Protecting the Vulnerable: The Importance of Hospital Community Benefits in Evaluating Hospital Mergers

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Paper prepared for delivery at the 53rd Annual Meeting of the Northeastern Political Science Association, November 13, 2021 in Boston.

American hospitals remain at the forefront of the COVID-19 pandemic. Beginning in March 2020, hospitals around the nation cancelled elective surgeries, along with diagnostic imaging and other non-emergent care, resulting in a loss of approximately $161.4 billion for U.S. nonfederal hospitals in the first months of the pandemic.[1] The American Hospital Association (AHA) projected total fiscal losses during the first four months of the pandemic would exceed $202.6 billion, or more than $50.7 billion per month.[2] Even before the pandemic, the Congressional Budget Office estimated that between 40% and 50% of hospitals could face negative margins by 2025.[3] In this uncertain fiscal environment, what should policymakers and the public expect non-profit hospitals to contribute to their surrounding communities? In addition, how should we measure the community benefits provided by America's hospitals?

Our paper examines the role of state governments in establishing guidelines for hospital community benefits. Since no clear federal standards exist to govern the level of community benefits hospitals must provide, state policies vary widely across the nation. We review state policies towards community benefits in New England and explore lessons from other states, such as Oregon, which established clear guidelines for hospitals. In particular, we argue that a careful assessment of both current – and prospective – community benefits should be a key factor in evaluating whether hospital mergers are in the best interest of their communities. Policymakers should focus on developing community benefit standards that hold hospitals accountable for improving the health of vulnerable populations.

Before the COVID-19 pandemic, about one-quarter of U.S. hospitals had negative operating margins; at the beginning of 2021, half of hospitals reported operating losses.[4] As of May 2021, Kaufman Hall – a prominent health care consulting firm – reported that the median operating margin for hospitals was 2.6% excluding federal stimulus funding from the CARES act. If CARES assistance was included, the margin increased to 3.5%.[5] Furthermore, the cost of uncompensated care –

[1] American Hospital Association. 2020. "Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19." https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due
[2] American Hospital Association. 2020. "Hospitals and Health Systems Face Unprecedented Financial Pressures."
[3] Diorio, Alexia, Tamara Hayford, Lyle Nelson. 2016. "Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios." Washington, DC: Congressional Budget Office. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/workingpaper/51919-Hospital-Margins_WP.pdf

[4] American Hospital Association. 2021. "COVID-19 in 2021: Pressure Continues on Hospital Margins Report." https://www.aha.org/guidesreports/2021-03-22-covid-19-2021-pressure-continues-hospital-margins-report

[5] Swanson, Erik. 2021. "National Hospital Flash Report Summary: June 2021." Chicago, IL: Kaufman Hall. https://www.kaufmanhall.com/insights/research-report/national-hospital-flash-report-summary-june-2021

including bad debt (patients who were billed for care but could not pay) and charity care (care provided with no expectation of payment) increased 13% over 2020 levels.[6]

Hospitals' financial health shapes their "ability to invest in new facilities, treatments, and technologies to better care for patients."[7] Although hospital operating margins – typically defined as median Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA) improved markedly in 2021, overall operating margins remain below pre-pandemic levels.[8] It may take some hospitals years to recover from the fiscal stress of the COVID-19 pandemic, impacting their ability to "invest in community services."[9] AHA President Rick Pollack noted that "hospitals are projected to lose between $53 and $122 billion in revenue in 2021. This comes on top of losses of $320 billion in 2020 and full recovery is years away."[10] Thus, public deliberation about hospitals' obligations to provide community benefits is likely to occur in the context of a challenging fiscal environment for the foreseeable future. The ongoing organizational and financial demands of responding to the COVID-19 pandemic, in short, may limit the ability of many institutions to address other important community needs in the coming years.[11] This underscores the importance of carefully evaluating community benefits provided by U.S. hospitals.

More than half (57%) of U.S. community hospitals are non-profit institutions.[12] In exchange for their tax exempt status, non-profit hospitals must provide benefits to their surrounding community and report these benefits annually to the Internal Revenue Service on Schedule H of Form 990.[13] Qualifying hospitals must document how they serve the interests of the broader community, offer emergency services, and provide care to all patients regardless of their ability to pay.[14] In addition,

[6] American Hospital Association. 2020. "Hospitals and Health Systems Face Unprecedented Financial Pressures."
[7] American Hospital Association. 2021. "COVID-19 in 2021: Pressure Continues on Hospital Margins."

