

**Minnesota Nonprofit Hospitals' Community Benefit:
Adequate For Tax Exemption?**

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Executive Summary

As the number of Americans without health insurance continues to increase meeting the health needs of the public is becoming an increasingly greater challenge. Among the entities considered accountable for the health of our community are nonprofit hospitals, which are required to provide community benefits – including healthcare for the uninsured – as a condition of their tax exempt status. For health policy-makers and other stakeholders, nonprofit hospitals represent a crucial resource for increasing indigent populations’ access to health care services. However, the community benefit mandate placed on nonprofit hospitals in the Internal Revenue Service’s (IRS) Internal Revenue Code (IRC) does not explicitly define what type of benefits or the amount of benefit that is required to meet the standards set forth by the law. Moreover, the most recent revision of IRC 501(c)(3) enacted in 1969 changed the language that required nonprofit hospitals to provide free care to the best of their financial ability (known as the financial ability standard), so that the provision of free care was not necessary for a nonprofit hospital to fulfill the community benefit requirement.¹

In recent years, states and localities facing budget cuts have begun paying attention to the benefits provided by their community’s nonprofit hospitals in lieu of property and sales taxes.² In this era of ever increasing health care costs and rising rates of uninsurance, the capability of publicly funded hospitals to meet the health care needs of the indigent population has diminished, obliging the majority of nonprofit hospitals to share this responsibility.³ A number of approaches taken by government officials and other stakeholders to increase nonprofit hospital accountability, such as litigation, legislation and collaborative initiatives substantiate this notion.⁴ Minnesota is amid this

trend of nonprofit scrutiny, with the momentum generated by the state Attorney General Mike Hatch's audits of several large nonprofit health care organizations, revealing an array of unscrupulous practices. Discriminatory pricing (uninsured billed "at charge" rather than at the discounted rates charged to those with insurance), excessive executive compensation, and aggressive debt collection practices were among the issues raised in the audits.⁵

In the aftermath of this negative publicity, Minnesota's largest integrated delivery systems and hospitals implemented organizational policy changes in response to Hatch's findings and pursued industry-wide agreements to provide discounts to low-income, uninsured consumers. Despite these current events, the state's ability to monitor nonprofits' community benefits and ensure adequate amounts are provided remains weak.

Minnesota could pursue a number of actions to ensure its nonprofit hospitals are adequately benefiting our communities. I analyzed five strategies that address the issue of nonprofit accountability, including two carried out in Minnesota as well as three approaches taken by other states. I evaluated the strategies' ability to meet each of four objectives that I identified after a review of the literature. Public accountability and protection of the safety net were consistent themes I encountered in my research and provide the foundation for the following objectives: 1) Increase access to care for low-income uninsured, 2) Reward or compensate hospitals with greater burdens of uncompensated care, 3) Increase transparency of hospitals' programs and costs that are considered to fulfill their community benefit requirement, and 4) Ensure hospitals' community benefits meet the needs of the community.

My analysis of the five approaches suggests that a voluntary initiative – such as Massachusetts’ Community Benefit Reporting initiative – is the best option for Minnesota to protect its safety net and hold nonprofit hospitals accountable for their tax exempt status. Furthermore, recent events suggest that Minnesota’s hospital industry is willing to take collective action to improve the public opinion of hospitals and restore accountability through self regulation.

The time is ripe for health care leaders, policy makers, and legislators in Minnesota to initiate a collaborative approach to more clearly define the public’s expectations of nonprofit health care organizations, starting with hospitals. The financial advantages enjoyed by tax exempt entities should not be underestimated, nor should their accountability to their communities be dismissed.

I. Introduction

Rapidly increasing health care costs in combination with the recent economic downturn in the United States is eroding the health care safety net.⁶ Simply said, resources for providing health care to those unable to pay are being pared down while the population in need is growing. As the public health insurance programs around the country face cuts in funding, greater attention is being paid to safety net providers to ensure that we are maximizing already scarce resources. This increased scrutiny has taken its toll on nonprofit hospitals, which have been under fire from the Minnesota Attorney General Mike Hatch since Medica was required to split from Allina due to corporate misconduct and improper stewardship of assets.⁷ Most recently, Hatch brought media attention to Fairview Health Services' in his report on Fairview's overly aggressive debt collection practices.⁸ In addition, Hatch targeted several other major Minnesota health care providers by publicizing unfair pricing of services to the uninsured. This project was motivated by this series reports on Minnesota's nonprofit health care organizations.

The structure of this paper mirrors the process of discovering the complexities of nonprofit hospital accountability. I first present the history of hospitals' nonprofit status, and on how the legal requirements that qualify a hospital for nonprofit status have changed over time. In particular, I focus on a chronically ambiguous, yet highly important, legal obligation of every nonprofit organization to provide some sort of benefit or service to the community. In contrast to for-profit organizations which exist to earn profits for their owners, nonprofit organizations are supposed to operate within the best interest of their communities, given the financial advantages of their nonprofit status.

I then turn my attention to Minnesota, whose hospital market is unique in that all but one hospital are nonprofit. In my analysis, I consider the current role of the state government in holding nonprofit hospitals accountable for fulfilling the obligations of their legal nonprofit status. Integral to this evaluation are the factors that set Minnesota apart from much of the country, such as the relatively low rates of uninsurance and lower than average amount of uncompensated reported by hospitals and clinics.⁹ Finally, in light of the questionable operations of certain nonprofit health care organizations that were recently uncovered by the Attorney General, and the industry's response to that publicity, I present four policy objectives for the state. I use then use these objectives to analyze the desirability of several policy options based on the degree to which the objectives are met.

History of Nonprofit Hospitals

The foundation of the United States health care system is a product of an incremental political process shaped by economic and social events. Unfortunately, this foundation has resulted in an inefficient and irrational system rife with perverse incentives. Modern day nonprofit hospitals exemplify this dilemma. Unlike the traditional, though changing, attitude toward public education, there is no consensus among US citizens as to whether health care is a public resource or a market good.¹⁰ This leads one to question: why are so many of our hospitals nonprofit? The simple answer is history.

In their naissance, US hospitals primarily served the sick and poor who were unable to pay for physician home visits and likely deprived of shelter. Hospitals originated as charitable institutions, funded by philanthropic donors. Throughout the years, medicine evolved into a discipline of research and innovation, and hospitals

provided a convenient location in which to centralize practices in this developing field.¹¹ No longer were hospitals a haven for the indigent, as paying patients began to enter the equation.¹² The notion of hospitals as charitable institutions, however, endured this transition, permitting financial benefits under early tax law.

In 1956 the IRS created explicit language for what qualified hospitals as charitable and thus eligible for tax exemption under IRC 501(c)(3).¹³ In following hospitals' origins, the ruling adopted a narrow definition of charitable, requiring that hospitals provide free or discounted care for the poor in order to maintain the tax advantages of nonprofit status. The ruling included what came to be known as the "financial ability standard," in which the extent of uncompensated care sufficient to meet the IRS charitable standard was determined by each hospital's financial ability to provide such care. The ruling specified that a nonprofit hospital "...must, to the extent of its financial ability, be operated for those not able to pay for care. It may not be operated exclusively for those able to pay, and may not refuse patients who cannot pay for care." Provider backlash to this ambiguous yet seemingly restrictive language was prompt, and in 1959 the IRS revised Rev.Rul. 56-185 to encompass a broader notion of charity, promulgating that, "charitable must be interpreted in its generally accepted legal sense."¹⁴ The change in wording did little to clarify this policy.

