How Do Hospitals Set Their Charity Care Policies? Evidence from Nonprofit Tax Returns

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Abstract

Hospitals play an important role in the social insurance system by providing free and discounted care to the uninsured. Despite the large economic cost of care for uninsured patients absorbed by hospitals, relatively little is known about how hospitals determine the amount of free and discounted care they provide. In this paper, I study how nonprofit hospitals change their policies regarding the supply of charity care in response to changes in local need, hospital income, and regulation/public pressure. To do so, I use data from IRS 990 tax returns for nonprofit hospitals between 2010-2015. These data provide the first opportunity to look at hospitals’ charity care policies over time and across states. A unique feature of the IRS 990 is that hospitals are required to list the federal poverty level (FPL) income thresholds at which they provide free and discounted care in addition to disaggregated information about charitable expenditures. I link these outcome measures to data on changes in state regulations, public funding for low-income care, and measures of need in every state. I find that hospitals’ charity care spending and policies significantly respond to external pressure at the margin. In contrast, charity care policies do not respond to changes in community need or hospital financial status in the two years following Medicaid expansion. These results indicate that extrinsic motivation may be the driving factor behind changes in hospital charity, not altruism.

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1 Introduction

In the United States, private organizations provide charity and administer aspects of the social safety net in domains such as education, housing, and social services. This is especially true in healthcare, where hospitals serve vulnerable populations by providing medical care for which no payment is received. The government relies on hospitals to provide unreimbursed care because many are charitable, tax-exempt organizations. Approximately 60% of the nation’s 5,000 acute care hospitals qualify for tax exemptions as nonprofit entities (AHA (2017)). In 2011 alone, these exemptions cost federal, state, and local governments $25 billion (Rosenbaum et al. (2015)).

Whether nonprofit hospitals provide sufficient charity to justify their tax-exempt status is a contentious issue and a source of longstanding public scrutiny.¹ Policymakers and community leaders have accused nonprofit hospitals of providing inadequate charitable services and investing too much in for-profit business ventures, aggressive billing and collection practices, and compensation for senior administrators (Rubin et al. (2013)). Over the past decade, the federal government has imposed new regulations for nonprofit hospitals, state courts have taken away certain hospitals’ tax exemptions on account of providing inadequate charity, and state attorneys general have increased monitoring of nonprofit hospital behavior in different states. At the same time, demand for uninsured hospital care has decreased in states that expanded Medicaid under the Affordable Care Act (ACA), and there have been renewed calls for nonprofit hospitals to do more in exchange for their tax exemptions.² This increasing pressure on hospitals to act more charitably raises important questions surrounding what factors incentivize nonprofits to do more for their communities.

Economists have long debated and proposed conflicting theories surrounding nonprofit firms and whether they behave differently than other private organizations (See Chang and Jacobson (2012) for an overview). Some theories posit that nonprofit hospitals are output maximizers with altruistic preferences (Newhouse (1970); Frank and Salkever (1991)). Meanwhile, other theories hypothesize that nonprofit hospitals behave like other types of private organizations and maximize profits (Pauly and Redisch (1973); Weisbrod (1988)). As a result of this disagreement and additional difficulties quantifying hospital charity, what

¹Hospital spending on charitable activities falls short of the value of their tax exemption on average. However, many argue nonprofit institutions do more than provide discounted services and are important public actors because of their mission and related preferences (Rubin et al. (2013); Horwitz (2006)).

²See https://www.politico.com/interactives/2017/obamacare-non-profit-hospital-taxes/ for a discussion of post-ACA debate surrounding nonprofit charity. It is important to note that there is still significant demand for charity care post-ACA. Approximately 30 million Americans remain uninsured, and many who gained coverage through subsidized exchanges face deductibles that exceed their available liquidity (CBO (2015); Hamel et al. (2015))
motivates nonprofit hospitals to be charitable remains an open question.

This paper uses a new source of hospital financial data from the Internal Revenue Service Form 990 (IRS 990) to study hospital charity. The IRS 990 data comprise the first consistent, national metric for quantifying hospital policies and expenditures related to charity. Since 2009, nonprofit hospitals have had to fill out a specific section of their federal tax return form related to hospital charity. This section, Schedule H, asks hospitals to provide information on the federal poverty level (FPL) income thresholds at which they provide free and discounted care in addition to disaggregated information about charitable expenditures.

I analyze the factors that motivate nonprofit hospitals to behave more charitably towards poor and uninsured patients using the IRS 990 data. To identify how nonprofit hospitals respond to changes in community need, hospital financial status, and public pressure, I take advantage of changes in government funding for low-income medical care and state regulation of nonprofit hospitals between 2010 and 2015. In this period, the ACA Medicaid expansions provided insurance to individuals under 138% FPL in thirty states. Additional Medicaid Section 1115 waivers created new pools of funding to reimburse hospitals for uninsured patient care in four states. Nonprofit hospital regulations also changed the requirements surrounding tax-exemption rules and hospital charity in nine states. These laws varied in their content, scope, and regulatory oversight.

I find nonprofit hospitals significantly increased the income thresholds for charity care and charitable expenditures in response to regulations enforced by state attorneys general and courts. Hospitals did not change these thresholds as a result of regulations imposed by state health agencies. Furthermore, Medicaid expansion did not lead hospitals to significantly increase or decrease their charity care policies despite drastically reducing expenditures on free and discounted care. Responses to Medicaid expansion did not differ by safety-net hospital status or baseline level of charitable spending. These results indicate that hospitals respond more to external constraints than changes in demand or income at the margin. This research lends support to theories of the nonprofit firm as profit or revenue-maximizing organizations and suggests significant potential gains from increased regulatory oversight in the nonprofit hospital market.

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3One reason economists have had difficulty quantify hospital objectives is that measuring charitable output is challenging. Previous sources of hospital financial data either provided broad, inconsistent measures of charity or only covered single states. The Medicare Cost Reports are the only alternative source of national data. These data have historically been of relatively low quality (Dranove et al. (2017)). The data only require hospitals to provide accurate estimates of combined measures of care for the poor and uninsured that do not differentiate between types of care. The HCRIS also contains no information on measures of charity beyond uncompensated care.

4While some set minimum requirements for overall spending on charity, others laid out specific policies and practices related to billing for low-income care or evaluating community health needs. Five of the regulations were initiated by high-profile court cases and newspaper stories or were enforced by state attorney generals.
The remainder of the paper proceeds as follows. Section 2 discusses the relevant institutional details surrounding hospital provision of charity care. Section 3 describes a model of altruistic behavior by nonprofit hospitals and presents predictions of how nonprofit hospitals should adjust their charitable behavior in response to different changes in their environment. Section 4 focuses on the hospital-level data used in this analysis and the empirical approach. Section 5 estimates how various changes in the market for low-income hospital care affected nonprofit provision of charity, and Section 6 concludes.