[8] Swanson, Erik. 2021. "National Hospital Flash Report Summary: June 2021."

[9] American Hospital Association. 2021. "COVID-19 in 2021: Pressure Continues on Hospital Margins."

[10] Pollack, Rick. 2021. "Value of Health Systems Shown Clearly During the Pandemic." Paid advertisement – *Wall Street Journal*.
[11] American Hospital Association. 2021. "COVID-19 in 2021: Pressure Continues on Hospital Margins."

[12] Kaiser Family Foundation. 2021. "State Health Facts: Hospitals by Ownership Type." https://www.kff.org/other/state-indicator/hospitals-by-ownership/.
[13] RTI International. 2021. "Community Benefit Spending 101." http://www.communitybenefitinsight.org/?page=info.cb101.
[14] Internal Revenue Service. 2021."Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3)." https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

the Affordable Care Act (ACA) also required tax-exempt hospitals to conduct a community health needs assessment.[15]

Community benefits take many forms. The term "community benefit" was first coined in 1969 to describe spending that would fulfill the requirements for tax exemption under the Internal Revenue Code. Since non-profit hospitals qualify for "favored tax treatment" documenting these community benefits is a key task to ensure that they are providing meaningful services to residents in exchange for their tax exempt status.[16] The current reporting format through Schedule H leaves considerable discretion to institutions and does not necessarily capture all community benefits provided by tax-exempt hospitals.[17] The ACA established new categories for measuring activities and services that would qualify as community benefits.[18] Community benefits can include investments in housing, economic development initiatives, community support, environmental improvements, community leadership development and training, health advocacy, and workforce development.[19] The definition of these categories, and the allocation of activities among them for reporting purposes, rests with hospitals themselves as they prepare their Form 990 submissions. While these guidelines encourage institutions to allocate resources towards activities that improve health outcomes, the ACA did not establish a minimum threshold for hospital community benefits that institutions must meet to qualify for tax-exempt status.

The general nature of these reporting requirements – which simply ask that the funds be used to "promote community health" – led some advocates to calls for establishing clearer guidelines or a specific dollar threshold for hospital community benefits. In addition to requiring hospitals to report benefits through IRS Form 990, state officials can also establish targets related to health equity, access to care, or quality measures. The COVID-19 pandemic underscored the importance of carefully defining and measuring community benefits, as many tax-exempt hospitals incurred significantly higher costs in caring for their communities and significant revenue losses due to government-

[15] Internal Revenue Service. 2021. "Requirements for 501(c)(3) Hospitals Under the Affordable Care Act - Section 501(r). *IRS*. https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.
[16] James, Julia. "Nonprofit Hospitals' Community Benefit Requirements: Health Affairs Brief." *Health Affairs*, February 25, 2016. https://www.healthaffairs.org/do/10.1377/hpb20160225.954803/full/.
[17] American Hospital Association. 2020. "Results from 2017 Tax-Exempt Hospitals' Schedule H Community Benefits Reports". *American Hospital Association*. https://www.aha.org/guidesreports/2020-07-14-results-2017-tax-exempt-hospitals-schedule-h-community-benefit-reports.
[18] Hilltop Institute. 2014. "Hospital Community Benefit". https://www.hilltopinstitute.org/our-work/hospital-community-benefit/.
[19] Nelson, Gayle, Jessica Skopac, Carl Mueller, Teneil Wells, and Cynthia L Boddie-Willis. 2014. "Hospital Community Benefits after the ACA: Addressing Social and Economic Factors That Shape Health." The Hilltop Institute, May 2014. https://www.hilltopinstitute.org/wp-content/uploads/publications/HospitalCommunityBenefitsAfterTheACA-ShapeHealthIssueBrief9-May2014.pdf.

mandated suspension of non-essential services such as elective surgeries.[20] For example, a recent Price Waterhouse Coopers advisory noted that "some costs of responding to the pandemic may be reportable as financial assistance or other community benefit expenses," but COVID-19 relief funds are "reportable as direct offsetting revenue."[21] The COVID-19 pandemic affords an opportunity to assess how local hospitals meet the needs of their communities. Such an assessment can foster greater transparency about the level – and distribution of - community benefits.

Community benefits take on renewed importance in the context of a growing consolidation within the U.S. hospital industry. Studies commissioned by the American Hospital Association argued that mergers will lower costs through greater economies of scale, consolidated purchasing, and organizational efficiencies. Integration, in this view, rather than collaboration through affiliation agreements among separate systems, is necessary to generate significant quality improvement and better value. The pursuit of greater efficiencies, however, raises fundamental questions about where such cuts will occur. In this context, community benefits serve as a key 'vital sign' for policymakers and regulators to evaluate the impact of mergers on patients and their communities.