Over the next ten years, health care experienced changes that would eventually lead to the final revision in 1969, which again addressed criteria for qualifying nonprofit hospitals' charitable standard.¹⁵ The landmark enactment of Medicare and Medicaid in 1965 established the first government funded health insurance for the elderly, disabled and indigent populations. As a result of this coverage expansion, the charity care burden on hospitals declined while patient care revenues increased.¹⁶ The 1969 IRS ruling was responsive to the changing financial conditions of nonprofit hospital operations,

eliminating the financial ability standard – which was poorly interpreted and difficult to comply with – and replacing it with a broader “community benefit” standard. The major implication of this substitution was a de-emphasis on nonprofit hospitals’ provision of charity care, since the “promotion of health” under the revised language was deemed beneficial to the community as a whole, regardless of whether certain populations, not necessarily the indigent, were the sole recipients of a particular benefit. Finally, the additional requirements of the community benefit standard require nonprofit hospitals to possess an independent, community-based board of directors, an open medical staff – with privileges available to all qualified physicians, an emergency room open to nonpaying patients, and nondiscriminatory treatment of Medicare and Medicaid patients.¹⁷

Undoubtedly, hospitals’ operation of 24-hour emergency rooms showcases a major and highly important community benefit. IRS ruling 83-517, the final ruling relating to nonprofit hospitals’ provision of community benefits, in an effort to support efficiency, maintained that hospitals without emergency rooms could satisfy the community benefit standard “...if a state agency determined that the operation of that ER would unnecessarily duplicate emergency services already provided by another facility in the community or if a facility is a specialty hospital limited to the treatment of conditions unlikely to require emergency care.”¹⁸

Today the 1969 IRS community benefit standard persists as the most widely interpreted, and variably applied, determinant of federal 501(c)(3) nonprofit hospital status. The intended purpose of this standard is to hold nonprofit hospitals accountable for providing community benefits commensurate with the value of tax benefits. Precluding the community benefit standard are other general requirements, applied to all entities seeking 501(c)(3) nonprofit status. Broken down into two tests, the operational

test states that an organization must be operated exclusively for religious, charitable, scientific, testing-for-public-safety, literary, or educational purposes; the organizational test requires that none of the net earnings can inure to the benefit of any private shareholder or individual.¹⁹

Advantages of Hospitals with Nonprofit Status

The public generally expects that hospitals designated as nonprofit are greater attuned to community needs, purposely existing to respond to those needs,²⁰ and are therefore held in higher esteem than their for-profit counterparts. This greater degree of public trust can be considered advantageous, but it can quickly backfire if the public becomes suspect of the hospital's operations with regard to profitability, executive pay, or divergence from its central mission.²¹ Along these same lines, with higher expectations comes the awareness that nonprofit hospitals enjoy the benefits of tax exemptions, although the extent of this advantage may be unbeknownst to the general public. The five major financial advantages of nonprofit hospitals are the following:²²

1. Income tax exemption
2. The ability to raise tax-free debt
3. Tax-free earnings on investments
4. Donations from the community

Tax-free for both the donor and nonprofit hospital

5. Property tax exemption

This is determined at the state and local level, and is not a consistent benefit for all nonprofit hospitals

The following section provides greater detail of nonprofit hospitals' tax exempt status from the vantage of the local, state and federal government levels.

Tax Exemptions

In addition to understanding the genesis of the nonprofit, tax-exempt hospital, it is important to bear in mind the legal nuances and accompanying obligations of organizations granted this status. The financial advantages listed in the previous section derive from an assumption of tax exemption at all three government levels (local, state and federal). These exemptions, however, are not consistent for all nonprofit hospitals. Below is a detailed summary of the nonprofit hospital as a legal entity and the current events surrounding tax exemptions granted by the federal, state, and local governments.

Federal

Nonprofit organizations classified under the federal Internal Revenue Service Code 501(c) receive exemption from corporate income taxation. A subset of nonprofit organizations, classified under Code 501(c)(3), are bestowed additional tax advantages, including the direct benefit from tax-exempt bond financing which allows an organization to raise tax-free debt, and the indirect benefit attributable to donor deduction of contributions from individual or corporate taxable income.

Nonprofit organizations under this legal distinction must complete an annual Form 990, which is the federal government's mechanism for monitoring the social value provided by nonprofit organizations.¹ Typically filed one year after the close of a hospital's fiscal year, Form 990 contains the hospital's income statement, balance sheet, and a statement of changes in net assets. Footnotes to identify accounting policies and cash flow data are not reported on this form.

¹ Sample of Form 990 available at <http://localtrestrain.aft.org/krswbtt/KTRSdoc/Samples/Smp1990.htm>

State/Local

Property tax exemption, the remaining financial advantage enjoyed by nonprofit hospitals mentioned in the previous section, is contingent on state and local law and therefore is not a uniform benefit of nonprofit hospitals nationwide. Many state and local authorities recognize the federal government's distinction of nonprofit organizations, imposing no additional requirements for nonprofits to prove legitimacy of this legal status; however, many states and localities have begun challenging in court, the charitable mission of their communities' hospitals.²³ Minnesota's nonprofit hospitals are exempted from state income tax under Minnesota Statute Section 290.05 Subd. 2.

II. What Activities Qualify as Community Benefit?

The 1969 IRS ruling opened the door for a very wide interpretation federal standards regarding nonprofit hospitals' benefit to the community. Although free care is no longer required to fulfill the federal standards, it remains one of the most relied upon community benefits. And, despite the fact that the federal government does not explicitly outline other activities that do qualify as benefits to the community, there is a general consensus among stakeholders as to what benefits provided by hospitals are consistent with this central mission of the nonprofit hospital.²⁴ The real controversy arises in the question of *how much* community benefit should hospitals be providing, and if the amount quantified and declared by hospitals is accurate.

Generally accepted community benefits, broadly categorized, include free or uncompensated care, teaching, research, patient education, community outreach, and critical care services such as operation of an emergency department, trauma center, burn unit and NICU.²⁵ Within these categories are a few further sources of disagreement or ambiguity. For example, the validity of patient education pamphlets as a community

benefit has been questioned by critics who claim this tactic is simply a marketing ploy moonlighting as a community benefit for the convenience of management.²⁶ Even the most quantifiable community benefit, free health care services, is subject to uncertainty due to discrepant accounting practices across the industry.

Over the years, the controversy over nonprofit hospitals' worthiness of the tax exemptions has persisted. A number of private and public efforts to establish clarity in the federal government's community benefit standard have occurred over the past thirty years; most notably, the Catholic Health Association (CHA) in collaboration with the Voluntary Hospital Association (VHA, Inc.), a national cooperative of leading not-for-profit health care organizations, developed guidelines and a software tool for organizations to quantify their benefit, complete with standardized community benefit categories, definitions and reporting guidelines. Their definition of community benefit is "...a planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs. It implies collaboration with a "community" to "benefit" its residents – particularly the poor, minorities, and other underserved groups – by improving health status and quality of life."²⁷ The guidelines also provide a series of questions to aid health care organizations which are trying to determine whether a program or cost is a community benefit. The questions are below:

- Does the activity address an identified community need?
- Does the activity support an organization's community-based mission?
- Is the activity designed to improve health?
- Does the activity produce a measurable community benefit?
- Does the activity survive the "laugh" test (meaning it is not of a questionable nature that could jeopardize the credibility of the inventory)?
- Does an activity require subsidization (meaning it results in a net financial loss after applying grants and other supplemental revenue)?

Clearly the issue of nonprofit hospital accountability to the community continues to gain attention from industry stakeholders, civil servants, and society at large.

Charity Care

Although attempts to establish a uniform method for quantifying hospitals' community benefits have received attention, policy makers and industry experts still often use nonprofit hospitals' amount of uncompensated care and/or charity care as a proxy measure of community benefit. However, it is important for stakeholders to realize that bad debt and charity care are separate and distinct financial measures.

Uncompensated care is a summary measure of bad debt plus charity care. Charity care, as mentioned previously, is a valuation of care that is provided to patients without expectation of payment. Bad debt, on the other hand, is a valuation of care provided to patients who were expected or determined eligible to pay, but full payment was not received.²⁸ Thus, because charity care is based on individual hospital policies, two hospitals over the course of a year may provide the same amount of uncompensated care, however, if one has a more generous charity care policy, the annual amount of charity care reported would be different, creating difficulties in comparing the two hospitals.

Variation in accounting for charity care and bad debt is yet another factor that blurs the evaluation of hospitals' charitable missions. If a hospital that writes off the remainder of an uncollected bill as charity care, after a portion was obtained by debt collectors, the benefits conferred are mitigated if the patient is financially crippled by the portion collected from the hospital. This highlights the need to establish uniform accounting practices and charity care policies.