2 Understanding Charity Care

Charity care refers to free and discounted care hospitals provide to poor and uninsured patients. These are services for which the hospital neither received, nor expected to receive, any payment. At nonprofit hospitals, there is a standard procedure for determining when they bill patients for services. Figure I illustrates this procedure.

Uninsured patients not covered by Medicaid or another indigent care program may be eligible for free and discounted care under a hospital’s charity care policy. These policies consist of financial criteria, typically Federal Poverty Level (FPL) thresholds, under which hospitals are willing to provide free or partially subsidized care. If a patient falls under these policies, the patient’s hospital bill is relieved, and the cost to the hospital of providing this care is classified as charity care.\(^5\) In 2012, the vast majority (94\%) of US nonprofit hospitals had such policies (Nikpay and Ayanian (2015)).\(^6\) If a patient is ineligible for charity care, the hospital will bill them for their stay.\(^7\) If a patient does not pay the whole bill or any portion of it, the hospital will classify the underpayments as bad debt. While charity care refers to services for which a hospital never intended to collect payment, bad debt refers to costs related to services for which a hospital attempted to collect payment but was ultimately not paid (AHA (2010)).\(^8\) Hospital best practices prohibit hospitals from classifying any

\(^5\)In a subset of US hospitals, insured patients with high deductibles or large copays are also eligible for charity care.

\(^6\)How much nonprofit hospitals must publicize these policies varies by state. Since 2016, new federal rules have required all nonprofit hospitals to have these policies, post them in emergency room waiting areas, and include them with patient bills. Since my study only goes through 2015, I do not capture the effect of these federal laws.

\(^7\)There is substantial variation in what hospitals charge uninsured patients. They often charge list prices for services, which are higher than the rates charged to privately insured or Medicare patients. Some hospitals offer significant self-pay discounts to bring list price closer to actual charges to insurance. In 2012, only 29\% of nonprofit hospitals reported charging uninsured patients based on privately insured or Medicare rates (Nikpay and Ayanian (2015)). Under new rules starting in 2016, all nonprofit hospitals must charge self-pay patients the same rate as commercially or publicly insured patients.

\(^8\)There are significant differences in how much action hospitals take to collect these bills. While some use credit reporting or legal action, most do not.
expenditures previously billed to patients as charity care in the IRS 990, so charity care and bad debt are reported as distinct financial measures.\textsuperscript{9}

Uncompensated care, which is the measure most often used in the economics and health policy literature, is an aggregate measure of charity care spending, bad debt, and payment shortfalls from Medicaid and other state programs. While uncompensated care provides a more full measure of hospital expenditures on the poor and uninsured, relying on that measure alone masks wide variation in the degree of generosity hospitals exhibit in serving these patients. By looking at disaggregated measures of charity care spending and income thresholds for providing charity care, I gain additional insight into hospital decision margins surrounding the supply of charity.

2.1 Why Do Nonprofit Hospitals Provide Charity Care?

There are a variety of financial and regulatory incentives surrounding nonprofit hospital provision of charity. Two of the most prominent reasons why nonprofits provide charity are federal tax regulations and preferential tax treatment. An important federal regulation for hospitals is the Emergency Medical Treatment and Labor Act (EMTALA).\textsuperscript{10} EMTALA, which was enacted in 1986, requires hospitals to stabilize and treat anyone coming into an emergency department, regardless of their insurance or ability to pay. The federal government does not directly cover the cost of providing emergency care under EMTALA – hospitals must cover the cost of caring for uninsured patients themselves. To the extent that hospitals serve uninsured patients, their total charity care and bad debt expenditures are higher.\textsuperscript{11}

An additional reason that nonprofit hospitals provide charity is federal tax exemption rules. The Internal Revenue Service (IRS) has a “community benefit standard” (IRS 501c) for determining whether a hospital is entitled to exemption from federal income tax.\textsuperscript{12} Under this standard, hospitals must provide charity care and engage in a menu of activities such as community health improvement, teaching, and research to maintain their tax-exempt status. In 2016, the IRS implemented additional rules (IRC 501r) stating that hospitals establish written financial assistance policies, abide by best billing practices, and assess the health

\textsuperscript{9}Under the best practices for Charity Care from the Healthcare Financial Management Association Statement No 15, hospitals cannot bill patients that fall under the hospitals’ charity care policies.

\textsuperscript{10}An additional historical regulation/factor is Hill-Burton obligations. In 1946, Congress based the Hospital Survey and Construction Act (commonly known as Hill-Burton), to encourage hospital construction. In exchange for federal funds, hospitals had to provide care to the poor.

\textsuperscript{11}It is important to note that even with EMTALA, the uninsured still receive less intensive care than the insured for emergency treatments in hospitals (Doyle (2005)).

\textsuperscript{12}Nonprofit status also allows hospitals to benefit from tax-exempt bond financing and receive charitable contributions that are tax-deductible to the donors.
needs of their communities every three years. It is noteworthy that under both the new and old standards, much is left to the provider’s discretion. There is no pre-specified level of charity care or overall community benefits that hospitals must provide, and hospitals have full control over the eligibility thresholds they set for free and discounted care. Appendix A includes a history of the federal community benefit standard.

While both EMTALA and federal community benefit standards require that hospitals serve uninsured patients, they do not dictate how much care hospitals provide or whether uninsured individuals pay for this care. For instance, in 2012, hospitals dedicated 3.05% of their total expenditures to charity care on average, but there was considerable variation in this number (SD 3.39). Additional factors that may influence the degree to which hospitals provide free or discounted care for the uninsured vary across hospitals and include state regulation, demand for services, and hospital financial status.

Since states and localities grant nonprofits additional income, sales, and property tax-exemptions, they also have regulatory power. Thirty-two states have laws regulating nonprofit hospital behavior. A subset of these states, including Utah, Illinois, Pennsylvania, and New Jersey, have taken away select hospitals tax exemptions on account of providing inadequate charity (See Nelson et al. (2013) for a detailed overview of state regulatory policies). While both factors may influence the degree to which hospitals provide charity care, demand for uninsured patients and hospital operating margins may also affect hospital charity. Recent analysis suggests that each additional uninsured person costs local hospitals $900 each year in charity care and bad debt expenditures (Garthwaite et al. (2018)). Hospitals with very low margins may not be able to afford to be generous with care for uninsured patients. In this research, I focus on exploring the role of each of these factors in a hospital’s decision of whether to provide charity care to more individuals.