Numerous empirical studies found that in the wake of a merger, prices tend to rise, as larger hospitals systems command higher reimbursement rates from third-party purchasers. Since uninsured patients often pay the highest posted charges, rather than a discounted rate, higher prices for hospital care threaten to exacerbate existing concerns about medical debt and bankruptcy. In several recent decisions, the Federal Trade Commission challenged proposed hospital mergers in New Jersey, Pennsylvania, and Tennessee because applicants failed to "demonstrate cognizable, merger-specific efficiencies."[22] Parties in proposed mergers have a clear burden of proof – they must provide convincing evidence that the merger will yield tangible benefits for consumers and patients. One way for hospitals to do so is to specify - in advance – measurable benchmarks for how transactions will improve access and quality of care. In 2019, for example, Oregon established a "first in the nation approach to community benefit spending."[23] State officials in Oregon sought to address unmet needs and health inequities by setting minimum spending thresholds for hospitals and

[20] Price Waterhouse Coopers (PwC). 2021. "Form 990 Reporting for Tax Exempt Hospitals Impacted by Pandemic". *PwC*. https://www.pwc.com/us/en/services/tax/library/form-990-reporting-for-tax-exempt-hospitals-impacted-by-pandemic.html.
[21] PwC, "Form 990 Reporting for Tax Exempt Hospitals."
[22] https://www.ftc.gov/system/files/documents/cases/d09399_administrative_part_3_complaint_-_public.pdf.
[23] Kacik, Alex. 2021. Oregon sets floor for community benefit spending; other states may follow. *Modern Healthcare*. February 8, 2021.

tracking their investments.[24] After discussing Oregon's approach to defining and regulating hospital community benefits, we review policies governing hospital community benefits in New England.

Oregon

Oregon embraced the Affordable Care Act by expanding Medicaid eligibility; in 2021, 30% of the state's residents are enrolled in Medicaid.[25] Nevertheless, access to care remains a concern for thousands of residents who remain uninsured or underinsured. While 58 of the state's 60 acute care hospitals in Oregon are nonprofit institutions that are exempt from taxation, Rep. Andrea Salinas, the chair of the Health Care Committee in the Oregon House, noted "normal ordinary people who used to have great health insurance, and used to be able to access it, suddenly go into medical debt and generational poverty" as a result of high hospital bills.[26] Salinas also critiqued nonprofit hospitals for not "stepping up voluntarily and not actually fulfilling their charitable mission." Other stakeholders also pointed to the industry's health profits after the passage of the Affordable Care Act expanded Medicaid, relieving hospitals of much of their charity care burden. As one physician noted, many institutions are "wildly profitable and their tax-exempt status is a very valuable asset."[27]

In 2019, legislators in Oregon enacted House Bill 3076, establishing the state as a national leader in hospital community benefits reporting and standards. HB 3076 required nonprofit hospitals and clinics to provide financial assistance to low-and-middle income patients. It also directed the Oregon Health Authority to "establish a community benefit spending floor for hospitals and hospital systems."[28] All nonprofit hospital systems in the state are required to have a "written financial assistance policy" clearly posted in admitting areas and on hospital websites to provide financial transparency for patients. For uninsured or self-paying patients with household incomes less than 200% of the federal poverty line, all hospital charges are to be waived. For patients whose income lies between 200 and 400 percent of the federal poverty guidelines, HB 3076 directed hospitals to bill patients at the same rate Medicare would pay. In addition, hospitals are required to discount the cost of care by 50% for the first $1,000 of charges, 90% of the charges more than $1,000 and not more than $5,000, and 100% of any charges in excess of $10,000.

[24] Kacik, "Oregon sets floor."
[25] Botkin, Ben. 2021. "Health Care Industry Voices Concerns Over State's Medicaid Plan." October 4. https://www.thelundreport.org/content/health-care-industry-voices-concerns-over-state's-medicaid-plan
[26] Foden-Vencil, Kristian. 2019. "Legislators Try to Make Hospitals Justify their Nonprofit Status." June 6. https://www.opb.org/news/article/hospital-oregon-health-insurance-non-profit-legislation/.
[27] Foden-Vencil, "Legislators Try."
[28] House Bill 3076. 2019. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/HB3076/Introduced