Costs and Charges

Further complicating this matter is the difference between hospitals' costs and charges. The government, group insurers, and other third party payers negotiate discounted hospital rates for health plan enrollees. Uninsured patients lack access to the deep discounts negotiated by "bulk buyers" of health care services and are consequently often billed "at charge" for services rendered. This pricing disparity results in inflated financial accounting of the annual value of charity care provided. Moreover, as Mike Hatch argued in his testimony before the Senate Finance Committee,²⁹ ethical issues ensue; for the uninsured patients who are expected to pay, services billed are nearly double the cost of the same services billed to those with some type of insurance coverage. In effect, hospitals charge the most money for services to the population with the least ability to pay.

This type of unfair pricing for the uninsured has led to numerous class action lawsuits among uninsured patients, as well as lawsuits filed by attorneys general on behalf of the uninsured, charging hospitals with discriminatory pricing.³⁰

Returning to the fact that financial accounting of uncompensated care, for both bad debt and charity care, is based on charges rather than costs, estimating community benefit using these financial data should be done so with caution. Again, this lack of uniformity, attributable to community-wide variance in accounting practices and contract negotiation outcomes, precludes the use of financial reporting data of "free care" as an accurate and valid proxy measure of community benefit.³¹

III. Project Motivation

Bearing in mind the ongoing concerns over hospital billing practices and financial transparency in an era of scarce public health care resources, continued attention

is needed to address the behavior of nonprofits hospitals whose financial advantages, governed by loosely defined legal obligations, are significant. In this section I outline the more recent events surrounding this issue that set the stage for Minnesota to craft a solution to this problem.

Uninsured and Uncompensated Care

Since the 1980's nonprofit hospitals have been on the radar screen nation-wide. According to data from the American Health Association's Annual Survey of Hospitals (1983-1995), uncompensated care – a widely used proxy for nonprofit hospitals' community benefit – grew annually in the early 1980's by an average of 9%. However, in the remainder of the 1980's and into the early 1990's, the annual uncompensated care growth rate decreased by 1.1% to 4.4%.³² Further analyses by Mann and colleagues showed that this trend mirrored growth rates in hospital expenses, and thus average uncompensated care as a proportion of hospital expenses remained stable during this time period, at 6.0%. Regardless of these data, critics contend that nonprofit hospitals are starting to look increasingly similar to their for-profit counterparts, at least from the vantage point of their business activities, including uncompensated care.³³

Accountability and Stewardship

Among the allegations against nonprofit hospitals' business activities are discriminatory pricing and aggressive debt collections. Those involved in recent lawsuits claim that these are deliberate practices, carried out with the intention of deterring patients who are unable to pay for services.³⁴ Consumers' information disadvantage is more burdensome for the uninsured; for instance, an uninsured individual seeking emergency services is likely be required to sign an admission agreement, claiming

responsibility to pay the bill without knowing what that bill will end up costing. At this point, insured consumers are not affected by their relative lack of pricing information. Hospitals are reluctant to release this pricing information because it would reveal discount agreements reached between the hospital and third party payers during contract negotiations. This negotiation process ultimately harms the uninsured by deterring those who feel the system overcharges them.

In Minnesota, this issue recently surfaced in the mainstream media following Attorney General Mike Hatch's audit report on Fairview Health Services' questionable billing and debt collection practices, as well as its hospital executives' compensation.³⁵ The underlying premise of the report is the assertion that problems which compromise the proper stewardship of charitable assets exist with nonprofit governance. Fairview, being the most recent subject of Hatch's continual audits, is now bearing the brunt of public scrutiny, although it is clear from this and previous reports and audits that suspicion of nonprofit health care organizations is arising from issues that expand beyond the narrow, quantifiable measure of uncompensated care.³⁶

Hospital Role

In this section I examine the role of nonprofit hospitals in providing our poor and indigent populations with access to health care services; however, I want to emphasize again that fulfillment of the community benefit standard is not limited to the provision of free care. Minnesota's hospitals are a critical part of the safety net, whose services may soon be in greater need, as we've seen the uninsurance rate increase significantly from 5.4% in 2001 to 6.7% in 2004.³⁷ There is also evidence that hospitals' amount of uncompensated care is associated with insurance coverage.³⁸ Minnesota's current political and economic situation has resulted in fewer resources available to cover the

health care needs of our population. At this juncture, it is important to ensure that Minnesota nonprofit hospitals are providing needed services as part of their community benefit requirement, particularly because research indicates that local property tax exemptions typically constitute the majority of nonprofit hospitals total tax value.³⁹ Therefore, it is in the best interest of state and local officials to monitor whether or not hospitals are providing benefits to the community commensurate with the value of their tax exemptions.

Moreover, the federal government has recently communicated the importance of maintaining the nonprofit hospital's role in the safety net in an IRS field memo dated March 9, 2001, responding to a regional IRS lawyer's query on hospital indigent-care policies.⁴⁰ The memo outlines 14 questions the IRS agent could use in determining a hospital's charitable policies, which speak to the federal government's perspective on nonprofit hospital community responsibilities:

- Does hospital have a plan or policy to provide free or low-cost care to the poor?
- Does the hospital tell the public about the terms and conditions of its charity-care policy?
- What inpatient, outpatient and diagnostic services does the hospital provide for free or at reduced rates?
- Does the hospital keep detailed records about the number of times and circumstances under which it actually provided free or reduced-cost care?
- How and when does the hospital decide whether a patient will be able to pay for care?
- What is the hospital's policy on treating poor and indigent patients as inpatients and outpatients?
- Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care?

Although this memo provides a concrete set of criteria for IRS agents who are evaluating nonprofit hospitals' charitable policies, the questions are merely for reference and these data are not systematically collected.⁴¹

It is clear that nonprofit hospitals' provision of free care is likely considered a top priority for community benefit by the federal government. Legislation to tighten up charity policies has also been attempted at the federal level in several instances over the past fifteen years. The unifying components of these failed bills were some sort of specification standard or amount of charity care that hospitals must provide in order to qualify for tax exempt status. A bill proposed by Donnelly (D-MA) in 1991 sought to temporarily revoke hospitals' tax exempt status if one of five specific criteria – 1) sole community hospital, 2) disproportionate share hospital, 3) disproportionate patient percentage similar to competitors, 4) 5% of gross revenues to charity care, or 5) 10% of gross revenues to community services) – was not satisfied.⁴² A second failed bill that was part of the Clinton Health Plan of 1994 proposed an amendment to section 501(c)(3) that required tax-exempt health care organizations to conduct annual assessments of community needs and develop a plan to address those needs.⁴³ Although the federal government has yet to require nonprofit health care organizations to conduct needs assessments, several states – not including Minnesota – have mandated nonprofit hospitals to do so.⁴⁴

IV. Minnesota Perspective

Despite the absence of major legislation at the federal level, the issue of nonprofit hospital accountability is not subsiding.⁴⁵ In order to fully understand Minnesota's status for holding nonprofit hospitals accountable, I searched Minnesota Statutes and corresponding Administrative Rules for policies relating to the reporting and transparency of data regarding nonprofit hospitals' provision of community benefits and free or uncompensated care.

Regulatory Oversight and Enforcement

The Minnesota Attorney General and his staff of eight, though responsible for investigating violations of the law in respect to unfair, discriminatory, and other unlawful practices in the business and commerce,⁴⁶ are not responsible for regulatory oversight of nonprofit hospitals' community accountability. In his statement before the Senate Finance Committee, convened April 5, 2005, to consider improvements for encouraging increased accountability of tax exempt organizations, the Minnesota Attorney General pointed out that his office relies on the Internal Revenue Service to determine whether or not 501(c)(3) organizations are engaged in charitable activities that meet the standards defined in the Code.⁴⁷ Hatch also maintained that despite lacking financial and compliance auditors, his office has repeatedly been forced to take action against nonprofit health care organizations, insisting that self-regulation is failing to ensure appropriate behavior.

