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BRIEF REPORT

Rural nonprofit hospital community benefit and financial assistance spending: A call for greater reporting transparency

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Abstract

Purpose: US nonprofit hospitals must provide community benefits including financial assistance to be tax-exempt. Rural residents particularly benefit from financial assistance because they have higher medical debt on average. The Internal Revenue Service allows nonprofit hospitals that are members of health systems to report expenditures for their entire system (group returns) rather than for individual hospitals. Our study examined how (if at all) rural nonprofit hospitals filing group returns are different than those filing individual returns.

Methods: We used 2021 data extracted from Community Benefit Insight and the American Hospital Association for 100 rural nonprofit hospitals in Wisconsin and Minnesota. We conducted bivariate analyses examining differences in mean total community benefit spending and mean financial assistance spending as a percentage of total operating expenses for hospitals filing individual versus group returns. We conducted multivariable regression models examining the association of filing group returns and individual returns with community benefit spending and financial assistance spending.

Findings: Bivariate analysis revealed significant differences between group return hospitals and individual return hospitals in spending on community benefits (5.81% vs. 9.49%, respectively) and on financial assistance (0.36% vs. 0.71% respectively). Multivariable regression demonstrated filing group returns is significantly negatively associated with community benefit expenditures ($\beta = -2.90$, $p < 0.05$) and financial assistance expenditures ($\beta = -0.31$, $p < 0.01$).

Conclusion: In our sample, filing group returns was associated with less spending on community benefits and financial assistance. To understand this finding, researchers need data on individual hospital spending to increase transparency and accountability.

KEYWORDS
community benefits, financial assistance, hospital, medical debt, rural

INTRODUCTION

Since 2009, US nonprofit hospitals have been required to annually report their "benefits to the community" to the Internal Revenue Service (IRS).[1] Broadly, nonprofit hospital community benefits are "the initiatives, activities and investments undertaken by tax-exempt hospitals to improve health in the communities they serve" and are separated into seven categories for tax reporting purposes.[2] While nonprofit hospitals must report their spending in all seven categories to the IRS, there are no federal requirements dictating which categories they must spend on or how much they must spend. Recent studies have criticized suboptimal nonprofit hospital spending, particularly in the category of financial assistance (free or discounted care for patients), noting for-profit hospitals currently spend more on financial assistance than nonprofit hospitals,[3] and the value of nonprofit hospitals' tax savings are higher than their community investments.[4]

Financial assistance spending is of particular interest to researchers and policymakers given its potential to reduce medical debt by providing free or discounted care to patients who cannot pay. Analyses of Census Bureau data found 15% of US households had medical debt as of 2021,[5] and a 2022 Kaiser Family Foundation survey found 1 in 5 US adults were paying off bills owed for medical care.[6] The ACA required nonprofit hospitals to maintain a written financial assistance policy, limit charges, and set billing and collection limits.[7] However, financial assistance eligibility requirements remain at nonprofit hospital discretion and reports of nonprofit hospitals reporting patient debt to credit agencies persist.[8]

Due to the discretionary nature of the federal financial assistance requirements, nonprofit hospital financial assistance expenditures vary considerably and research is limited on how this variation is distributed across geographic locations.[8] Residents of rural areas, on average, have higher levels of medical debt,[9] experience worse health and mental health outcomes,[10] and face higher rates of hospital closures.[11] The combination of these factors underscores the need for rural residents to receive adequate financial assistance and highlights the necessity of transparent reporting requirements to examine spending.