Furthermore, every hospital must also conduct a community needs assessment every three years to "identify care needs of the community it serves and shall develop a three-year strategy for meeting health care needs." Reminiscent of federal health planning initiatives in the 1970s and early 1980s needs assessments must also incorporate "opportunities for public participation in the development and implementation of the strategy."[29] HB 3076 also established a minimum standard for community benefits spending by hospitals. A hospital or hospital system that fails to meet the community benefit spending floor established by HB 3076 during a 12 month period is required to spend "the amount equal to the difference between its community benefit spending and the community benefit spending floor, the maximum amount possible while retaining sufficient days cash on hand to maintain the hospital or hospital system's current credit rating, in improving community health, addressing health disparities or providing charity care; and (b) Not be exempt from taxation under ORS 307.130 for the next 24-month period." This threatened loss of non-profit status represents a veritable sword of Damocles hanging over the head of noncompliant hospitals.

The Oregon Health Authority uses a statewide Community Benefits Reporting Form (CBRF) that requires nonprofit hospitals to report the costs of providing charity care and operating public programs. This system has its roots in a 2007 statute (HB 3290) that defined community benefits as "a program or activity that provides treatment or promotes health and healing in response to an identified community need."[30] Community benefits include charity care, losses related to care paid for by Medicaid, Medicare, and other public insurers, community health improvement services, research, financial and in-kind contributions to the community, and community-building activities. The increasing importance of hospital community benefits in Oregon reflects the work of the Oregon Health Equity Alliance, which published a report questioning the tax-exempt status of nonprofit hospitals in the state. [31]

[29] For more discussion of federal health planning initiatives, see James Morone, *The Democratic Wish*. New York: Basic Books, 1990.
[30] Oregon Health Authority. "Community Benefit Reporting Form Instructions State of Oregon." https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/CBR-Directions.pdf.
[31] Oregon Health Equity Alliance. "Hospital Community Benefits in Oregon: Our Hospital, Our Benefit?" https://static1.squarespace.com/static/5a2075ac8a02c7cbf8664919/t/5cf20e62adb6f600012c4d52/1559367267859/Hospital+Community+Benefits+in+Oregon.pdf.

Connecticut

Connecticut hospitals spent $2.2 billion on community benefit initiatives in 2019. In 2019, hospitals in Connecticut had a banner year and posted a 12% increase in operating revenue.[32] This increase outpaced higher costs for uncompensated care, which rose 4.3% in 2019 to $806 million.[33] Additional state funding also helped to cushion the blow from the COVID-19 pandemic, as the state provided an infusion of $40 million on top of over $980 million in federal coronavirus relief funds to support Connecticut's acute care hospitals in 2020 and 2021.[34] Acknowledging in its February 2021 Community Benefit Report that "other health needs continue to exist in [Connecticut] communities, even as we battle COVID-19," the Connecticut Hospital Association emphasized the importance not neglecting underlying community needs during the pandemic.

Current law in Connecticut requires that hospitals which voluntarily develop community benefit programs must meet certain reporting requirements and mandates all hospitals to file their charity care policies with the state. In addition, before a Certificate of Need can be granted for a transfer of ownership (e.g., merger) between two health systems, institutions must demonstrate that their community benefit activities align with the State Health Improvement Plan.[35] At present, however, Connecticut does not require hospitals to provide a minimum level of community benefits in order to maintain their tax-exempt status. In recent years, advocacy groups have pressed for more targeted allocations of community benefit dollars to ensure that hospital community benefit spending is not limited to just Medicaid and Medicare shortfalls and uncompensated care. In March 2021, the Universal Health Care Foundation of Connecticut testified before the state Public Health Committee in support of House Bill 6550, which proposed revisions to hospital community benefits programs. The proposed bill would establish a community benefit and community building spending floor and would require state officials to make reports available to the public and to create an annual summary and analysis of the reports.

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[32] Singer, Stephen. 2020. "Report: In Pre-Pandemic 2019 CONNECTICUT Hospitals Posted a Solid 12% Revenue Boost." *Hartford Courant*, September 9. https://www.courant.com/business/hc-biz-connecticut-hospitals-finances-20200910-xg24blj2trhxhmilr6bmxlxevi-story.html.

[33] Singer, "Report: In Pre-Pandemic 2019 CONNECTICUT Hospitals Posted a Solid 12% Revenue Boost."

[34] Lamont, Ned. 2021. "Governor Lamont Allocates $40 Million To Connecticut's Hospitals To Support Ongoing COVID-19 Response Efforts." February 4, 2021. https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2021/02-2021/Governor-Lamont-Allocates-40-Million-To-Connecticut-Hospitals.