Minnesota Laws and Statutes

The Minnesota Legislature's website (<http://www.leg.state.mn.us/leg/statutes.asp>) provides a search engine for statutes and administrative rules, as well as a tool for tracking the status of bills in legislation. My search yielded several policies related to the collection of uncompensated care and provider financial data. Minnesota Statutes, sections 144.695 to 144.703, known as the Health Care Cost Information Act of 1984, established the Minnesota Department of Health as the responsible agency for making publicly available – as outlined in this legislation – accurate and reliable information about the financial, utilization, and service characteristics of Minnesota hospitals. The force and effect of this law is outlined in Chapter 4650 of Minnesota Rules. A careful search through these rules shows that Minnesota does require annual reporting of charity

care; to guide hospitals in defining charity care *for reporting purposes*, “charity care” is defined in 4650.0102, Subp. 9 as follows:

“Charity care adjustments” means the dollar amount that would have been charged by a facility for rendering free or discounted care to persons who cannot afford to pay and for which the facility did not expect payment. For purposes of reporting under part 4650.0112, charity care adjustments are included in adjustments and uncollectibles.’

Bad debt is also formally defined under 4650.0102, Subp. 7 as follows:

“Bad debt expense” means the dollar amount charged for care for which there was an expectation of payment but for which the patient is unwilling to pay.’

Interestingly, both of these definitions use the wording, “dollar amount charged.” For reporting purposes, the current language does not specify differences between costs and charges. To address these inflated numbers, government-reporting agencies such as the Minnesota Department of Health adjust these data to a cost basis, using the ratio of the hospital’s expenses to total charges. This adjustment provides an estimate of hospitals’ actual cost of providing uncompensated care.

The reporting rule, Administrative Code Minn. R. 4650.0112, requires hospitals to submit annually, the following financial information:

1. A statement of adjustments and uncollectibles by type of payer for charity care (both for inpatient and outpatient care);
2. Donations and grants for charity care with estimates of the percentage received from private and public sources, and public funding for operations; and
3. A description of charity care policies and a detailed breakdown of charity care services provided, including, but not limited to, unpaid public programs, nonbilled services, and other community services such as outreach activities.

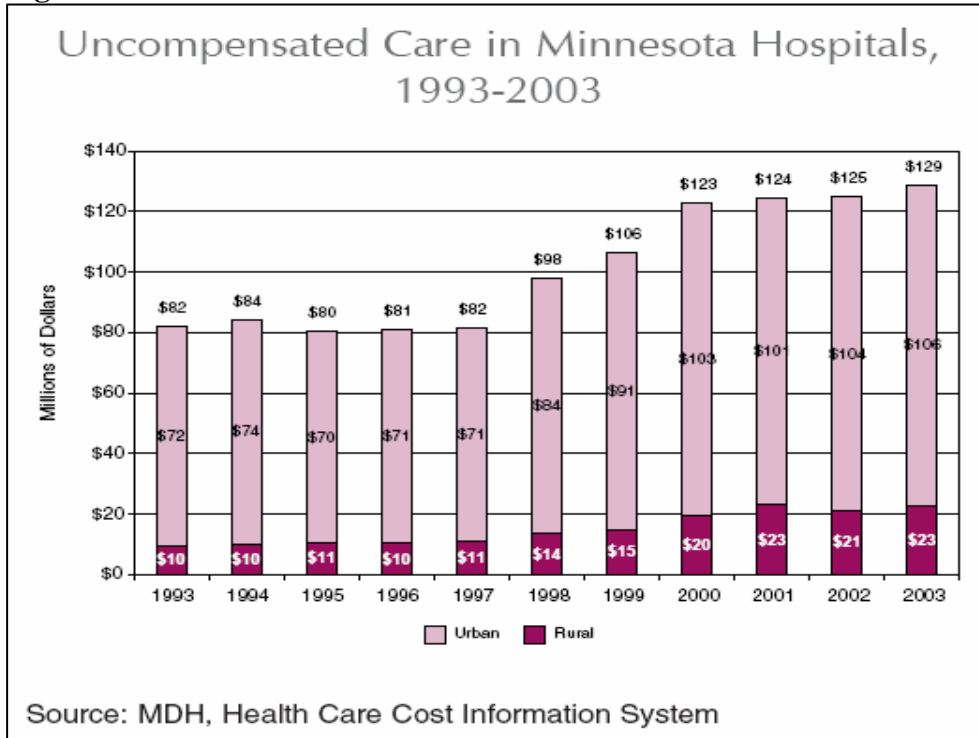
These annual reports are filed with the Commissioner of the Department of Health, and currently no penalties exist for noncompliance.

Health Economics Program

Additional Minnesota Statutes and Rules, aside from those outlined by the Health Care Cost Information Act of 1984, pertain to the collection of data from all providers. Sections 62J.41 and 62J.301 Subd. 3 and Minnesota Rules, Chapter 4651 give authority to the Commission of Health to collect descriptive and financial aggregate data. These data – collected through the Health Care Cost Information System (HCCIS) – are used by the Health Economics Program (HEP) of the Minnesota Department of Health (MDH) in the “Health Care Provider Financial and Statistical Report.” This report serves as a central repository of data, which can be subsequently tapped for additional analyses for publications as well as reports mandated by the legislature.⁴⁸

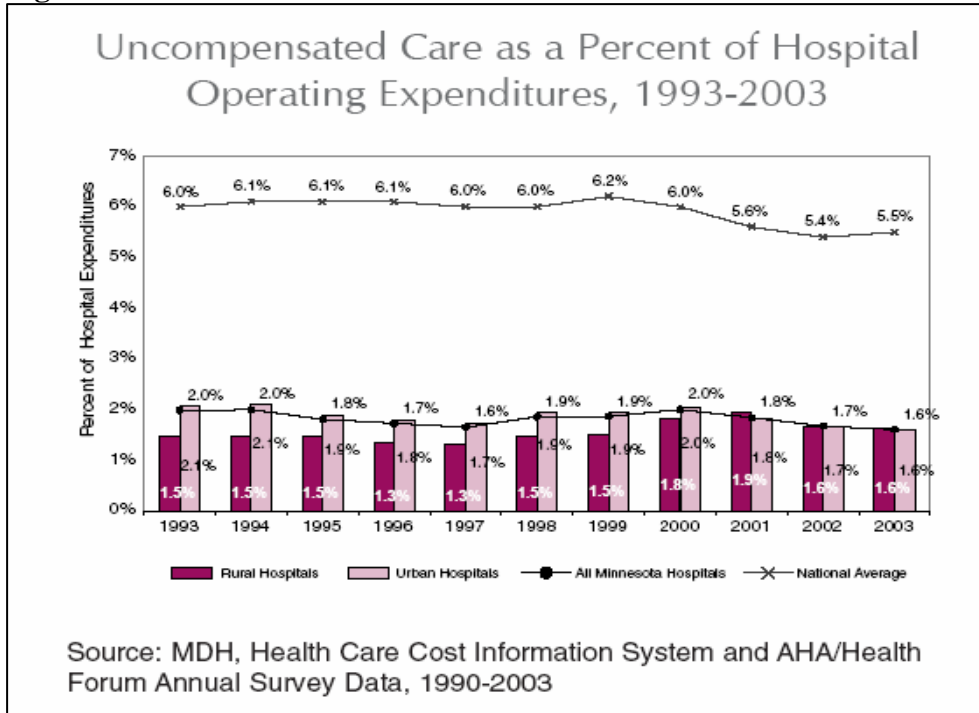
The Health Economics Program does monitor and publish reports on uncompensated care using this annually collected data. A November 2004 Issue Brief provides an interesting perspective on the distribution of uncompensated care across Minnesota hospitals. For both rural and urban hospitals, the aggregate amounts of uncompensated care increased over the ten year observation period, however, uncompensated care as a percentage of operating expenditures has remained relatively stable at a range of 1.6% to 2.0% (see Figures 1 and 2). Interestingly, Figure 2 shows that Minnesota’s uncompensated care as a percentage of operating expenditures is far below the industry average, which ranged from a low of 5.4% in 2002 to a high of 6.6% in 1999. This is perhaps evidence of Minnesota’s high rate of employer-sponsored health insurance coverage and innovative public health insurance programs, which have consistently kept the uninsurance rate at one of the lowest in the country.

Figure 1.



