The Balance of Charity Care: Meeting the Needs of the Uninsured

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Charity care appears to be a relatively simple concept: the government subsidizes health care for those that cannot afford it through tax exemption incentives to nonprofit hospitals. In reality, however, charity care involves a complex interaction of hospital economics, social and regulatory expectations, and a direct impact on access to care for the under and uninsured. The very definition of charity care is a hotly debated issue at both the federal and state levels that has resulted in lawmakers questioning the qualifications for nonprofit hospital status and hospitals rushing to justify the exemptions on which they depend. This debate directly impacts the under and uninsured. Legislators and nonprofit hospitals should share the ultimate goal of improving access to care using this charitable tool because removing the exempt status of nonprofit hospitals could negatively affect the very population it is meant to support.

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I. OVERVIEW OF CHARITY CARE

In order to qualify as a tax exempt organization for the purposes of the Internal Revenue Service (IRS), a hospital must be organized and operated exclusively for “religious, charitable, scientific … literary or educational purposes.” Hospitals that qualify as charitable organizations can receive federal tax exemption, issue tax free bonds, and collect charitable contributions. In turn, these hospitals provide “community benefits,” which the IRS broadly defines as promoting health care for the general benefit of the community as a whole. Charity care is the provision of free or reduced cost inpatient and outpatient healthcare services. It is one component of what makes up the concept of community benefits for tax exempt, nonprofit hospitals.

Federal lawmakers have been wrestling with how exactly to measure the charity care being offered in relation to the benefits of exemption. The basic issue of what qualifies as charity care for exemption purposes is subjective and leaves a great deal of interpretation up to hospitals. Individual hospitals across the industry use multiple methods to calculate what they consider to be charity care, thus making the determination of a true cost for charity care difficult. Hospitals

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2 Id.
4 Seaton & Koob, supra note 1, at 37.
5 Id.
6 Merza, supra note 3, at 215-16.
argue that more of their financial losses from bad debt (unpaid patient invoices) and shortfalls (under-reimbursed government health programs) should count towards the charity care they provide. 8 Other organizations, such as the Catholic Health Association, oppose the inclusion of bad debt and shortfalls, saying these losses are elements of doing business and not charitable as intended. 9 In considering how best to calculate charity care, the IRS has begun to gather information from exempt hospitals on community benefits standards to assist in future decision making. 10

A similar debate is taking place at the state level as legislators struggle to justify local tax exemptions. 11 The definition of what constitutes community benefits and charity care at the state level is not necessarily the same at the federal level and requirements differ further among individual states. Texas was the first state to require hospitals to allocate a certain percentage of their revenue to charity care in order to qualify for local exemptions. 12 A few other states, such as Pennsylvania, Utah, and West Virginia, require hospitals to provide a minimum amount of community benefits for their exempt status. 13 Most states have avoided legislation creating a standardized obligation and have instead opted to require nonprofit hospitals to conduct community health needs assessments and

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8 Seaton & Koob, supra note 1, at 39-40.
9 Id.
11 Id. at 426.
12 Id. at 452.
13 Id.
develop community health benefit plans to qualify for exempt status, reporting the amount of charity care provided to their respective state agency.14

II. CHARITY CARE STANDARDS IN ILLINOIS

The Illinois legislature passed the Illinois Community Benefits Act in 2003 requiring metropolitan hospitals with more than 100 beds to report to the state ten categories of community benefits, including charity care.15 The other nine categories include: bad debt; government sponsored indigent care; government sponsored program services; subsidized health services; education; research; language assistance services; donations; and volunteer services.16 Illinois hospitals argue that they are subsidizing a significant burden for the government by providing these services and care to the uninsured.17 Hospitals would like all of the contributions they make to their communities to count, not just a narrowly defined amount of charity care.18 They contend that when all of these categories are taken into consideration, nonprofit hospitals have earned their tax exemptions.19

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14 Id. at 452-53.
16 Id.
17 Id.
18 Id.
19 Id.
In 2006, legislators attempted to pass a bill requiring Illinois hospitals to spend 8% of their annual earnings on charity care. Hospitals argued that the differences in the needs between communities make a “one size fits all” method of standardized charity care impractical and takes away hospitals’ ability to manage their resources to meet those unique needs. The 2006 legislation was not successful, but it cannot be assumed that similar legislation will not be presented again in the future.