[35] See Conn. Gen. Stat. §19a-649 (a), (b)

Maine

A 2016 Hilltop Institute report noted that Maine had no specific requirements governing the provision of community benefits, no required community health needs assessment, and no required community benefit plan or implementation strategy.[36] However, both nonprofit and for-profit hospitals must report any free care provided to the state Department of Health and Human Services. Institutions must also provide free care to Maine residents with income up to 150% of the federal poverty level.[37] While Maine has no statewide standard for hospital community benefits requirements, the Maine CDC, Central Maine Healthcare, Northern Light Health, MaineGeneral Health, and MaineHealth collaborated to create the "Maine Shared Community Health Needs Assessment," which culminated in a 2019-2022 timeline. As one hospital CEO noted, "in a small population state with a large geography like Maine, we need to think of health care not like a commodity, but like a scarce resource, a delicate ecosystem that needs protecting."[38]

Massachusetts

Massachusetts hospitals operate in a challenging fiscal climate. The Center for Health Information and Analysis reported that seven of the state's ten multi-hospital acute care health systems were profitable in 2020. In addition, the CHIA found that "Thirty-one of the 45 hospitals that are part of multi-acute hospital health systems reported positive total margins in 2020. The margins include $1.5 billion in COVID-19 relief funding… Without the relief funds, 13 of the 45 hospitals would have reported positive total operating margins."[39]

Current law in Massachusetts states, "No original license shall be granted to establish or maintain an acute care hospital… unless the applicant agrees to maintain or increase the percentage of gross patient service revenues allocated to free care."[40] The Attorney General's Community Benefits Guidelines "represent a unique, non-regulatory approach that calls upon hospitals and HMOs to identify and respond to unmet community health needs by formalizing their approach to community

[36] Hilltop Institute. 2016. "Community Benefit State Law Profile: Maine." www.hilltopinstitute.org/wp-content/uploads/hcbp/hcbp_docs/HCBP_CBL_ME.pdf.
[37] Hilltop Institute, "Community Benefit State Law Profile: Maine."
[38] Valigra, Lori. 2019. "Why Maine Hospitals are Teaming Up Instead of Competing." *Bangor Daily News*. April 15. https://bangordailynews.com/2019/04/15/business/why-maine-hospitals-are-teaming-up-instead-of-competing/

[39] Center for Health Information and Analysis. 2021. "Massachusetts Acute Hospital & Health System Financial Performance: FY 2020 Report." Center for Health Information and Analysis. https://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2020-annual-report/Acute-Hospital-Health-System-Financial-Performance-Report-FY2020.pdf. MA Health & Hospital Association.
[40] MA General Law Section 51G(3), https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section51G.

benefits planning, collaborating with community representatives to identify and create programs that address those needs, and issuing annual reports on their efforts." These guidelines, however, are just that – an encouragement to meet the needs of communities that do not mandate that the hospitals adopt specific programs.[41] A 2021 analysis of hospital community benefits recommended that "all non-governmental hospitals should be reporting, with greater categorical consistency, and there should be specific designation when determination of need obligations drive the expenditure." The report also recommended that "hospital spending should be focused more 'upstream' on social and environmental determinants of health" and noted that "community engagement needs to be taken more seriously at all steps of the process."[42]

New Hampshire

Prior to the COVID-19 pandemic, non-profit hospitals in New Hampshire reported a slim operating margin of 1.2% in 2019. Hospital margins fell further in 2020 as the pandemic lockdown restricted elective procedures. Hospitals in New Hampshire reported approximately $500 million in lost revenues between March and December 2020.[43] The state's largest hospital system - Dartmouth-Hitchcock Health – illustrates the fiscal impact of the COVID-19 pandemic. Dartmouth-Hitchcock Health reported a healthy operating margin of 3.0% in 2019, but lost $84 million during the 2020 fiscal year. Many tax-exempt nonprofit hospitals in New Hampshire updated their charity care policies after the Affordable Care Act expanded Medicaid eligibility and allowed individuals to purchase health insurance policies through the federal marketplace. As a result, some advocates that residents will forego medical care because they are afraid that they will not be able to pay for it.[44]

Nonprofit hospitals are governed by the state's laws regarding 'charitable trusts.' Since 2000, every health care charitable trust in the state with a fund balance in excess of $100,000 must develop a community benefits plan within 90 days of the start of its fiscal year.[45] Each institution's plan must include a mission statement, community needs assessment and activities designed to address identified needs, and an annual report on community benefits activities and outcomes (and their