Adapted from “Uncompensated Care in Minnesota Hospitals, 1993-2003.” Minnesota Health Economics Program, Issue Brief 2004-08, Figure 1.

Figure 2.

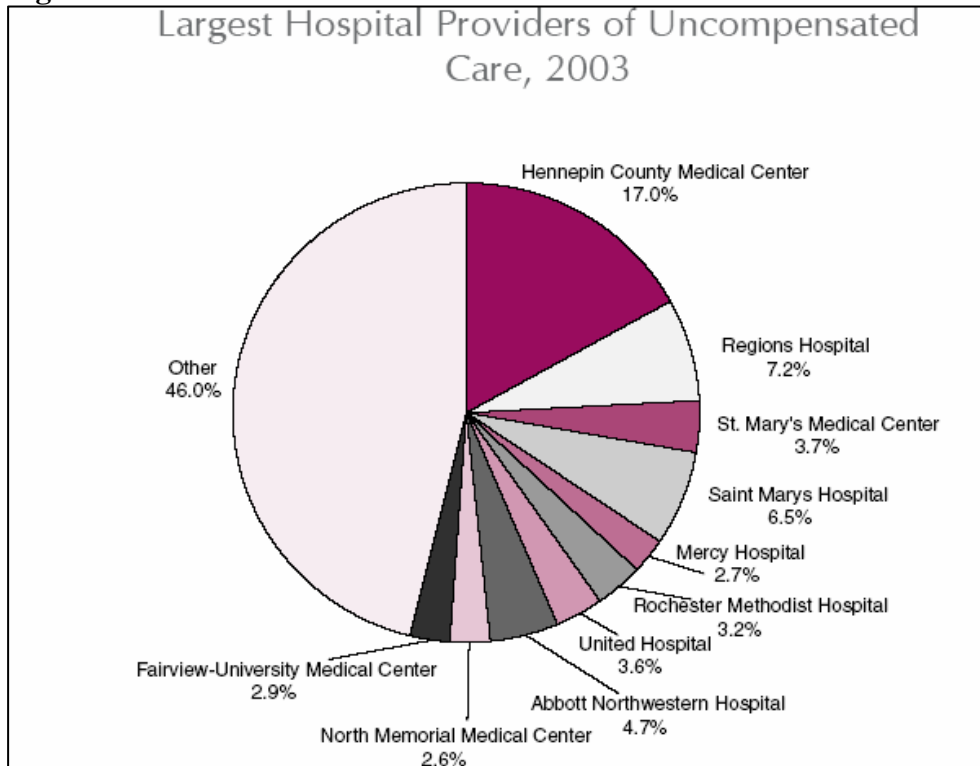


Adapted from “Uncompensated Care in Minnesota Hospitals, 1993-2003.” Minnesota Health Economics Program, Issue Brief 2004-08, Figure 3.

Figures 3 and 4 clarify the unequal distribution of uncompensated care. Of the top ten providers of uncompensated care, publicly owned Hennepin County Medical Center (HCMC) provides 17% of the total amount of uncompensated care provided in 2003, accounting for 5.3% of its operating expenses. On the opposite spectrum, Fairview-University Medical Center (F-UMC) provided 2.9% of Minnesota's total amount of uncompensated care – placing it among the top ten providers of uncompensated care – however, the amount provided was only 0.6% of its operating expenses. These numbers lead one to question how these two hospitals, very close in geographical proximity, provide such different amounts of free care.

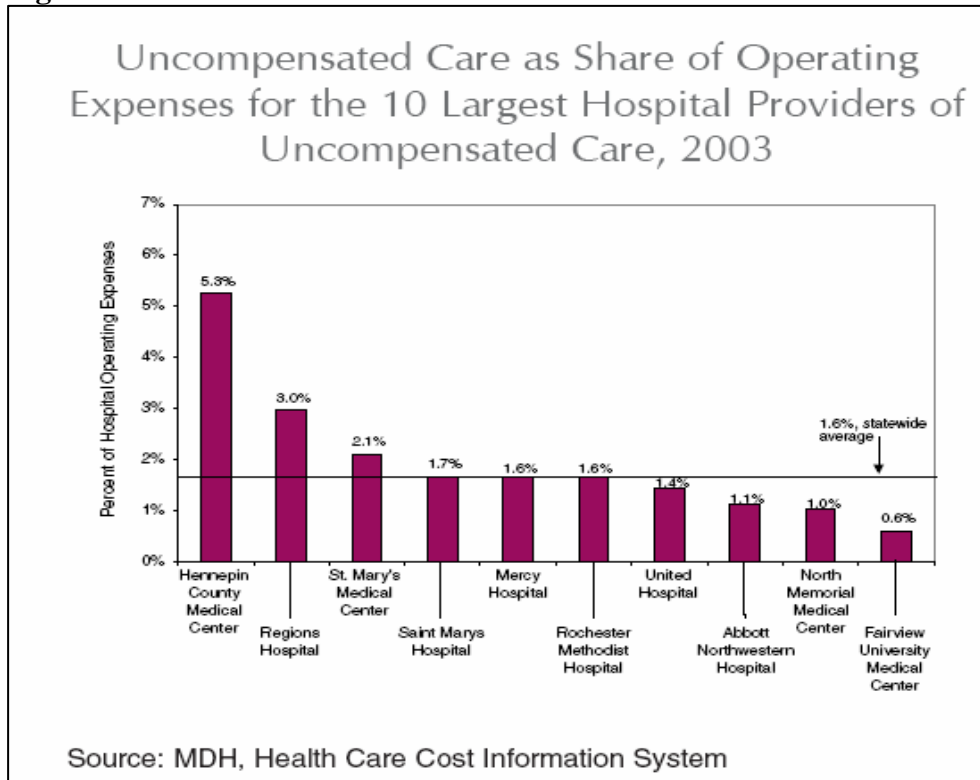
It is important that the state support safety net hospitals to ensure their financial viability. Research indicates a negative correlation between an institution's financial strength and greater amounts of uncompensated care and service to large numbers of patients covered by public programs.⁴⁹ Poor balance sheets can jeopardize hospitals' credit worthiness, and thus ability to gain access to capital. Furthermore, the industry is capital-intensive, driven by the competition between hospitals to have the latest technology, which places nonprofit hospitals committed to providing charity care at a competitive disadvantage. This is a major disincentive for hospitals to provide uncompensated care.

Figure 3.



Adapted from "Uncompensated Care in Minnesota Hospitals, 1993-2003." Minnesota Health Economics Program, Issue Brief 2004-08, Figure 4.

Figure 4.



Adapted from "Uncompensated Care in Minnesota Hospitals, 1993-2003." Minnesota Health Economics Program, Issue Brief 2004-08, Figure 5.

Uncompensated Care Task Force

In 1998, the Legislature, in response to provider concerns over the growing burden of uncompensated care, requested that MDH report on options for reducing and financing uncompensated care.⁵⁰ The report, released in February 1999 entitled “Uncompensated Health Care in Minnesota: An Interim Report to the Legislature,” resulted in several recommendations for addressing this problem. The Legislature charged the Commissioner with refining data collection mechanisms and simplifying the public program enrollment process in hopes of expanding insurance coverage to eligible individuals. The two requests reflect the report’s findings that uncompensated care is really a symptom of the lack of population-wide comprehensive health insurance coverage, and that because of this lack of universal insurance coverage, it is necessary to ensure providers’ financial ability to provide uncompensated care. The Commissioner of Health convened a Task Force comprised of key stakeholders to reach a consensus on policy recommendations for a second report to the Legislature.

In line with the conclusions of the 1999 MDH report, the recommendations of the Task Force could be broadly categorized into two strategies: those intended to expand insurance coverage and those that seek to offset provider costs of uncompensated care. Finally, the Department of Health outlined two additional issues in its report to the Legislature based on Task Force recommendations:⁵¹

“A key area for further exploration is to better understand the state’s role in the area of uncompensated care. It is clear there is an important role for the state, but it is not as clear how that role should be distinguished from that of the private health care sector, the federal government and local governments. The private health care system in this state is, by and large, not for profit and hospitals are nearly all tax exempt. There is a relationship between this status and the return of community benefits, including charity care, and the Department believes an exploration of the interplay between these roles would be useful in guiding policy development in this area.