Illinois courts have also participated in the debate about what qualifies as charity care. The state’s concern is property tax exemption for nonprofit hospitals. In Provena Covenant Medical Center v. Illinois Department of Revenue, the Illinois Supreme Court heard arguments on the issue of whether a nonprofit hospital has provided enough charity care to justify the state’s charitable purpose property tax exemption. In short, Provena appealed a decision by the Department of Revenue finding that Provena failed to meet the exemption requirements because only approximately 0.7% of its total revenue had been provided in charity care (not including any other unreimbursed costs), which was insufficient to qualify for the exemption. Provena appealed, and, initially, the

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21 Id.; Metropolitan Chicago Healthcare Council, supra note 15.

22 Jaeger, supra note 20.


trial court found in favor of Provena. The Fourth District Appellate Court later reversed the decision, upholding the department’s original determination that the hospital had not met the standard.

The Department of Revenue claimed that Provena had received more in tax benefits than the hospital had given in charity care, but the very question at issue is what constitutes charity care for the purposes of the exemption? Provena argued that it provides a variety of “community benefits,” including charity programs and absorbing under reimbursed costs from government health programs, which should count towards its charity care for purposes of the exemption. The Department of Revenue argued that the amount of charity care in the form of true “gifts” (or unbilled charges) in relation to the hospital’s annual revenue is what should be considered charity care, not the overall contribution to the community. Thus, according to the Department of Revenue, Provena’s charity care was not enough to justify the exemption claimed by the hospital. A decision by the Illinois Supreme Court, which is currently reviewing the nonprofit hospital standard for meeting the exemption, is eagerly anticipated because of the impact it will have not only on Illinois hospitals and residents, but the precedent it may set across the country.

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25 Id.
26 Id.
27 Jaeger, supra note 20.
28 Hylak-Reinholtz, supra note 23, at 41.
29 Id.
30 Id.
31 Id. at 44.
III. THE UNINSURED AND ACCESS TO CARE

Nonprofit hospitals have been severely criticized for taking actions that seem inapposite to the concept of acting as a benefit to their communities. For example, nonprofit hospitals have historically charged the uninsured a premium price for services while offering deep discounts to insurance companies, managed care plans and those with government assistance. This price shifting has resulted in negative press for hospitals. Additionally, much attention has been focused on the aggressive collection practices hospitals have taken against those unable to pay for health care. Several federal cases have been brought against hospitals claiming unfair billing practices. Courts have ultimately held that the federal tax code does not hold hospitals responsible for providing a certain amount of free or discounted care, but it has still been a loss for hospitals in the court of public opinion.

In response, many hospitals have independently revised their charity care policies. Historically, hospitals have used the Federal Poverty Level (FPL) to determine eligibility for charity care discounts, typically employing some type of sliding scale based on a patient’s income against the FPL. For those uninsured patients who may not qualify for the charity care discounts based on FPL, more hospitals are moving towards a flat-fee discount. This shift has gained support for three main reasons: (1) to accommodate an increasing number of indigent and

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32 PricewaterhouseCoopers’ Health Research Institute, supra note 7, at 16.
33 Merza, supra note 3, at 217.
34 Helvin, supra note 10, at 439-40.
35 Id.
36 PricewaterhouseCoopers’ Health Research Institute, supra note 7, at 15.
37 Id.
working uninsured who make too much to qualify for a full charity care benefit or
government assistance; (2) recent flexibility as a result of direction from the
Centers for Medicare and Medicaid Services and the Office of Inspector General
allowing hospitals to offer discounts to the uninsured without jeopardizing their
Medicare reimbursement; and (3) the increased scrutiny from the media and
regulatory agencies. 38 By expanding eligibility for charity care programs and
offering greater discounts to the uninsured, hospitals have expanded access to
care. 39

Despite hospitals receiving negative attention concerning charity care,
hospitals continue to play a major role in supporting the under and uninsured.
The more obvious benefits are those provided in the form of free services such as
poison control, literacy training, child, and maternal healthcare, special programs
for the elderly and disabled, among others. 40 What may not be as obvious to the
general public is the purely economic benefits hospitals offer to the community.
In 2004, it is estimated that Illinois hospitals subsidized $1.686 billion in
shortfalls, which is the difference between the hospitals’ costs and the
reimbursement rate of government healthcare programs. 41 Additionally, it was
estimated that in 2004, Illinois hospitals’ bad debt, or those invoices that went
unpaid, totaled $1.130 billion. 42 This is in comparison to the total of charity care,

38 Id.
39 Helvin, supra note 10, at 457.
40 Merza, supra note 3, at 219-20.
41 Id. at 219.
42 Id.
where no bill was sent to the patient, which only amounted to $250 million.\(^{43}\) These numbers tell the story of how hospitals struggle with their attempt to meet community needs as well as the bottom line.