[41] Office of the Attorney General. "The Attorney General's Community Benefits Guidelines for Non Profit Hospitals." *Office of the Attorney General.* https://www.mass.gov/doc/community-benefits-guidelines-for-non-profit-hospitals/download.
[42] Enid Eckstein & Paul A. Hattis. 2021. "Breaking Down Hospital Community Benefits." *CommonWealth Magazine*. https://commonwealthmagazine.org/opinion/breaking-down-hospital-community-benefits/.
[43] Rosenbluth, Teddy. 2021. "A Year of COVID: New Hampshire Hospitals Are Struggling Financially." *Concord Monitor*. https://www.concordmonitor.com/hospital-financial-impact-COVID-39301570.
[44] Concord Monitor. 2014. "Editorial: Tax Exemption for Hospitals Due for Review." *Concord Monitor*. https://www.concordmonitor.com/Archive/2014/05/Edithospitals-cmforum-060114.
[45] New Hampshire General Court. Section 7:32-j Exemption. http://www.gencourt.state.nh.us/rsa/html/i/7/7-mrg.htm.

associated costs).[46] Through its affiliation with The Foundation for Healthy Communities, the New Hampshire Hospital Association also works with member hospitals & health systems to support their efforts to conduct community health needs assessments and prepare reports on community benefits for public dissemination.[47]

At present, New Hampshire has no proposed legislation to establish minimum community benefits standards for hospitals. The New Hampshire Hospital Association's (NHHA) Community Benefits Reporting Guide, however, notes that institutions should "provide a consistent framework for describing and quantifying the range of potential community benefit activities among the varied health care charitable trusts in our state." In its 2020 Community Benefits Report, the NHHA estimated that the value of community benefits in 2018 was $496,749,032. A majority of community benefits ($304,032,711) was accounted for by unreimbursed Medicaid and Medicare costs, charity care, and patients unable to pay for billed services. The remainder was allocated to other community benefits (e.g., community health improvement services, health professions education, subsidized health services, research, and cash and in-kind contributions).[48]

Rhode Island

The fiscal health of Rhode Island's hospitals improved in 2020 and 2021 as a result of an infusion of federal and state funding to offset declining patient volume during the pandemic. After posting a loss in its 2019 fiscal year, Lifespan – the state's largest hospital system – earned a $21 million profit in its 2020 fiscal year, thanks in large part to an infusion of coronavirus relief from the federal and state governments.[49] Notably, Lifespan also posted a healthy profit on its operating margin (excluding investments) of $55 million in 2020, compared to a loss of $23 million in 2019 despite losing $126 million as a result of the state's ban on elective procedures during the COVID-19 pandemic.[50] Rhode Island's hospital market is on the cusp of a major transformation, as the state's two largest hospital networks seek approval to merge into an integrated academic health system led by Brown University. Former Governor Gina Raimondo strongly endorsed this proposal, declaring that "There is no question that a local, integrated health care system is in the best interests of Rhode Islanders."

[46] NH Gen. Court. "Section 7:32-e Community Benefits Plans." http://www.gencourt.state.nh.us/rsa/html/i/7/7-mrg.htm.
[47] New Hampshire Hospital Association. "Community Benefits." https://nhha.org/for-patients/community-benefits.
[48] Foundation for Healthy Communities. Feb. 2021. "2020 Community Benefit Report." *New Hampshire Hospital Association*. https://www.healthynh.org/images/NH_2020_Community_Benefits_Report_FINAL.pdf.
[49] Nesi, Ted. 2020. "Top RI hospital group Lifespan books $21M profit, bolstered by CARES Act." December 1. WPRI. https://www.wpri.com/business-news/top-ri-hospital-group-lifespan-books-21m-profit-bolstered-by-cares-act/.
[50] Nesi, "Top RI Hospital Group."