Despite the need for transparent reporting, nonprofit hospitals are currently able to report all seven categories of community benefit spending at the level of the health system, rather than at the individual hospital level. Therefore, a single form may be submitted to the IRS on behalf of all affiliated entities within the health system (group tax returns), which consolidates spending at the group level. Nationally, in 2019, more than 40% of nonprofit hospitals filed group tax returns.[12] The Government Accountability Office recommended the IRS require individual hospital level reporting in 2020, but the IRS declined to make this change noting, "…such reporting would impose greater burdens on tax exempt hospitals and the IRS with no tax administration benefit."[7] Past tax law research has cited administrative efficiency on the part of nonprofit hospitals and the IRS' limited resources as rationale for the allowance of group returns.[13]

The practice of filing group tax returns renders cross-hospital comparisons inaccurate at the individual hospital level and obscures actual spending among the individual hospitals that comprise the group. To address this, previous research has excluded nonprofit hospitals that file group tax returns from analyses,[14] and through their exclusion, research conclusions may only be representative of spending among independent hospitals. Research that does not group tax filers may become less representative as rural hospitals are increasingly merging, with fewer rural hospitals remaining independent.[15]

During this time of consolidation, it is increasingly important to understand how health system-level reporting practices conceal community benefit and financial assistance spending behaviors of nonprofit hospitals in rural areas. We posited that by allowing nonprofit hospitals to obscure their community benefit and financial assistance expenditures, hospitals could overstate their spending. This study examines the variation in community benefit and financial assistance spending among rural nonprofit hospitals that filed group returns in Wisconsin and Minnesota. We sought to determine in what ways group filers were different (if at all) from individual filers, and thereby expose the barrier to accurate comparison that group filing creates. Through this research, we aim to inform best practices for research and policymaking concerning tax reporting transparency for nonprofit hospitals.

METHODS

We used publicly available 2021 nonprofit hospital tax data from Community Benefit Insight[16] and 2021 hospital characteristics data from the American Hospital Association (AHA) Survey[17] for two states, Wisconsin and Minnesota ($N = 100$). Community Benefit Insight compiles data sourced from the IRS, the Centers for Medicare and Medicaid Services (CMS), the Kaiser Family Foundation, and the Hilltop Institute.[18] Community Benefit Insight retains data on nonprofit hospitals that are short-term/acute care, children's hospitals, or critical access hospitals.[18] Long-term and/or psychiatric nonprofit hospitals are not included in the data.[18]

We limited our sample to rural nonprofit hospitals using the Rural Urban Continuum Codes 04–09 available from Community Benefit Insight.[19] The key outcome variables of interest were community benefit spending and financial assistance spending as a percentage of total operating expenses. Total operating expenses are defined as, "all expenses associated with operating the tax-exempt hospital, such as salaries, employee benefits…" etc. By examining broad community benefit spending and financial assistance spending as a percentage of total operating expenses, we are better able to assess spending in relation to hospital finances. The key independent variable of interest was whether a hospital filed a group tax return. Our covariates included nonprofit hospital system membership, gleaned from AHA survey data; church affiliation; teaching affiliation, defined as whether the hospital is a member of the council of teaching hospitals; hospital bed count; and net margin ratio, calculated by subtracting total operating expenses from total hospital revenue and then dividing by total revenue.[20]

We examined hospital characteristics overall and by group return filing status. We conducted two tailed *t*-tests with unequal variance

TABLE 1 Sample demographics of rural hospitals in Wisconsin and Minnesota in 2021.

Characteristics	Minnesota & Wisconsin Rural nonprofit hospitals		
	Full sample ($n = 100$) *n* (%)	Group returns ($n = 23$) *n* (%)	Individual returns ($n = 77$) *n* (%)
Member of a health system	63 (63.0)	23 (100)	42 (54.55)
Church affiliated	12 (12.0)	2 (8.70)	10 (12.99)
Teaching affiliated	11 (11.0)	2 (8.70)	9 (11.69)
Hospital bed count Mean (SD)	48.76 (59.66)	71.83 (103.55)	41.87 (36.38)
Net margin ratio Mean (SD)	0.09 (0.10)	0.05 (0.07)	0.10 (0.11)
Community benefit expenditure as a percentage of total expenses Mean (SD)	8.64 (5.28)	5.81 (1.91)	9.49 (5.66)
Financial assistance expenditure as a percentage of total expenses Mean (SD)	0.63 (0.45)	0.36 (0.19)	0.71 (0.05)

examining differences in community benefit and financial assistance spending as percentages of total operating expenses between nonprofit hospitals filing a group tax return and nonprofit hospitals filing an individual tax return. Next, we conducted multivariable linear regressions estimating the association of group return status with community benefit spending and financial assistance spending as percentages of total operating expenses while controlling for relevant covariates. These analyses examined whether and to what extent group filing hospitals were different from individual filers regarding community benefit and financial assistance spending. All analyses were conducted using Stata SE v.17.0.