The task force report to the Commissioner correctly noted that the problem of uncompensated care in Minnesota was one of distribution. The Department believes this issue should be further examined, to guide policy as to whether this distributional problem is best addressed through new funds or through better use of existing resources within the health care system.”

Although the work of the Task Force primarily focused on the financing of uncompensated care, the Department of Health is clearly interested in better defining the state’s role in assuring nonprofit hospitals provide uncompensated care as a component of their community benefit requirement. In the next section I outline five diverse approaches – including two adopted by Minnesota, and three implemented in other states – that hold nonprofit hospitals accountable to their communities.

V. Policy Options

Table 1 provides a summary of legal, legislative and voluntary initiatives regarding uncompensated care and community benefits (see Appendix A). Legal initiatives refer to entities that have challenged in court the adequacy or legitimacy of community benefits provided by nonprofit hospitals or hospital systems. Rulings in favor of the plaintiff typically have resulted in legislative action enacting laws to hold nonprofit hospitals accountable for their nonprofit status. A detailed discussion of the history of legal challenges is beyond the scope of this paper; however, I have included a summary of landmark court decisions for a reference on the alternative routes that some localities have taken in order to improve nonprofit accountability.

Expanding on several examples from the summary table, the following case studies provide a more in-depth examination of strategies that Minnesota and other states have taken to ensure nonprofit hospitals are delivering adequate benefits for the community.

Voluntary Reporting (MA)

A voluntary approach, such as the Massachusetts' Attorney General-facilitated community benefit reporting initiative can potentially serve as a model for Minnesota. Acute care hospitals in Massachusetts are accountable to the public through means of industry pressure to participate in the voluntary community benefit accounting process, whereby benefits are quantified annually by participating hospitals using guidelines and reporting tools developed by the Massachusetts Attorney General. "The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals" was produced in collaboration among the Attorney General, hospital industry representatives, the Massachusetts Hospital Association, and community advocacy groups – a stakeholder collaborative similar to the Minnesota Uncompensated Care Task Force.

The guidelines, in addition to providing a framework for determining community benefit values, encourage nonprofit hospitals to write a community benefits mission statement, as well as develop a community benefits plan. The guidelines suggest that Massachusetts hospitals conduct community assessments, involve representatives of the community in which they serve, prioritize health needs for the community benefits plan, and outline outcome measures for future evaluative purposes. Reviews and reports following full implementation of the hospitals' plans are submitted to the Attorney General's office for public record.

The Attorney General's office maintains a central repository of community benefits information and posts this information on its website.⁵² The website includes links to hospital and HMO community benefits annual reports and community benefits programs, and provide users with a searchable statewide program database of reported

hospital and HMO community benefits programs for users wishing to access detailed information. Although several states have legislatively mandated nonprofit hospitals to conduct annual health needs assessments and devise community benefits plans, the Massachusetts approach is unique in that hospitals participate on a voluntary basis; however, *every* nonprofit acute care hospital in the commonwealth participates in the program – a likely result of industry pressure.⁵³ Moreover, stakeholders publicly support this program, as evidenced by this quote by Ronald Hollander, the president of the Massachusetts Hospital Association.

“The Massachusetts Hospital Association and its member hospitals are committed to their core mission of providing access to quality health care for patients and communities. In meeting this mission, hospitals engage their communities in the process of identifying community health care needs. Working with their voluntary Boards of Trustees, hospitals determine their priorities as well as the allocation of resources available to meet these needs. Since the early 1990s, acute care hospitals in the commonwealth have documented this process through voluntary community benefit reporting. The Attorney General's community benefits initiative is in accord with the long-standing goals of hospitals in Massachusetts. In times of great stress, perhaps one of the biggest benefits to a community is the availability of hospitals to all individuals 24 hours a day, seven days a week, regardless of a patient's ability to pay. In times of severe financial distress, collaborative initiatives like the community benefits process are essential to assist in identifying needed resources to provide the core services and emergency care that are a community's most important community benefit. MHA and our member hospitals have been and continue to be supportive of the Attorney General's Community Benefits process.”⁵⁴

Prescribed Amount of Uncompensated Care (TX)

Texas was the first state to pass legislation that requires nonprofit hospitals to provide a specific amount of charity care. Hospitals have the option to choose one of three standards in which they must meet to maintain their tax exempt status.⁵⁵

- (1) provide charity and government sponsored indigent health care at a level which is reasonable in relation to community needs as determined by the community needs assessment, the available resources of the hospital and tax-exempt benefits received; or
- (2) provide charity care and government sponsored indigent healthcare in an amount equal to 100 percent of the hospital's tax-exempt benefits, excluding federal income tax; or
- (3) provide charity care and community benefits in a combined amount that is equal to at least five percent of the hospital's net revenue, of which charity care and government sponsored indigent care are provided in an amount equal to four percent of the hospital's net patient revenue.

In addition to requiring a prescribed amount of charity care, the statute also states that hospitals must develop a mission statement, perform a community health needs assessment, and develop a Community Benefits Plan (CBP). Furthermore, Texas nonprofit hospitals must evaluate the effectiveness of their CBP using measurable objectives. A number of factors have limited the success of this legislation.⁵⁶ Inadequate funding of the regulatory body, the Department of Health, weakens its ability to monitor hospital compliance. In addition, it is impossible to draw comparisons across hospitals because Texas lacks uniform reporting requirements and quantitative or qualitative standards to determine community benefits.

Improve Reporting/Standards (MN)

As noted earlier, the Commissioner of Health convened a Task Force following the release of a 1999 Minnesota Department of Health interim report on uncompensated care to the Legislature. The culmination of the Task Force's work resulted in a set of recommendations and findings which were subsequently published in the "Task Force Report to the Commissioner."⁵⁷ This report contains a useful algorithm for hospitals to identify patients who qualify for full charity care, those who qualify for discounted charity care, and those whose unpaid bills should be classified as bad debt. This

algorithm, developed in 1994 by the Metropolitan Healthcare Council in *Community Benefit Financial Statement Disclosure Guidelines*,⁵⁸ was recommended by the Minnesota Department of Health as a method for standardizing the *collection and reporting* of charity care and bad debt.

Establishing a statutory language that addresses when and how patients should be identified for charity care is a crucial first step for states to achieve greater accuracy in monitoring this component of the safety net. These recommended guidelines explicitly outline patient eligibility for full charity care and establish discounted charity care guidelines, using a sliding scale that specifies the share of costs that is the responsibility of the provider and of the patient. Finally, the recommended guidelines eliminate the ambiguity of our current statutory language by explicitly stating that charity care does not include contractual allowances, bad debt, public program underpayment, cases paid for through charitable contributions, unreimbursed costs of research, professional courtesy discounts, and community outreach activities. Although these activities are considered community benefits, they should not be considered, nor accounted for, as uncompensated care.

The work put forth by the Task Force to develop uniform reporting standards was never enacted into law. The Minnesota Department of Health continues to collect hospitals' financial, utilization and service data. However, these data are compiled at the discretion of each hospital, placing limits on the ability of the state to accurately assess and compare hospitals' provision of uncompensated care.

Voluntary/Mandatory Discount Agreements (MN)

A fourth strategy with potential to increase nonprofit hospital accountability addresses the recent controversy over discriminatory pricing for services rendered to the

uninsured. Several Minnesota hospitals responded to the negative publicity of this practice by signing voluntary agreements to provide discounts to the uninsured. Fairview Health Services, the subject of Attorney General Mike Hatch's audit release in January of 2005, was the first health care system to announce discounts of this kind after signing an agreement with Mike Hatch just two months following his audit report.⁵⁹ The agreement that Fairview reached with Hatch also includes restrictions on debt-collection practices.