Furthermore, Brown University President Christina Paxson noted that "we're committed to creating an integrated health system that increases access to excellent health care and by doing so, reduces health disparities." The parties to the merger promise the new integrated academic health system will "improve population health and reduce health disparities in Rhode Island while reducing costs."[51] The merger will create a $3.5 billion health system. To date, however, the parties have only committed to invest an additional $10 million over a three-year period to improve access to primary care and behavioral health services and develop strategies to address disparities resulting from social determinants of health.[52]

Rhode Island requires all hospitals to meet the "community standard" for the provision of hospital care, community benefits, and uncompensated care under the authority of the state's Hospital Conversions Act.[53] To maintain its license, each hospital must provide a report of the cost of its charity care, bad debt, and Medicaid shortfalls.[54] The state requires hospital to provide free care to uninsured patients with incomes up to 200% of the Federal Poverty Line (FPL) and charge patients with incomes between 200-300% of the FPL on a sliding scale. Hospitals, however, are free to determine their own fee structure.[55] The state does not specify a minimum threshold or target for community benefits. Hospitals must adopt formal, board-approved plans for the provision of community benefits and conduct a comprehensive community needs assessment consistent with the goals of the state health plan.[56]

Vermont

The financial stability of hospitals in Vermont is more precarious than in other more populous New England states as a result of its rural character. Several Vermont hospitals faced financial challenges even before the COVID-19 pandemic. Springfield Hospital, for example, filed for bankruptcy protection in 2019. Most recently, the hospital's finances have improved, as the hospital recorded a $1.8 million operating loss in 2021, compared to $9.6 million in 2019.[57] The state's largest hospital – UVM Medical Center – ended the 2021 fiscal year with a $127 million surplus.[58] The Green

[51] See the website promoting the merger, which describes the commitment to community benefits at https://healthierri.com/our-vision/.
[52] See https://healthierri.com/our-vision/.
[53] Community Catalyst. 2021. "Rhode Island." https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/states/rhode-island.
[54] National Association for State Health Policy. 2018. "Hospital Community Benefits Comparison Table for Six New England States." https://www.nashp.org/wp-content/uploads/2018/05/Hospital-community-benefits-chart-final-5_3_2018.pdf.
[55] Community Catalyst, "Rhode Island."
[56] National Association for State Health Policy, "Hospitals Community Benefits Comparison."
[57] https://www.beckershospitalreview.com/finance/vermont-hospital-eyes-post-bankruptcy-partnerships.html
[58] https://vtdigger.org/2021/09/12/states-largest-hospital-uvmmc-asks-for-204-million-increase/

Mountain Care Board, a state agency tasked with controlling health care spending and reviewing hospital budgets noted that hospitals requested a 3.2% increase in 2020.

Current law in Vermont requires community hospitals to report community benefit expenses annually and to conduct community health needs assessments every 3 years.[59] While hospitals are required to develop strategic initiatives to address identified needs and provide annual updates on their progress, Vermont does not require nonprofit hospitals to provide community benefits or establish a monetary benchmark or minimum standard for the amount of community benefits. The legislation on hospital community reports was enacted in 2003, and last amended on January 1st, 2020.

Vermonters have recently expressed concerns with the lost revenue from nonprofit institutions. UVM, including the university and the hospital, "own more than $1 billion in property in the city [Burlington] and do not pay property taxes."[60] Nevertheless, "UVMMC reported close to $210 million in community benefit to the IRS this year" and "provided a total of $6.78 million in free or discounted care to uninsured patients, almost $1 million of which was provided to residents of Burlington." [61] In addition, the "hospital also donated approximately $775,000 to local community organizations, including the Howard Center street outreach team and the Chittenden County Opioid Alliance."[62]

Discussion

Our review of state policies regarding hospital community benefits underscores the wide variation in approaches within the New England region. Unlike Oregon, no New England state requires hospitals to provide a minimum level of community benefits, even though all have some form of required community benefit reporting.[63] Since all states provide nonprofit hospitals with exemptions from income, property, and sales taxes, policymakers have a legitimate interest in assessing the societal return on investment from these foregone revenues. In exchange for their tax-exempt status, we believe that public officials can – and should – establish measurable performance guidelines (or specific targets) to ensure that institutions provide concrete benefits to their

[59] https://www.healthvermont.gov/sites/default/files/documents/pdf/7.%202018%20Hospital%20Report%20Rule%20Clean%20Copy.pdf
[60] Landen, Xander et al. "Facing Financial Struggle, Vermont Hospitals Ask for Revenue Growth, Rate Hikes." VTDigger, August 18, 2019. https://vtdigger.org/2019/08/14/facing-financial-struggle-vermont-hospitals-ask-for-revenue-growth-rate-hikes/.
[61] Landen, Xander et al. "Facing Financial Struggle, Vermont Hospitals Ask for Revenue Growth, Rate Hikes." VTDigger, August 18, 2019. https://vtdigger.org/2019/08/14/facing-financial-struggle-vermont-hospitals-ask-for-revenue-growth-rate-hikes/.
[62] Landen, Xander et al. "Facing Financial Struggle, Vermont Hospitals Ask for Revenue Growth, Rate Hikes." VTDigger, August 18, 2019. https://vtdigger.org/2019/08/14/facing-financial-struggle-vermont-hospitals-ask-for-revenue-growth-rate-hikes/.
[63] National Association for State Health Policy. 2018. "Hospital Community Benefits Comparison Table for Six New England States." https://www.nashp.org/wp-content/uploads/2018/05/Hospital-community-benefits-chart-final-5_3_2018.pdf.