2.2 What Do We Already Know about Hospital Charity Care?

Hospital charity is an integral part of health care for the poor and uninsured. In 2012, hospitals provided over $46 billion in uncompensated care -- almost 30% of Medicaid inpatient and outpatient spending that year (Garthwaite et al. (2018)). Previous research using IRS 990 found that in 2009, tax-exempt hospitals spent 7.5% of total operating expenses on “community benefits” (Young et al. (2013)). More than 85% of these expenditures went to charity care and other patient services. Additional research has shown that this number

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13 States have additional oversight over what nonprofit hospitals must do to receive an exemption from state and local income, property, and sales taxes.

14 The fact that hospitals with the fewest resources are often located in the markets with the highest need has been discussed as a mismatch between supply and demand in the market for charity care (Ody et al. (2015)).
varies across states (Bakken and Kindig (2015)). Researchers have also looked at charity care spending in the context of overall community benefit spending and have found that nonprofit hospitals generally provide more community benefits than their for-profit counterparts (see Tahk (2014) for overview).

Additional papers have tried to quantify hospital responses to changes in policies affecting low-income care using time series data. In the health services literature, studies have shown mixed evidence surrounding nonprofit responsiveness community benefit laws in specific states (Gray and Schlesinger (2009); Kennedy et al. (2010); Chen (2016)). Meanwhile, in the economics literature, work by Duggan (2002), Almond et al. (2011), and Batty and Ippolito (2017) has shown that hospitals, including nonprofits, can, and do, target care for low-income individuals based on financial considerations and behave strategically in response to changes in the cost of providing uncompensated care. Most recently, research has shown that hospital uncompensated care spending decreased by as much as 25% in states that expanded Medicaid (Dranove et al. (2016); Nikpay et al. (2015); Cunningham (2015)).

Charity care is an increasingly important topic in economics. Work has shown that nonprofit hospitals respond to competition from for-profit hospitals in the market in setting charitable objectives (Horwitz and Nichols (2007)). Recent evidence suggests that nonprofit hospitals play an important role in the social safety net by providing charity care and that the availability of free or discounted care lessens the scope of the issues associated with being uninsured (Dobkin et al. (2018); Garthwaite et al. (2018)). Understanding nonprofit hospital charity is also important for insurance markets since recent work shows that uncompensated care may lower individuals’ willingness to pay for formal insurance (Finkelstein et al. (2019)).

3 Data and Empirical Strategy

3.1 Hospital Data

New data from the IRS Form 990 provide the first opportunity to look at hospitals’ charity care policies over time and across states. Form 990, officially the “Return of Organization Exempt from Income Tax,” is a standard form all nonprofit organizations must fill out. It is used by government agencies to prevent organizations from abusing their tax-exempt status. In 2009, the IRS created a new schedule for hospitals, called Schedule H, to enhance nonprofit hospital community benefit reporting. The IRS created this new section in response to calls from a variety of policymakers greater transparency regarding the community benefit
activities of tax-exempt hospitals. Schedule H established uniform reporting requirements for all tax-exempt hospitals in the United States and thus constitutes a valuable new source of data for monitoring tax-exempt hospitals’ provision of community benefits. Appendix B includes a copy of the IRS Form 990 Schedule H and the instructions provided to hospitals.

Form 990, Schedule H requires that hospitals disclose their expenditures for financial assistance at cost (i.e. charity care), the unpaid cost of government programs, and a variety of other community benefits and bad debt expenditures. Notably, hospitals are also required to list the federal poverty level (FPL) thresholds at which they provide free and discounted care, in addition, a variety of other data surrounding their practices for billing uninsured patients. While the Form 990 Schedule H data do have shortfalls– namely they are only available for nonprofit hospitals and groups of related hospital facilities often report their finances together– they constitute an important, new source of detailed information on hospitals.

The information in the forms allows me to overcome two obstacles to measuring hospital charity care in the past. First, previous spending measures were either ill-defined or did not discriminate between charity care and bad debt/shortfalls. Second, other sources of data only include expenditures, which are a less direct measure of hospital behavior than hospital policies.

I obtain annual data from the IRS Form 990 and IRS Form 990 Schedule H through GuideStar, an organization that collects, digitizes, and sells information on the entire population of U.S. tax-exempt organizations’ Forms 990 and attached schedules. I also acquire additional information from IRS Form 990 using electronic tax return submissions provided by ProPublica. These data include tax-return information from 2,636 unique hospital organization filers. Fifteen percent of these were from organization filers that operate multiple

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15Among those calling for greater transparency was Senator Charles Grassley, who, at the time, served as chairman of the Senate Finance Committee, which held hearings in 2006 regarding community benefits provided by tax-exempt hospitals.

16Other benefits include unreimbursed costs of community health improvement services and community benefit operations, health professions education, subsidized health service, and research, as well as any cash and in-kind contributions for community health promotion.

17Young et al. (2013) checked the validity of Schedule H measures against other sources of public state and proprietary hospital data and found that the data was consistent and appropriate for comparisons across hospitals and over time.

18In other data, hospitals report the uncompensated care and charity care outcomes as charges. Those measures provide an inaccurate description of actual costs. A well-known problem with hospital finance is the gap between the list price hospitals charge, the payments facilities receive from insurers, and the actual cost of serving patients. In two other sources of national hospital data (AHA and HCRIS), hospitals provide an aggregate measure of uncompensated and do not need to provide consistent distinctions between bad debt and charity care (AHA, 2017, RESDAC, 2017). This can lead hospitals to report charity and bad debt interchangeably. For instance, if a nonprofit hospital becomes concerned that they are being too aggressive (or not aggressive enough) in tracking down non-payments, they would have the leeway to reclassify bad debt costs as charity care or vise-a-versa.
hospital facilities – meaning that financial data was reported across facilities in the organization. On average, these organizations included 2.6 facilities. I run my analysis at the group level because spending cannot be accurately attributed to different facilities and facility charity policy data appear to be set at the organization level. Charity care policies do not differ between hospital facilities in the same organization for 95 percent of hospitals outside of Illinois, where facilities within the same organization are required to meet different thresholds depending on whether they operate in urban or non-urban areas.

I merge the IRS filings to the American Hospital Association annual survey data in each year. These data provide important information on hospital characteristics such as patient mix, hospital size, and hospital affiliations. In the case where organizations represent multiple hospital facilities, I link to the facility in that organization that has the same address as the organizational filing. In the case where no organization has the same address, I use additional information on location and hospital name and characteristics to determine the main facility.