Most recently, four additional Minnesota hospital systems – Allina, North Memorial, Park Nicollet, and HealthEast Care – announced their commitment to offer discounts to the uninsured, stating patients without insurance would be charged no greater than what is paid by large insurers. Specifically, under the plan negotiated with Mike Hatch, uninsured patients with a family income below \$125,000 will be charged the best price that the participating hospitals give to managed care members. Mayo Clinic also says it intends to sign the agreement.⁶⁰

The discount agreements reached among Minnesota's largest providers signals willingness by the industry to take collective action to solve this problem. At this point, hospitals and health systems have signed a voluntary commitment to provide discounts for uninsured patients, however, nearly 20% of Minnesota's hospital industry may still be charging the uninsured at inflated prices. In order to establish industry-wide discounting practices, Minnesota could consider a policy that would mandate all hospitals to provide discounts to the uninsured.

UC Pool (MA)

Uncompensated care pools are established with the intention of ensuring appropriate distribution of funding to hospitals for uncompensated care. This approach correctly acknowledges that the burden of uncompensated care is not equally distributed across

hospitals and community health centers. For example, Massachusetts funds an uncompensated care pool to subsidize a portion of hospitals' costs for treating patients qualifying for one of three categories:⁶¹

- Full UC (household income less than or equal to 200% FPL*)
 - Patient are not required to contribute to the cost of their care;
- Partial UC (household income from 200% to 400% FPL)
 - Patients are responsible for contributing a portion of the cost of care, based on a sliding scale.
- Medical Hardship (allowable medical expenses exceed 30% of family's income)
 - Patients are responsible for contributing 30% of family income plus available assets.

The Pool was created in 1985 and has experienced subsequent modifications in 1988, 1991, and 1997. Currently, funding for the pool is provided by a combination of the following: 1) hospital payments – calculated by multiplying a fixed “uncompensated care percentage” of 1.528% by the total private sector charges to determine each hospital's annual gross liability to the pool, called “hospital assessments’ (provider tax), 2) a surcharge of 1.85% fixed for pool fiscal year 2003 (PFY03) on payments to hospitals (health plan tax), 3) state general funds and, 3) the tobacco settlement fund.⁶²

The hospital assessments for PFY03 provided 49.3% of total funding for the pool, while the surcharge on payments to hospitals provided 29.0%. Pool funds are then re-distributed back to inpatient and outpatient hospitals and community health centers based on allowable costs.⁶³ This standard, for hospitals and community health centers to

* Federal Poverty Level

identify patients eligible for free care, ensures greater transparency in that all providers are operating within one charity care policy.

In 1996, an Uncompensated Care Pool shortfall left hospitals unreimbursed for the full coverage of free care, motivating the Massachusetts Legislature to commission a study of the Uncompensated Pool recipients' income distribution to verify funds were being used appropriately.⁶⁴ Analysis of over 350,000 bad-debt and free-care hospital write-offs, matched with tax records from the state's Department of Revenue (to determine patients' income levels) indicated only 1% of free care and 4% of emergency bad debt (which is also reimbursed through the pool) was attributed to patients whose incomes exceeded 400% FPL.⁶⁵ In contrast, patients with incomes below the poverty level represented 84% of free-care cases and 78% of emergency bad-debt cases. These results indicate that many patients are inappropriately excluded from the Uncompensated Care Pool, highlighting concerns about hospitals' ability to identify and encourage the use of subsidized care.⁶⁶

The pool's budget shortfalls – allowable uncompensated care costs exceeding available funds – continue as a chronic barrier to fulfilling its intended purpose of increased access. Shortfalls are exacerbated by the increasing demand on the pool, resulting from tightened eligibility for Massachusetts' Medicaid program, MassHealth. A 2002 issue brief, written by Robert Seifert, the Policy Director of the Access Project, provides an in-depth assessment of Massachusetts' Uncompensated Care Pool. Seifert recommends that Massachusetts preserve its Medicaid program's eligibility and benefits, broaden pool funding by examining groups that may be evading responsibility for the uncompensated care burden, use pool funds to support demonstration projects to encourage more integrated care for the uninsured, and finally improve the accounting and reporting mechanism.⁶⁷

Aside from the budget shortfalls, the Massachusetts Uncompensated Care Pool appears to successfully provide incentives and reward providers that bear greater burdens of uncompensated care.

VI. Policy Objectives and Analysis

In this section, I will outline criteria to evaluate the strategies that I expanded on in the previous section. My goal is to objectively analyze these policy options and recommend the optimal strategy for Minnesota.

Critical Goals

I used the following objectives to determine the desirability and tradeoffs of each policy option described in the previous section. I chose the objectives based on my review of the literature. Public accountability and protection of the safety net were two themes that recurred as important goals for stakeholders, providing a foundation for my critical evaluation of the policy options in consideration.

Protection of the Safety Net

1. Access for Uninsured

Increasing access to care for low-income uninsured is undoubtedly a high priority. As the rates of uninsurance continue to increase, the community's need for access to free or reduced-cost health care services will grow. It is critical that our society continues to devote its resources to caring for our indigent populations.

2. Redistributive Mechanism

Research indicates that hospitals that provide disproportionately great amounts of charity care are often at a competitive disadvantage.⁶⁸ By

rewarding or compensating hospitals with greater burdens of uncompensated care, the community can ensure that these hospitals remain financially viable and thus able to continue to provide services for those unable to pay.

Public Accountability

3. Transparency

Nonprofit status exempts Minnesota hospitals from paying several kinds of taxes that would have otherwise been devoted to the community.

Therefore, the community must have full access to nonprofit hospitals' documentation that places a financial value on the community benefits provided in lieu of taxes. Transparency of this information can enable accountability to the public by providing the community with a mechanism in which to leverage its clout.

4. Meet Community Needs

Finally, an important objective is to ensure that hospitals' community benefits meet the needs of the community. Because the demographics of Minnesota's population vary depending on geography, what is needed by one community is likely to be different from what is needed in another community.

Table 2 displays each of the four policy options against the five policy objectives. Using a scale of one to five, I rated – *based on my perception* – the ability of each policy option to meet the objectives that I described in section V. The objectives represent two important components of nonprofit hospitals' benefit to the community: protection of the safety net and public accountability.

I considered all five strategies as able meet the objective of increasing nonprofit hospitals' transparency. Regardless of the type of initiative carried out by states, there will be heightened public attention; however, the Massachusetts community benefit reporting initiative is likely to provide the public with the greatest information on the community benefits provided by local nonprofit hospitals. The other four policy options do not specifically address community benefit, but rather focus on one way in which nonprofit hospitals benefit the community: provision of free care to those unable to pay. For this reason, the ability of the other four options to meet the "community need" objective is also limited. For the three options with direct effects on charity care provision, I did assign 1 point for meeting community needs. I reasoned that these options indirectly satisfy or encourage one community need – provision of health services for the indigent. Therefore, I also considered that all of the policy options (with the exception of Minnesota's strategy of improving accounting practices) satisfy the objective to increase access for the uninsured. Finally, only two options employ a redistributive mechanism to achieve greater equality in the burden of charity care provided. Both the Texas approach and the Massachusetts' uncompensated care pool approach address the distribution problem of uncompensated care.

The summation of points for each strategy indicates that the best approach to achieve my desired policy objectives is Massachusetts' voluntary community benefits reporting initiative.

Table 2. Analysis of Minnesota Policy Options for Improving Nonprofit Hospitals' Community Benefit†

POLICY OPTION	POLICY OBJECTIVE				Total
	Protect the Safety Net	Redistributive Mechanism	Transparency	Public Accountability	
Improve Accounting (MN)	-	-	2	-	2
Voluntary Initiative (MA)	2	-	5	5	12
Prescribed Amount of UC (TX)	2	3	3	2	10
Voluntary Discounts (MN)	1	-	2	1	4
Uncompensated Care Pool (MA)	2	5	2	2	11

† Policies are subjectively rated on a scale of 1 to 5. A score of 5 indicates the policy meets the objective; 0 indicates it does not meet the objective.