communities. Merger applications, in particular, afford public officials the opportunity to establish transparent standards to promote health equity and improve access for vulnerable populations as a condition of winning regulatory approval from state regulatory bodies.

Before the COVID-19 pandemic, hospitals' provision of uncompensated care declined from 4.1% of total expenses in 2018 to 3.9% in 2019, excluding Medicare and Medicaid shortfalls. Data from the American Hospital Association also revealed that hospitals' support for indigent care clinics, meal deliveries, and other community health benefits also fell from 2016 to 2019.[64] The COVID-19 pandemic placed a significant burden on hospitals but the industry's financial condition improved over the past 18 months as a result of an infusion of federal and state funding. Hospital balance sheets in 2021, in short, are stronger than expected. The nation's largest non-profit health care systems also spent less on free- and reduced-price care for patients in 2020 as patient volume for emergency department visits, elective surgeries, and other hospital services declined during the pandemic lockdown. Furthermore, while reduced patient volumes resulted in lower charity care costs for hospitals during the pandemic, the federal government also reimbursed providers for COVID-related testing and treatment for uninsured patients at Medicare rates.[65]

Most community benefits reported by hospitals take the form of 'shortfalls' or 'underpayment' by public payers such as Medicaid, Medicare, and the State Children's Health Insurance Program. In 2016, for example, Oregon hospitals reported $1.6 billion in underpayment as community benefits. This dwarfed the $150 million spent on charity care, $34 million dedicated to 'community health improvement services, and $14 million in 'community building activities' not directly related to health care (e.g., programs to address housing, homelessness, and other social determinants of health).[66] The use of payment shortfalls, along with the cost of medical education and research, however, remains hotly contested as a measure of community benefits. In 2021, the Lown Institute noted that "health policy experts have argued that these categories do not constitute direct benefits for community health."[67] Hospitals routinely negotiate discounts with private insurers that pay less than their posted charges in exchange for patient volume. Few patients – apart from the uninsured (e.g., self-paying) – actually pay the 'list price' for care. As the Lown Institute noted, "Hospitals offer

[64] Bannow, Tara. 2021. "Community Hospital Finances Strong Until COVID Struck." *Modern Healthcare*. January 25, pp. 12-13.
[65] Bannow, Tara. 2021. "COVID-19 Curbed Health Systems' Charity Care Spending in 2020." *Modern Healthcare*. March 29, pp. 6-7.
[66] Oregon Association of Hospitals and Health Systems. 2018. "What Counts as Community Benefit?"
[67] Lown Institute. 2021. "Winning Hospitals 2021 – Community Benefit." https://lownhospitalsindex.org/2021-winning-hospitals-community-benefit/#methodology.

discounted rates for most insured patients, yet these are not considered community benefits; it is unclear why discounts for Medicaid patients should be an exception."

The Lown report recommended that hospitals spend at least 5.9% of their overall expenditures on charity care and 'meaningful community investment to justify their nonprofit status.[68] Setting a fixed target for community benefit spending, however, can be problematic. For example, a floor could increase community benefit spending by lagging hospitals, but could discourage other institutions from exceeding the minimum threshold.[69] In lieu of a fixed percentage target, we recommend that state officials tailor performance guidelines to the needs of specific communities by negotiating public commitments to fund specific programs and activities as part of state oversight of mergers and acquisitions. Such agreements would hold hospitals accountable for addressing identified needs and could also raise awareness of the availability of free and discounted care for vulnerable populations. Furthermore, such a process will afford credit-claiming opportunities for hospitals to tout specific programs and commitments to justify their tax-exempt status. Negotiated agreements, in turn, will provide tangible evidence of how institutions will address important community priorities and can shape future investments by drawing upon public feedback.

[68] Lown Institute. 2021. "Winning Hospitals 2021 – Community Benefit."
[69] Kacik, Alex. 2021. "Oregon Sets Floor for Community Benefit Spending; Other States May Follow Suit." *Modern Healthcare*. February 8, pp. 6-7.