I focus on five main outcomes in the IRS Form 990 Schedule. These variables are presented in Table 1. The first two measures, the free care threshold and discounted care threshold, are hospital charity care policies. The free care threshold is the poverty level under which patients are eligible for free care at a given hospital. The discounted care threshold is the poverty level under which patients are eligible for discounted care at a given hospital. The discounted care threshold is a less reliable measure than the free care threshold because it does not indicate anything about the discounts provided.¹⁹

The next three outcomes relate to hospital spending. The first, charity care spending, captures the total percentage of hospital expenditures attributed to providing free or discounted care to the uninsured. The second, charity care + bad debt, captures the total percentage of hospital expenditure attributable to charity care and unpaid medical bills. The final, community benefit spending, captures the total percentage of hospital expenditures spent on programs or activities that provide treatment and/or promote health as a response to identified community needs. Community benefit is what the federal government considers hospital charity. Total community benefit includes charity care expenditures, but not bad debt.

Hospital charity care policies differ substantially across hospitals. Figure 2 includes a histogram of all hospitals free and discounted care policies in 2012. It shows that policies are generally clustered around even cutoffs in the FPL such as 100, 200, and 300%, but there is wide variation in the policies hospitals have. Discounted care thresholds are generally less

¹⁹For instance, discounted care thresholds mask substantial heterogeneity in the amount of care patients at certain poverty levels are responsible for under different hospitals charity care policies – since hospitals do not report information about the discount schedule to the IRS.
condensed than free care thresholds. This is likely attributable to hospitals setting different
discounts schedules for different income groups under these policies. Additional analysis
presented in Table 2 verifies that hospitals adjust these thresholds over time. Between 2010
and 2015, 35% of filers changed their free care thresholds at least once, and 46% of filers
changed their discounted care thresholds. The vast majority of these changes (70% and 90%)
involved increasing the thresholds. When hospitals adjust these policies, they tend to change
them by large amounts (between 77 and 135 percentage points).

In Figure 3, I plot the relationship between changes in free care thresholds and changes in
charity care expenditures and bad debt expenditures, controlling for changes in discounted
care thresholds. The first panel shows that changes in hospitals’ free care thresholds are
associated with significant changes in the percent of total hospital expenditures dedicated
to charity care. A 100 pp increase in a hospital’s free care threshold translates to a 0.10 pp
change in charity care expenditures (mean expenditures over the sample period are 2.7%).
The second panel shows that there is no statistically significant relationship between free care
thresholds and bad debt. The expected sign of this relationship is not obvious. Increases in
hospital free care policies mean individuals who were previously billed are now eligible for
charity care (negative relationship), but changes in hospital free care policies are also likely
correlated with changes in the overall generosity of collection practices (positive relationship).

Table 3 presents an overview of the characteristics of hospitals are with above-median free
care thresholds and above-median charity care spending in 2012. High charity care providers
tend to be larger organizations – they operate more hospital facilities and have a higher
number of beds on average. They also tend to better off financially – they have both higher
revenue and are more likely to be in the top quartile by operating margins. Furthermore,
they are more likely to be teaching hospitals, safety-net hospitals, and academic medical
centers. They do not, however, have substantially different patient mixes than low-charity
providers. The percent of admissions from Medicaid and Medicare are almost identical for
the two types of organizations. In general, the hospitals that provide low levels of charity
care are small community hospitals.

3.2 Additional Data

In order to capture changes that occurred in hospital markets over my sample period, I link
these data on hospital charity and finances to a variety of other data on Medicaid expansion,
Medicaid Section 1115 Low Income Care Pools, state nonprofit hospital regulation, state
funding for public health improvements and hospitals, and local household income.

The first source of data I link to is data on state Medicaid expansions. ACA Medicaid
expansion increased eligibility for Medicaid to 138% of the Federal Poverty Level in 30 states between 2010 and 2014. A large body of literature has shown that Medicaid expansion resulted in significant coverage gains and reductions in uninsured rates in these states (see KFF (2018) for overview of literature). Nationally, the uninsured rate among the non-elderly fell 16.7% in 2013 to 10.6% in 2015. As a result of these expansions, demand for charity care fell and hospital revenue increased.

The second source of data surrounds Medicaid Low-Income Care Pools. These pools, which are Medicaid demonstration projects, were created through Medicaid Section 1115 waivers to help hospitals and other health care providers defray the cost of hospital care for uninsured individuals that is not otherwise reimbursed.\(^{20}\) Between 2010 and 2015, four states created new low-income pools (LIPs) – Arizona (Jan 2012), Texas (Jan 2012), Kansas (Jan 2013), and New Mexico (Jan 2014).\(^{21}\) While these pools serve a similar purpose, they are not identical in structure or operation across states. Every pool reimburses qualified hospitals and providers for a portion of their uncompensated care, but the scope of compensation and number of hospitals qualifying for the program differ greatly across states. For instance, Texas’ pool was 1.8 billion in 2016 while Arizona’s was only $94 million. Furthermore, the pool in Arizona only reimburses a small set of providers in major cities, while the others reimburse the majority of hospitals in the state. Outside of Medicaid expansions and Low-Income Care Pools, there were no other large changes in state funding for uninsured hospital care over this time period.\(^{22}\)

The third source of data includes information on changes in state nonprofit hospital regulation between 2010 and 2015. Over this time period, nine states changed their requirements for nonprofit hospital community benefit. A description of each of these laws can be found in Appendix D.\(^{23}\) To identify changes in state community benefit and charity care laws, I primarily relied on data collected by the Hilltop Institute at the University of Maryland-Baltimore County, which contains information about the laws in each state governing nonprofit hospitals and their community benefit, and data collected by Community

\(^{20}\)A comprehensive overview of Medicaid LIPs is available from FamiliesUSA. http://familiesusa.org/product/explainer-medicaid-uncompensated-care-pools

\(^{21}\)Five additional states -- CA, FL, HI, MA, and TN -- have low-income care pools throughout my whole study period.

\(^{22}\)A common source of funding for low income hospital care is Medicaid Disproportionate Share Payments. Outside of states that distribute these payments through Section 1115 waivers described above, states provide hospitals with DSH funds as lump-sum payment. States have significant purview over how these funds are distributed and the allocation mechanisms differ greatly across states. Small changes to the allocation mechanisms are made on a regular basis – there were over 300 approvals for state changes between 2010 and 2015. However, there were no large changes to the general procedure states used to directly target funds to charity care outside the Section 1115 waivers discussed.