IV. THE POTENTIAL FOR CRISIS AND PROPOSED SOLUTIONS

The fate of hospital tax exemption, soon to be determined by the Illinois Supreme Court in Provena, is significant to the discussion of access to care because of the potential negative impact a shift could have on the uninsured. Should a hospital not be able to meet a strict standardized definition of charity care to qualify for exemption, a number of changes decreasing access to care are possible. For instance, hospitals previously operating as nonprofit entities may convert to for-profit entities and change their service offerings.\(^{44}\) This could include the downgrading or elimination of services vital to communities, such as trauma care, neonatal care, burn units, and community immunization programs.\(^{45}\) For those hospitals in low income neighborhoods, a loss of the exemption would be devastating to the economic viability of the hospitals, causing them to close. As a result, a tremendous dislocation in healthcare delivery to those in poorer neighborhoods would be created.\(^{46}\) In the end, with fewer nonprofit hospitals operating, the burden of care for the uninsured will fall to the remaining for-profit hospitals, in turn affecting their viability.\(^{47}\)

\(^{43}\) *Id.*
\(^{44}\) *Id.* at 223.
\(^{45}\) *Id.* at 220.
\(^{46}\) *Id.* at 225-26.
\(^{47}\) *Id.* at 228.
Hospitals face great uncertainty in what future regulation may bring, but as an industry, there are ways hospitals may mitigate their situation. PricewaterhouseCoopers’ Health Research Institute explored the issue of charity care in hospitals and completed a report that outlined what seems to be a manageable and comprehensive approach for hospitals to both increase efficiency and improve charity care.\(^\text{48}\) The Institute’s suggestions include: modify patient charges for the uninsured to the same rates paid by those with government or private insurance; educate and assist patients in utilizing charity care; minimize requirements and simplify the process; utilize skilled and highly trained individuals in patient access and patient accounting to consistently and effectively administer financial assistance; establish a mechanism to work with uninsured patients on payment plans before taking collection or legal action; distinguish clearly the internal calculation of charity care from other community benefits; create a community benefits report publicly disclosing clearly defined calculations of charity care and community benefits; and provide financial counselors at the point of entry most commonly used by the uninsured, the emergency room, identifying and assisting those patients earlier in the process.\(^\text{49}\)

It logically follows that if nonprofit hospitals, as an industry, uniformly took actions such as these, there would be less need for potentially harsh legislation and overregulation.

\(^{48}\) PricewaterhouseCoopers’ Health Research Institute, \textit{supra} note 7, at 21.

\(^{49}\) \textit{Id.} at 22, 23, 26, 27, 28, 30.
V. CONCLUSION

The concept of charity care is by no means a lost cause. It is a valuable community service vital to the needs of the increasing uninsured population. The potential still remains for nonprofit hospitals to serve their communities in a charitable manner by improving access to healthcare for the under and uninsured in return for government tax incentives. In fact, it seems access to care depends on a compromise that allows nonprofit hospitals to continue providing these services. Solutions in this debate between government and hospitals can come from both sides of the table, with hospitals being more proactive in their utilization of charity care and government entities recognizing the complexity and value of being a provider of vital community healthcare.

From a legislative standpoint, it seems that it is in the best interest of lawmakers to support tax exemption for nonprofit hospitals. Overall, the services provided by hospitals do benefit their communities and uninsured population. As is the nature of an industry such as this, additional regulation seems unavoidable. Systems appear to function better when clear definitions and expectations are set forth for participants. If additional legislation only makes achieving tax exempt status more difficult, however, it will be a failure for the uninsured as the legislation will abate access to the very care meant to be subsidized. The ultimate goal of any future legislation should be to strike a balance between the objective of charity care, effectively serving the under and uninsured in communities, and the economic realities of the hospital business.