RESULTS

When comparing hospital characteristics by group return status, we found hospitals that filed a group return had a higher mean bed count (71.83), and a lower net margin ratio (0.05) as compared to hospitals that filed individual tax returns. Hospitals that filed individual returns were more likely to be church affiliated (12.99% vs. 8.70%) and teaching affiliated (11.69% vs. 8.70%) as compared to hospitals that filed group returns. 54.55% of hospitals that filed individual returns were members of a health system. Lastly, we found nonprofit hospitals filing group returns reported a lower percentage of spending on community benefits (5.81 vs. 9.49) and financial assistance (0.36 vs. 0.71) as a percentage of operating revenue as compared to the individual filing subsample. All sample characteristics are presented in Table 1.

Table 2 presents bivariate analyses estimating the differences in spending on community benefits and financial assistance as a percentage of total hospital expenses by group filing status. We found that nonprofit hospitals filing a group return reported statistically significantly less spending on community benefits as a percentage of total hospital expenses by 3.68% (5.81% vs. 9.49%, $p < 0.001$) and significantly less on financial assistance as a percentage of total expenses (0.36% vs. 0.71%, $p < 0.001$) as compared to nonprofit hospitals filing an individual tax return.

Multivariable regression analyses controlling for hospital characteristics are presented in Table 3 and revealed filing a group return was associated with significantly lower community benefit expenditures as a percentage of total expenses by 2.90 percentage points (95% CI: −5.43 to −0.37; $p < 0.05$). System membership was also associated with significantly lower community benefit expenditures (−3.24 percentage points, 95% CI: −5.43 to −01.06; $p < 0.01$).

Multivariable regression models also indicated that filing a group return was associated with significantly lower financial assistance spending as percentage of total expenses by 0.31 percentage points (95% CI: −0.53 to −0.09, $p < 0.001$), while higher net margin ratios were associated with higher financial assistance spending (0.92, 95% CI: .07 to 1.77, $p < 0.05$).

LIMITATIONS

This study is cross-sectional and therefore cannot determine causality. Additionally, we looked at two states, Wisconsin and Minnesota, and while we believe the issues presented here have national repercussions, the spending patterns in these two states may not be generalizable to other regions in the United States. We selected covariates based on previous research,[21] however we did not have data on certain hospital-level financial or market-level characteristics. This research focused on broad community benefits and financial assistance, as the impetus of this study was concern about medical debt, however future research could examine all seven categories of community benefit.

TABLE 2 Bivariate analysis of mean percentage community benefit expenditure and mean percentage financial assistance expenditure for rural Minnesota and Wisconsin hospitals filing group or independent returns in 2021.

	Full sample ($n = 100$)			
Outcome variable	Group return ($n = 23$) Mean (SD)	Individual returns ($n = 77$) Mean (SD)	Percentage point Difference	p
Community benefit expenditure as a percentage of total expenses	5.81 (1.91)	9.49 (5.66)	3.68	<0.001
Financial assistance expenditure as a percentage of total expenses	0.36 (0.19)	0.71 (0.05)	0.15	<0.001

TABLE 3 Multivariable regression models for community benefit expenditures as a percentage of total expenses and financial assistance expenditures as a percentage of total expenses for rural Minnesota and Wisconsin nonprofit hospitals in 2021.