\(^{23}\)The nine states include Nevada, Minnesota, South Carolina, Illinois, Washington, Colorado, North Carolina, Pennsylvania, and New Jersey.
Catalyst for their Free Care Compendium, which contains information on funding and regulation of charity care and other hospital financial assistance. Since neither dataset covered my full sample period (2010-2015), I supplemented the data with primary source analysis using Thomas Reuters Westlaw and discussions with policy makers and advocates in the field. Further information on how I tracked laws along with the final dataset is also provided in Appendix D.

I classify the laws into four categories. The first category, court backed regulations, includes regulations in New Jersey (2015), Illinois (2010), and Pennsylvania (2015) that arose from of high profile state supreme court cases where large, nonprofit hospitals lost their tax-exempt status on account of insufficient charitable activity. The second group of laws, Attorney General backed regulations includes changes to laws in Minnesota (2012) and Illinois (2012) that were implemented and overseen by state attorneys general. The role of the attorney general in regulating nonprofits is unique to IL, MN, and three other northeastern states (MA, VT, NH). In most states state health agencies oversee nonprofit tax-exemptions. The third group of laws, news coverage backed regulations, include a law in North Carolina mandating new financial assistance practices that was passed in response to front-page expose on nonprofit hospital abuse that ran on the front page of the Charlotte Observer. Historically, large expose pieces have led to changes in hospital charity.\(^{24}\) The final group of laws includes regulations where none of these factors were present. These laws represent both the majority of law changes over my study period and the majority of state regulations surrounding nonprofit care.

Finally, I link the hospital financial data to data on changes in local income and state funding for health and hospitals. I merge the hospital IRS filings with data from the 2010-2015 five-year American Community Survey (ACS). From the ACS, I derive the average household income in a health service area (HSA) in each year.\(^{25}\) I then merge the hospital filings to data on government expenditures from the Annual Survey of State and Local Government Finance to control for spending on health and hospitals in the state. These variables are meant to capture changes in investment in public health spending and hospital funding within a state over time.\(^{26}\) I chose to control for total health and hospital spending in the state (aggregate measures spending at the local, county, and state level) rather than spending in individual counties or HSAs where hospitals are located, because states often use


\(^{25}\)Hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area. There are 3,436 HSAs unique HSAs in the United States.

\(^{26}\)These measures include things like funding for hospitals and community health investment. Most importantly, they do not include capture spending on Medicaid.
intergovernmental transfers to shift the source of expenditures between counties and states for key public health and hospital programs.

3.3 Empirical Specification

I estimate difference in differences styled model surrounding changes in federal funding and the passage of state regulations. Specifically, I look at how changes in local need, hospital financial status, and regulation affect measures of hospital charity.

I formally estimate the effect of these changes on hospital charity using the specification below, in which h indexes hospitals and t indexes years.

\[
Charity_{ht} = \tau_h + \tau_t + \beta_1 Pool_{ht} + \beta_2 Expansion_{ht} + \beta_3 Regulation_{ht} + X_{ht} + \epsilon_{ht}
\]

The outcome variable \( Charity_{ht} \) represents the amount of charity a given hospital, h, provides in a given year, t. I consider the four measures of hospital charity previously discussed (1) the highest income level (FPL) that hospitals are willing to provide free care and discounted care total, (2) charity care spending as a percent of hospital expenditures, (3) charity care and bad debt spending as a percent of hospital expenditures, and (4) community benefit spending as a percent of hospital expenditures.

The model includes hospital fixed effects (\( \tau_h \)), year fixed effects (\( \tau_t \)), and an error term (\( \epsilon_{ht} \)). In addition, the model includes a series of controls (\( X_{ht} \)) for local factors that may affect hospital charity over time. These factors include local per capita income and spending on hospitals and health in the state.

The primary coefficients of interest are, \( \beta_1 \), \( \beta_2 \), and \( \beta_3 \). These are the coefficients on the variable described by \( Pool_{ht} \), \( Expansion_{ht} \), and \( Regulation_{ht} \), which are indicators for whether a hospital is from a state that passed one of these policies, in a year after the policy’s implementation. The coefficients of interest describe differential changes in hospital charity that occurred within hospitals as a result of these policies. It is important to note that since these changes are identified off of changes within hospitals over time, they cannot explain differences in charity provision across hospitals in the baseline period.

4 Results

As discussed above, policy makers have struggled with the question of how best incentivize nonprofit hospitals to provide charity and economists have long debated conflicting theories of the nonprofit firm. New data and recent changes in the market for low-income hospital care provide insight into what policies and factors nonprofit hospitals are most responsive to. Specifically, changes in statewide funding for Medicaid expansion (thirty states), hospital...
low income care (four states), and statewide changes in how nonprofit hospitals are regulated (nine states) can provide insight into how hospitals set their charity care policies. In this section, I present evidence surrounding the evolution of nonprofit hospital charity care policies in response to these changes.

Table 4 includes summary statistics for my five outcome variables. Of the 14,069 hospital-year observations, 13,211 of them are for hospitals that report having charity care policies. On average, hospitals free care thresholds are 181% FPL, but there is large variation (sd 62). Average discounted care substantially higher than free care thresholds (mean 324% FPL, sd 115). Hospital charity care spending represents 2.7% of hospital expenditures in my sample. This is only a small portion of total spending on charity care + bad debt (7.9% of expenditures) and total community benefits (11.4% of expenditures). While these numbers align with other analysis researchers have produced using the Form 990, the average charity care + bad debt figure is higher than typically reported in other datasets such as the Medicare Cost Reports. This is likely due to differences in sample since IRS 990 only includes nonprofit hospitals. Table 4 also shows that average Health Service Area household income is 67,000 and on average state governments spent $200 per person on health programs and $400 per person on hospitals each year.27

The main estimates of my empirical specification are in Table 5. The key takeaways from these estimates are that while Medicaid expansion significantly reduced hospitals provision of charity care + bad debt (1.3 pp drop in percent of expenditures dedicated to charity care + bad debt with p<0.01), it did not incentivize hospitals to change their free or discounted care policies (0.449 percentage point change with no significance). State charity care funding pools significantly increased spending on charity care and charity-care and bad debt, but caused hospitals to reduce their free care thresholds. Meanwhile, nonprofit hospital regulations backed by court cases, attorneys general, and news coverage got hospitals to increase their free care thresholds by 2 pp, 10.15, and 10.83 pp respectively. This change is significant for attorneys general and news backed laws. These laws also incentivized hospitals to raise charity care spending (significant for news backed laws) and total community benefit spending (significant for all three). Meanwhile, in cases where none of these enforcement mechanisms were at play, changes in community benefit laws had no effect on spending or thresholds. In fact, the signs of the coefficients on these laws are negative for every outcome besides charity care, indicating that if anything, these laws caused hospitals to invest less in overall provision of charity. These results are consistent with a story where nonprofit

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27 The HSA household income number is higher than some may expect. This is because it is 1) household, not individual income 2) mean income, not median 3) reported at the HSA level. Many HSAs only include one city. For instance, Greenwich, CT, one of the wealthiest cities in the U.S. has its own HSA.
hospital charity is responsive to tough external constraints and not intrinsic motivation at the margin.