VII. Conclusion and Recommendation

Based on my analysis of the five strategies to address nonprofit hospitals' community benefits, I recommend that Minnesota pursue a voluntary community benefit reporting initiative similar to the one in Massachusetts. In addition to satisfying the objectives, this strategy has the potential to succeed in Minnesota, considering the current health care climate. Several voluntary collective actions are already being taken among Minnesota nonprofit health care organizations. For example, the Minnesota Community Measurement project uniformly collects quality performance data from medical groups for the purpose of tracking improvement and identifying areas in need improvement.⁶⁹ This project is a corollary of a longer-standing and highly innovative organization known as ICSI, which stands for the Institute for Clinical Systems Improvement. This organization, formed in 1993 is sponsored by the same six health plans that were

instrumental in launching the Minnesota Community Measurement Project. ICSI supports medical groups in pursuing quality improvement, and enlists clinicians to develop evidence-based guidelines that are then used to focus those quality improvement efforts.⁷⁰ These collaborations have established a foundation of successful collective action in Minnesota; a community benefits reporting initiative could build on the momentum of these efforts.

In addition, several other existing groups and programs could be mobilized in initiating a voluntary community benefits reporting program. Under a legislative mandate, the Minnesota Department of Health launched the Eliminating Health Disparities initiative (MDH) in 2000 to provide funding for efforts to reduce health disparities in minority populations.⁷¹ Several health services researchers at the University of Minnesota's School of Public Health are involved in these efforts through their community-based participatory research, which seeks to engage and empower community members in addressing health issues facing their communities.⁷² This methodology of partnering with communities could assist hospitals in identifying community needs.

Finally, a community benefits reporting initiative would need to involve and engage hospital leaders, such as the representatives of the Minnesota Hospital Association. In Massachusetts, the Attorney General leads the community benefits reporting program. As previously mentioned the Minnesota Attorney General is highly involved in both health care and nonprofit accountability and may be a good candidate to lead this effort.

There is potential for Minnesotan communities to hold nonprofit hospitals accountable for their tax exempt status and gain greater benefits than what is currently being given. A voluntary community benefits reporting initiative would enable

communities to better judge the adequacy of nonprofit hospitals' community benefits because of increased transparency, thus building accountability to the public into hospital operations. In addition, there is potential to gain public support for nonprofit hospitals that provide greater burdens of charity care. Public attention to this crucial community service can protect the safety net and assure that indigent populations have access to health care services.

APPENDIX A

Table 1. Summary Matrix of Legislative and Legal Initiatives

SELECT STATE SUPREME COURT CHALLENGES				
State	Court Decision	Plaintiff	Verdict	Update
Pennsylvania	Hospital Utilization Project (HUP) vs. Commonwealth, PA	Court to interpret application of 1997 “Institutions of Purely Public Charity Act,” of the state constitution, in deciding whether a nonprofit entity qualifies for tax exemption.	PA Supreme Court enumerated five characteristics of a “purely public charity”: <ul style="list-style-type: none"> • Charitable purpose • Donate a substantial portion of services • Relief of government burden • Benefit persons who are legitimate subjects of charity • Operate free from private profit motive 	Result of PA Court decision was the “Institutions of Purely Private Charities Act,” a statute with five criteria for tax exemption. Similar to the Supreme Court characteristics with the addition of a “community service” requirement, which allows nonprofit hospital to pass one of five quantifiable tests.
Vermont	City of Burlington, VT vs. Medical Center Hospital	Tried to impose property tax on hospital challenging charity care was insufficient	<ul style="list-style-type: none"> • Ruled in favor of Medical Center Hospital • Hospital not required to show a majority of income derived from charitable sources • Tax exemption evolves with hospital’s changing “commercialized” function 	
Utah	Utah County vs. Intermountain Healthcare, Inc.	Local tax commissioner challenged hospitals’ local property-tax exemption in Utah Supreme Court.	<ul style="list-style-type: none"> • Ruled in favor of Utah County • Court developed six-point test to weigh institutions’ charitable purposes. • Charitable mission • No private inurement • Charity care • Total gift to the community exceed property-tax liability • “Gift” includes: 	Application of six-point test was not uniform. In response, Tax Commission developed six standards for interpreting Court’s decision, which has since been upheld by the Court.

			<ul style="list-style-type: none"> ○ Indigent care ○ Medicare ○ Medicaid ○ Public payment shortfalls ○ Donations of time ○ Donations of money 	
PROPOSED FEDERAL BILLS				
Representative	Year	Description		
Brian Donnelly (D-MA)	1989	A bill that would have required a specified level of charity care to qualify for tax exemption.		
Roybal	1990	<p>“Charity Care and Hospital Tax-Exempt Status Reform Act” This bill proposed to redirect use of exemption for benefit of the indigent.</p> <ul style="list-style-type: none"> • Proposed substantive test for hospitals <ul style="list-style-type: none"> ○ Service reasonable number of Medicare/Medicaid ○ Provide ample charity care <ul style="list-style-type: none"> ▪ Must expend 50% or more of value of the hospital’s tax exemption on unreimbursed charity care – bad debt expenses, care to indigents, costs in excess of Medicaid reimbursements, costs of services defined to improve health of underserved. ○ Provide ample community benefits <ul style="list-style-type: none"> ▪ Must expend 35% of value of exemption on qualified community benefits 		
Brian Donnelly (D-MA)	1991	<p>Bill would have allowed removal of tax exemption if a hospital was not meeting criteria below:</p> <ul style="list-style-type: none"> ○ Provide emergency services regardless of ability to pay ○ Met one in five community benefit standards <ul style="list-style-type: none"> ▪ Treating a disproportionate share of low income Medicaid or Medicare patients ▪ Being a sole community hospital (as defined by Medicare) ▪ Expending at least 5% of gross revenue to provide charity care ▪ Expending at least 10% of gross revenue to provide outpatient clinics in medically underserved areas. 		
Richard Gephardt (D-MO)	1994	Part of Clinton Health Plan – Amend section 501(c)(3) of the Code with requirements that health care organizations conduct annual assessments of community need for health care and outreach services, and develop a written plan of how those needs will be met.		

STATE LEGISLATION

State	Purpose	Requirement
CA, IN, NY, CT, NH	Account for and report community benefit.	<ul style="list-style-type: none"> • Mission statement • Community Health Assessment • Community Benefit Plan • Report Community Benefit (including charity care)
TX	Account for and report community benefit, and satisfy prescribed levels of charity care.	<ul style="list-style-type: none"> • Mission statement • Community Health Assessment • Community Benefit Plan • Report Community Benefit (including charity care) • Prescribed Level of Charity Care
MT, NC, SC	Approval of hospital transactions contingent on provision of charity care.	Agreement to provide certain community benefit in return for state antitrust immunity to joint ventures, partnerships, and mergers.
MA	Redistribute uncompensated care burden.	Hospitals pay into a fund – the amount is calculated by taking a percentage of private payer charges. The fund is supplemented by a health plan tax and state general funds and is called the Uncompensated Care Pool. Pool money is then redistributed back to hospitals based on the amount of uncompensated care reported.

VOLUNTARY HOSPITAL INITIATIVES

State	Description	Details
MA	A voluntary community benefits reporting initiative, led by the Attorney General.	<ul style="list-style-type: none"> • In collaboration with industry representatives, government officials, and community advocates, the Attorney General established community benefits reporting guidelines. • Participating hospitals conduct annual community health assessments, and collaborate with community members to devise Community Benefits Plans. • Hospitals implement plans and record the value of community benefits provided. • The Attorney General collects, and makes publicly available, hospital-level information on community benefits.

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- ⁶⁴ Weissman J.S., Dreyfoos P., and London K. “Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals.” *Health Affairs*, 1999; 18(4):156-66.
- ⁶⁵ Ibid.
- ⁶⁶ Ibid.
- ⁶⁷ Seifert R.W., “The Uncompensated Care Pool: Saving the Safety Net.” Massachusetts Health Policy Forum, 2002; Issue Brief No. 16.
- ⁶⁸ (See Rubinstein)
- ⁶⁹ Amundson GM. Making Quality Measurement Work. *Minnesota Medicine*, October 2003, Volume 86
- ⁷⁰ Institute for Clinical Systems Improvement website, <http://www.icsi.org/index.asp> accessed 07-12-05.
- ⁷¹ Minnesota Statute 145.928
- ⁷² University of Minnesota, School of Public Health website, http://www.hsr.umn.edu/res_pubs/info/projects_research.htm, accessed 07-21-05.
