nonprofit hospitals' net incomes.

In the three states where we were able to get information on the charity portion of uncompensated care costs, we found that about 57 percent of the nonprofit hospitals provided care whose value was less than the value of their potential tax liability.

For example, in New York and California, 43 and 71 percent of nonprofit hospitals, respectively, had an estimated potential tax liability that exceeded the amount of charity care they provided.

GOALS AND POLICIES DO NOT ENCOURAGE ELECTIVE TREATMENT FOR THE UNINSURED

When we visited the hospitals in five communities--one community in each state we reviewed--we found a general absence of proactive policies regarding the indigent. As a result, the distribution of uncompensated care among the communities' hospitals was largely based on historic treatment patterns or the hospitals' locations.

The admissions policies of many hospitals we visited--both nonprofit and for-profit--limited a majority of charity care to that initiated in the emergency room. Few hospitals had admissions or physician staffing policies that facilitated elective admissions for those who could not pay. In the communities with a mix of hospital ownership types, admissions and physician staffing policies at nonprofit and for-profit hospitals were similar.

For example, in Orlando, both nonprofit and for-profit hospitals sought to determine whether patients were able to pay before admitting them for nonemergency treatment. Two of the three

nonprofit hospitals in this community generally referred patients unable to pay to state and county clinics for elective care.

The willingness of physicians to treat Medicaid patients or other patients unable to pay for treatment also can affect the amount of nonemergency indigent care a hospital can provide. In the communities with relatively high numbers of medically indigent, hospital administrators told us that it was often difficult to get physicians to treat the indigent. In addition to receiving little or no payment from indigent patients, physicians often have to interrupt their regular practice to treat them. Some hospital administrators feared that if they increased the on-call duties of physicians practicing at their hospital, some would eventually move their practices to hospitals without so many indigent patients. Furthermore, officials from one nonprofit hospital told us that, because few of its physicians participated in the Medicaid program, they admitted few Medicaid patients to the hospital.

The hospitals we visited gave us information on their strategic goals and, in some cases, recent minutes of their board of directors' meetings. From these sources we tried to identify goals related to provision of charity care or community health services. The hospitals set numerous goals that related to expanding medical services to meet increased patient demand or to increase their market share. But generally no goals were directed at serving low-income community residents.

This absence of proactive policies among nonprofit hospitals can cause problems in delivering services to the indigent and could eventually cause gaps in services for entire communities. Delivering services to the indigent was a greater problem in some communities we visited than in others. In two communities we visited, uncompensated care costs were relatively high and the nonprofit hospitals providing the largest share of such care were seeking ways to reduce them. Hospital administrators in these communities were most concerned about controlling the costs of emergency and obstetrical services to the indigent.

COMMUNITY SERVICES PROVIDED BY MOST HOSPITALS

Provision of acute medical services to people unable to pay is only one way in which communities benefit from the presence of a hospital. For example, some hospitals, though not reporting high amounts of uncompensated care, may serve their communities' low-income residents through clinics that offer services or perform low-cost or free screening to all community residents. When we surveyed a sample of hospital administrators nationwide as to the types and extent of activities they perceive as providing community benefits, we found that nonprofits and for-profits were likely to provide similar services. For example, both nonprofit and investor-owned hospitals identified blood pressure tests, cholesterol tests, and various types of cancer screening as their

major health screening services. Nonprofit hospitals were more likely than investor-owned hospitals to offer these services but were (1) equally likely to charge patients a fee for them and (2) more likely to recover the costs of providing them.

CONCLUSION

We found that for many nonprofit hospitals, the link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak. If one goal of the tax exemption is to recognize the charitable role of hospitals and encourage them to continue or expand current levels of charity care and other services to the poor, changes in tax policy may be needed. One option would be to reestablish the link between tax exemption and the level of charity care provided by hospitals. In this way, nonprofit hospitals providing a valuable community service would retain their tax exemption. On the other hand, those that do not provide a reasonable level of charity care or other services to the poor would have it withdrawn.

Although IRS could revise the standard for charitable hospitals without a legislative mandate, given the important implications for health and tax policy, it would be preferable to have Congressional direction for such a policy change. Under current tax policies, some hospitals can and do take measures to avoid serving the indigent. Many simply do not explicitly address

the health needs of this segment of their communities. Such evasion, whether active or passive, increases the burden on the remaining hospital community that serve this population. Increased charity care alone will not solve the problems faced by our large uninsured and underinsured population, but it can be part of the solution.

- - - -

This concludes my prepared statement. I will be happy to answer any questions you may have.