The key identifying assumption for my specification is that no factors changed in these states/hospital markets that could have caused hospitals to increase their charity care thresholds absent the observed changes in public funding and regulation. To test this assumption and explore my results further, I run event series analysis for each of these specifications.

### 4.1 Medicaid Expansion

Figure 4 includes event study plots for Medicaid Expansion. The plots show a clear decrease in spending measures following the ACA. This finding is consistent with other studies on Medicaid Expansion and uncompensated care spending (Dranove et al. (2016); Cunningham (2015); Nikpay et al. (2015)). While pre-trends are consistent across expansion and non-expansion states for free and discounted care thresholds, there is no break following the ACA.

I run my main specification with interactions between Medicaid expansion and a variety of hospital characteristics to test how different types of hospitals responded. Table 6 includes results for hospital free care policies and discounted care policies. I find that hospitals with above median shares of low income individuals (defined as below 100% FPL) for their state and above median charity care spending in 2012 do not behave differently than their counterparts. This indicates responses to the ACA did not depend on the projected decreases in charity care spending or the relative level of need in the community (need to flesh out result more). There is no difference between academic medical centers, safety net hospitals, and church affiliated hospitals and their counterparts. While these types of hospitals typically provide more charity care on average (see Table 3), they do not change their policies more in response to the ACA. My results do show that two groups of hospitals change their policies more in response to the ACA. I find that sole community providers significantly decrease their free care policies by 13.6 pp more than non-sole community providers in response to the ACA (the result for discounted care policies is negative, 5.0 pp, but insignificant). I also find that hospitals in markets with above average shares of nonprofit beds increased their free care thresholds by 5.6 pp (p<0.1) more and their discounted care thresholds by 7.8 pp (p<0.05) more than hospitals in markets with below average shares of nonprofit beds. The share of for-profit beds in a market do not significantly impact nonprofit hospital responses to ACA expansion.

Taken together, these results indicate that responses to Medicaid expansion depended on market concentration (Flesh out more to talk about how it fits with previous literature).
(Want to do additional tests on share of low income patients in that market certain hospitals are treating.)

4.2 Low-Income Care Pools

Figure 5 shows event study plots for the implementation of Section 1115 low income pools broken down across states. Significant noise makes these regressions difficult to interpret. Further investigation shows that hospitals in states reacted vastly differently to funding. Differences across states can likely be attributed to differential crowd-out of existing sources of public funding for hospitals.

4.3 Regulations

Figures 6-9 contain event charts for the four categories of regulation. For court backed regulation (Figure 6), there is significant jump in hospitals discounted care thresholds following court cases. Further analysis in by state in Appendix E shows that this result holds for all three court cases studied (IL, NJ, and PA).

For AG backed regulation (Figure 7), there is a significant jump in every measure in the year following new regulations. While the free and discounted care threshold remain elevated, the charity care and bad debt measures return to previously low numbers after a few years. This is driven by higher than average decreases in charity care and bad debt due to the ACA in Illinois and Minnesota. One interesting takeaway from this chart is that the legal changes implemented in both IL and MN were relatively small, but still had large impacts due to the regulatory environment surrounding the law. For instance, in IL the AG enforced the previous court ruling and in MN the AG said new regulations would be more strictly enforced, but changed very little in the law.

For the news backed law in NC (Figure 8), there are clear jumps in both policy measures in the years following the passage of the law. One interesting thing here is that the news story happened a year prior to the law being passed. The lack of a jump between \( t=-2 \) and \( t=-1 \) indicates that it was the regulation combined with the news story, not the news story alone that changed hospital behavior.

Finally, for the four other laws where there is no significant source of regulatory pressure (Figure 9), there is no break following the laws implementations. Previous work looking at the effect of hospital regulations on nonprofit charity spending have found negligible effects of charity care regulations on hospital spending when regulations are broken down by type of nonprofit regulation (Chen (2016)). My results indicate this may be due to categorization of the laws based on content rather than strength of enforcement.
Further analysis in Figure 10 shows that the hospitals in each state that change their free care policies the most in response to all of these laws are hospitals are those with below median charity care policies at the start of my sample period in 2010. This holds the three categories of laws with strong enforcement where hospitals with low policies increase by more and laws with no enforcement where hospitals with low policies decrease their policies by more. There is no difference in policy responses based on measures of local poverty in 2010 (Figure 11). This indicates that it is hospitals who are low charity care providers, not those serving poorer or richer patients on average, that are most responsive to regulation.

5 Conclusion

In this paper, I analyze the factors that motivate nonprofit hospitals to behave more charitably towards poor and uninsured patients using new data from the IRS 990 on hospital charity. I find nonprofit hospitals significantly increased the income threshold for charity care and charitable expenditures in response to regulations imposed by state health agencies. Furthermore, Medicaid expansion did not lead hospitals to significantly increase or decrease their charity care policies despite drastically reducing hospital expenditures on free and discounted care. These results indicate that hospitals respond more to external constraints than changes in demand or income at the margin.

Moving forward, this work can be greatly expanded using additional data from the IRS 990. First, the project can use updated data post-501(r) regulations to look at national regulations. Second, the project can examine additional outcomes surrounding hospital billing and collection practices available in Schedule H. It would be especially interesting to identify how collection practices change in response to Medicaid Expansion. Initial analysis suggests that there was significant variation across hospitals in three key policies 1) whether they charged based on insured rates 2) whether they notified patients before initiating collection and 3) whether they posted policies in ER waiting rooms.