	Outcome variables	
Independent variables	Community benefit expenditure as a percentage of total expenses ($N = 100$) Coefficient (95% CI)	Financial assistance expenditure as a percentage of total expenses ($N = 100$) Coefficient (95% CI)
Group return	−2.90*	−0.31**
	(−5.43 to 0.37)	(−0.53 to 0.09)
System membership	−3.24**	0.05
	(−5.43 to 1.06)	(−0.14 to 0.24)
Church affiliation	−0.8	0.17
	(−4.02 to 2.42)	(−0.11 to 0.45)
Teaching affiliation	0.03	0.09
	(−4.10 to 2.42)	(−0.20 to 0.37)
Hospital bed count	−0.00	−0.00
	(−0.02 to 0.02)	(−0.00 to 0.00)
Net margin ratio	−10.02	0.92*
	(−19.78 to 0.27)	(0.07 to 1.77)
Constant	12.44***	0.57
	(10.46 to 14.43)	(0.40 to 0.75)

*$p < 0.05$.
**$p < 0.01$.
***$p < 0.001$.

DISCUSSION

In this cross-sectional analysis of community benefit and financial assistance spending among rural nonprofit hospitals in Wisconsin and Minnesota, we found notable differences in reported spending by whether a hospital filed taxes as a group or independently. In bivariate and multivariable analyses, we found nonprofit hospitals filing group returns reported significantly lower percentages of community benefit spending and financial assistance spending compared to individual filers.

Our analysis reveals the obfuscation caused by nonprofit hospitals' ability to file tax returns for their entire health system. By demonstrating differences in hospital spending by group filing status, this study has research and policy implications. First, our findings could suggest that the nonprofit hospitals that comprise health systems filing group returns significantly differ in their community benefit spending, in this case by spending less. Alternatively, these results could indicate that the tax filing system is playing a role, and allowing hospitals to file group returns may be a determinant in how community benefit funds are distributed and disclosed. Regardless of directionality, hospitals filing group returns significantly differed in their community benefit and financial assistance spending, and these analyses demonstrate that the current research practice of excluding nonprofit hospitals that filed a group return from research will bias estimates of community benefit spending in rural areas. Our results therefore highlight the need for policy interventions that ensure greater transparency in the reporting of community benefit spending by nonprofit hospitals especially as group filing is increasing nationally.[12]

Hospital community benefit spending can uniquely benefit rural communities, which often experience a combination of higher rates of health care unaffordability[22] and fewer opportunities to receive public services.[23] As a result, community benefit spending on financial assistance may be of particular importance. Carrying medical debt, which is common among rural residents, can deter patients from seeking future health care services,[24] which may worsen health outcomes and exacerbate rural health disparities.[25] Transparency in expenditure reporting could inform policymakers, facilitate targeted interventions, and ultimately enhance health outcomes in rural communities. The Government Accountability Office (GAO) has called for regulatory changes that would require the Internal Revenue Service to require nonprofit hospitals to submit community benefit data at the individual hospital level.[7] Our study supports this recommendation by providing empirical evidence that group filers are significantly different in their spending compared to individual filers and teasing out the reasoning for these differences is only possible through individual hospital reporting. In 2021, the IRS rejected the suggestion to require community benefit reporting at the individual level despite the GAO recommendation, citing that there would be no tax administration benefits from facility-level reporting requirements.[7] In addition, requiring nonprofit hospitals to file individual tax returns would cause an influx

of tax returns to the IRS and a greater task for nonprofit hospital accounting departments.

Despite concerns, this issue will become increasingly important as health systems continue to acquire more independent rural hospitals. This trend further limits researchers' ability to examine differences in spending with the necessary granularity to make accurate policy recommendations that ensure the continued health and economic vitality of rural areas. Regulatory changes promoting transparency in nonprofit hospitals' financial reporting would lead to a necessary understanding of how these hospitals are contributing to the health and well-being of rural communities.

CONFLICT OF INTEREST STATEMENT

H. MacDougall serves as a consultant for a current research project at the Lown Institute.

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