How hospitals charge uninsured and unprofitable patients continues to be a large policy issue. My research shows that hospitals are responsive to public pressure and that regulations can have a large impact on providers. It further suggests that state policy makers think not just about the content of regulations, but also about relevant enforcement bodies and mechanisms when implementing hospital charity regulations.
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FIGURES AND TABLES

How do Hospitals Set Their Charity Care Policies? Evidence from Nonprofit Tax Returns
Rebecca Sachs
Table 1: Measures of Charity from IRS 990

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Units</th>
<th>Definition</th>
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<td>Free Care Threshold</td>
<td>% Federal Poverty Level (FPL)</td>
<td>&quot;Patients under X% FPL eligible for free care at a given hospital&quot;</td>
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<tr>
<td>Discounted Care Threshold</td>
<td>% Federal Poverty Level (FPL)</td>
<td>&quot;Patients under X% FPL eligible for discounted care at a given hospital&quot;</td>
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<td>Charity Care Spending</td>
<td>% Total Hospital Expenditures</td>
<td>Free and discounted care</td>
</tr>
<tr>
<td>Charity Care + Bad Debt</td>
<td>% Total Hospital Expenditures</td>
<td>Free and discounted care and unpaid medical bills</td>
</tr>
<tr>
<td>Community Benefit Spending</td>
<td>% Total Hospital Expenditures</td>
<td>Tax Code Definition of Charity</td>
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Table 2: Changes in Free and Discounted Care Thresholds

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<tr>
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<th>Free Care Threshold</th>
<th>Discounted Care Threshold</th>
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<tr>
<td>Standard Deviation, 2012</td>
<td>62.0</td>
<td>112.6</td>
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<tr>
<td>Percent of hospitals that change policy, 2010-2015</td>
<td>35%</td>
<td>46%</td>
</tr>
<tr>
<td>Percent of changes that are positive</td>
<td>70%</td>
<td>92%</td>
</tr>
<tr>
<td>Avg magnitude of positive change</td>
<td>77 pp</td>
<td>135 pp</td>
</tr>
<tr>
<td>Avg magnitude of negative change</td>
<td>-93 pp</td>
<td>-118 pp</td>
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Table 3: Provider Characteristics, 2012

<table>
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<tr>
<th>Characteristic</th>
<th>Charity Care Below Median</th>
<th>Charity Care Above Median</th>
<th>Free Care Threshold Below Median</th>
<th>Free Care Threshold Above Median</th>
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<tr>
<td>Avg # Beds</td>
<td>162</td>
<td>192</td>
<td>142</td>
<td>198</td>
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<tr>
<td>Median Revenue ($ million)</td>
<td>77</td>
<td>127</td>
<td>53</td>
<td>148</td>
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<tr>
<td>Top Quartile Operating Margins</td>
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<td>29%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Bottom Quartile Operating Margins</td>
<td>25%</td>
<td>24%</td>
<td>29%</td>
<td>22%</td>
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<td>% Admissions Medicaid</td>
<td>16%</td>
<td>18%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>% Admission Medicare</td>
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<td>52%</td>
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<tr>
<td>Teaching Hospital</td>
<td>6%</td>
<td>7%</td>
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<tr>
<td>Safety Net Hospital</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Church Affiliated</td>
<td>17%</td>
<td>18%</td>
<td>12%</td>
<td>20%</td>
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<td>Observations</td>
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<td>1,159</td>
<td>880</td>
<td>1,466</td>
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</table>

Note: Beds, admissions, teaching hospital, safety net hospital, and church affiliation are all reported for the main facility in the organization.
### Table 4: Summary Statistics

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<th>(2) sd</th>
<th>(3) min</th>
<th>(4) max</th>
<th>(5) N</th>
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<td>Charity Care</td>
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<td>Charity Care + Bad Debt</td>
<td>7.890</td>
<td>7.256</td>
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<td>Community Benefit</td>
<td>11.419</td>
<td>10.022</td>
<td>0.060</td>
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<td>HSA Household Income (thousands)</td>
<td>67.632</td>
<td>20.278</td>
<td>27.960</td>
<td>265.160</td>
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<tr>
<td>Government Spending on Health Programs in State ($100/person)</td>
<td>2.554</td>
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<td>0.887</td>
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<td>Government Spending on Hospitals in State ($100/person)</td>
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<td>2.359</td>
<td>0.005</td>
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### Table 5: Main Regression Results

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<td>-0.268</td>
<td>-1.316***</td>
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<td></td>
<td>(1.957)</td>
<td>(7.364)</td>
<td>(0.181)</td>
<td>(0.365)</td>
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<td>State Charity Care Funding Pool * Post</td>
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<td></td>
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<td>Nonprofit Hospital Court Case * Post</td>
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<td></td>
<td>(2.819)</td>
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<td>(0.311)</td>
<td>(0.301)</td>
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<td>Attorney General Backed Law * Post</td>
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<td>0.648***</td>
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<td></td>
<td>(2.668)</td>
<td>(5.149)</td>
<td>(0.233)</td>
<td>(0.613)</td>
<td>(0.209)</td>
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<tr>
<td>News Coverage Law * Post</td>
<td>10.83***</td>
<td>11.17**</td>
<td>0.820***</td>
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<td>0.829***</td>
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<tr>
<td></td>
<td>(2.667)</td>
<td>(5.204)</td>
<td>(0.106)</td>
<td>(0.452)</td>
<td>(0.306)</td>
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<td>Other Law * Post</td>
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<td>-13.99</td>
<td>0.0076**</td>
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Robust standard errors in parentheses  
*** p<0.01, ** p<0.05, * p<0.1  
Note: All standard errors clustered at state level
Table 6: Free Care Policies and Medicaid Expansion

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>(1) None</th>
<th>(2) Med Poverty HSA Pop, 100% FPL</th>
<th>(3) Med Charity Care Charity spending</th>
<th>(4) Academic Medical Center</th>
<th>(5) Safety Net</th>
<th>(6) Church Affiliated</th>
<th>(7) Sole Community Provider</th>
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<td>Expansion*Post</td>
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Robust standard errors in parentheses
*** p < 0.01, ** p < 0.05, * p < 0.1
Note: All standard errors clustered at state level

Table 7: Discounted Care Policies and Medicaid Expansion

<table>
<thead>
<tr>
<th>VARIABLES</th>
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<th>(2) Med Poverty HSA Pop, 100% FPL</th>
<th>(3) Med Charity Care Charity spending</th>
<th>(4) Academic Medical Center</th>
<th>(5) Safety Net</th>
<th>(6) Church Affiliated</th>
<th>(7) Sole Community Provider</th>
<th>(8) Mean NP Beds</th>
<th>(9) Mean FP Beds</th>
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Robust standard errors in parentheses
*** p < 0.01, ** p < 0.05, * p < 0.1
Note: All standard errors clustered at state level
Figure 1: Charity Care Procedure
Figure 2: Distribution of Free and Discounted Care Policies, 2012
Figure 3: Relationship Between Expenditures and Free Care Policies
Figure 4: Medicaid Expansion

- Medicaid Expansion and Free Care Threshold
- Medicaid Expansion and Discounted Care Threshold
- Medicaid Expansion and Charity Care + Debt
- Medicaid Expansion and Charity Care at Cost
Figure 5: Section 1115 Low Income Pools by State
Figure 6: Regulation + Court Case
Figure 7: Regulation + AG

[Graphs depicting Attorney General Oversight Law Event Study for Free Care Threshold, Discounted Care Threshold, Charity Care, and Charity Care + Bad Debt]
Figure 8: Regulation + News
Figure 9: Regulation Only
Figure 10: Free Care Thresholds and Regulation by Relative Policy Generosity Within State
Figure 11: Free Care Thresholds and Regulation by Relative Local Poverty Within State
APPENDIX A: THE FEDERAL COMMUNITY BENEFIT STANDARD

In the United States, nonprofit hospitals qualify for tax exemptions as charitable organizations under the United States Code title 26, section 501, subsection (c). At the state and local level, nonprofit hospitals can also qualify for tax exemptions on the basis of their charitable status. In addition to tax exemptions, nonprofit status allows hospitals to benefit from tax-exempt bond financing and to receive charitable contributions that are tax-deductible to the donors.

Federal, state, and local standards for determining whether nonprofit hospitals qualify as tax-exempt, charitable organizations have evolved greatly over time. Throughout the late nineteenth and early twentieth century, the Internal Revenue Service (IRS) required nonprofit hospitals to be “operated to the extent of their financial ability for those not able to pay for services rendered.” Under this definition, hospitals demonstrated their charitable nature by providing care, i.e. charity care, to people who were unable to pay (Rubin, 2015).

However, with the creation of Medicare and Medicaid in the mid-1960s, the IRS introduced a new tax exemption standard, the community benefit standard, in 1969 for determining whether hospitals qualify as charitable organizations. At the time, policy-makers believed that Medicare and Medicaid would provide adequate insurance coverage for the country’s poor. As a result, there would be a significant reduction in the demand for charity care. Responding to these changes in the health care landscape, the 1969 IRS ruling greatly expanded the scope of hospitals’ potential charitable contributions to their communities beyond charity care to include other activities that promote community health.

The GAO (2008) describes the IRC Section 501(c) community benefit standard as the following:

“(Nonprofit) hospitals are able to qualify for federal tax exemption under section 501(c)(3) of the Internal Revenue Code since IRS and courts have recognized the promotion of health for the benefit of the community – where medical assistance is afforded to the poor or where medical research is promoted – as a charitable purpose. Specifically, nonprofit hospitals must be organized and operated exclusively for the promotion of health, ensuring that no part of their net earnings inure to the benefit of any private individual, and may not participate in political campaigns on behalf of any candidate or conduct substantial lobbying activities”
It is notable that the IRS allows hospitals broad latitude in determining what activities and services constituted community benefit under this standard. Community benefit activities are not limited to charity care, but rather include a menu of activities such as community health improvement, teaching, and research. This has resulted in great variation in what is considered a community benefit activity and how its value is measured.

It is also noteworthy that there is no pre-specified level of overall community benefits or any of its components that hospitals must provide. A common critique of the IRC 501(c) standard has been that it is vague and does not provide hospitals with enough guidance about what hospitals can and cannot do to stay exempt (Tahk, 2016).

In 2008 the IRS addressed some of these concerns by requiring hospitals to submit the IRS 990 Schedule H worksheet. The IRS 990 is a tax form that all tax-exempt organizations in the United States must file annually. The Schedule H worksheet is specifically for non-profit hospitals. The revised Schedule H promotes uninform and comprehensive reporting of community benefits and creates definitions of the activities that count as community benefits.

Schedule H community benefit activities include the net, unreimbursed costs of charity care (providing free or discounted services to patients who qualify under the hospital’s financial assistance policy); participation in means-tested government programs, such as Medicaid; health professions education, health services research, community health activities, and cash or in-kind transfers to other community groups (such as donating funds to a community health screening event or hosting a blood drive).

The Affordable Care contained the first significant changes to the federal community benefit standard since 1969. These new requirements, which are in Section 501(r) of the Internal Revenue Code, were recently finalized and go into effect this year. Under Section 501(r), hospitals must strive to ensure that patients who qualify for fully or partially subsidized charity care can apply for and receive it, are charged reasonable amounts, and are not subject to extraordinary bill collection practices when they have outstanding medical debt. Hospitals are also required to assess the health needs of their community every 3 years and provide implementation strategies to meet the assessed needs.
APPENDIX C: STATE COMMUNITY BENEFIT LAW DESCRIPTIONS

Nevada: Effective October, 2011 nonprofit and for-profit hospitals with over 200 beds had to include a notice of any discounts available in the first statement after discharge. Hospitals were required prior to the passage of this law to discount charges by 30% for the uninsured. Hospitals were also already required to provide indigent care equivalent to at least .6% of the hospital’s net revenues.

Minnesota: Effective July, 2012 Minnesota’s Attorney General executed voluntary agreements with each of Minnesota’s nonprofit hospitals. Under the 2012 Agreement (the third in a series of five-year agreements between the Attorney General and Minnesota hospitals), a nonprofit hospital’s Board of Directors must adopt a charity care policy that takes into consideration a patient’s financial ability to pay a medical bill.

South Carolina: Effective May, 2012 South Carolina includes providing community benefits as part of the CON. Prior to 2012, hospitals already had to implement certain financial assistance policies as part of the county-based Medically Indigent Assistance Program.

Illinois: Effective June 2012, Illinois required that nonprofit hospitals seeking property tax exemption provide charity care or other specified services or activities at levels at least equivalent to what the hospital otherwise would be required to pay in property taxes. This law also mandated that hospitals provide free care to individuals under 200% (urban) or 125% (CAH or rural) of the FPL. Hospitals already had to provide discounted care to individuals below 600% (urban) or 300% (CAH or rural) of the FPL as part of a 2008 law.

Washington: Effective January 2013, nonprofit hospitals have to prepare community health needs assessments. This is an early implementation of the national requirements that went into effect in 2016. Hospitals in Washington already had to report on community benefits and follow have financial assistance policies.

Colorado: Effective August 2012, hospitals had to make financial assistance available to “qualified” patients on a community-specific basis. The Colorado indigent care program was already in place. This related to hospitals not participating in the program.

North Carolina: Effective August 2013, hospitals had to provide the public access to their financial assistance policies, provide discharged patients an itemized list of charges upon request, and abide by reasonable collection practices.

