Charity Care Disparities in Illinois' Hospitals: A Policy Review

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Abstract

Illinois' Cook County Health system has, since the mid 1800s, prided itself in the care it provides for Chicagoland's underserved. However, for several decades the County system and Cook County taxpayers have borne the brunt of assisting these populations, especially in regards to supplying charity care, or free medical care that doctors provide to patients who are uninsured. A large gap exists in the charity care being contributed by Cook County Health and all other Chicago area hospitals which, as non-profit institutions, receive tens of millions in foregone property and sales taxes. This paper seeks to explore why that disparity exists, as well as what the Illinois' health care system could do to better allocate resources for indigent populations.

Keywords: Charity care, Cook County, health inequity, health disparities

Introduction

Cook County Health is comprised of a network of hospitals and community centers that provide care for the under- and uninsured. These and other non-profit hospitals receive a number of state and federal tax exemptions due to their status as non-profit, and, in return, are expected to provide an equal or greater amount of charity care to those who would otherwise be unable to afford their medical bills. Through a literature review and three personal interviews, the current state of the gap in charity care and tax exemptions is investigated. Personal interviews took place via telephone or Zoom. Data from the interviews and literature review were examined for themes and trends. This qualitative summary supported the analysis of quantitative data, which was collected by the Illinois Coalition for Immigrant and Refugee Rights (ICIRR) regarding Illinois hospitals' inpatient and outpatient charity care. The totality of evidence serves to highlight the discrepancy between charity care given and tax exemptions received among Illinois' non-profit hospitals.

The Issue of Charity Care in Cook County Health

Background. The Cook County Health network consists of two main hospitals: John H Stroger, located west of Chicago, and Provident Hospital, located south of Chicago, as well as more than a dozen community health centers (Cook County Health, n.d.) The original Cook County Hospital, founded in 1834, opened in 1857 as a teaching hospital (Ibid). Provident Hospital, opened shortly thereafter, was acquired by the Cook County Health system nearly a century later, as the hospital could not maintain its own rising costs of running an inner city hospital. Provident Hospital established the first nursing school for black women in Chicago, and is the location at which the hospital's founder, Dr. Daniel Hale Williams, an African-American surgeon, performed the nation's first open-heart surgery. These two events, along with several

other important milestones, demonstrate how, since its inception, Cook County Health has dedicated itself to racial and ethnic minorities. By 1960, County was serving as the primary provider for the black and Mexican immigrant communities (Kosuth, n.d.). Health inequities and lack of access to proper medical equipment ran rampant in the Cook County Health system, and one of the leaders in to exposing these problems was Dr. David Ansell.

In his book *County: Life, Death and Politics at Chicago's Public Hospital*, Dr. Ansell describes "an 'apartheid' system, 'separate and unequal,' both in the 1980s and now" (Graham, 2011). As a newly-graduated physician employed by Cook County Hospital in July of 1978, Ansell was met with appalling conditions. He described daily shortages of soap, towels, toothbrushes, sheets, and blankets, as well as filthy bathrooms and cockroaches roaming the halls (Ibid). He describes the way in which women in active labor stood in hallways, waiting for an available stretcher so as to lay down before giving birth—this was infamously dubbed Cook County's "labor line" (Ibid). Dr. Ansell admitted, "We were practicing Third World medicine in Chicago, one of the largest cities in the U.S. I shudder to think how many patients I may have harmed or killed because we could not diagnose or treat them quickly enough" (Ibid). These conditions continued until the 2002 appointment as CEO of Ruth Rothstein. However, Cook County's fundamental issue of having too many patients requiring medical care with too few resources persisted (Ibid). Through his experience, Ansell concluded that the problem wasn't finding more money for the Cook County and Hospital system, but rather the *very structure* of a two-tiered system of medical care, one for the poor and the other for the wealthier (Ibid). Cook County has been, and continues to be, the primary medical safety net for the Chicagoland region, having a network of community clinics with a "long history of caring for people who have nowhere else to go" (Schorsch, 2019). It treats the most vulnerable people—the patients who are

already sick with conditions like heart disease, high blood pressure, or diabetes—and has historically been a destination for the uninsured and people who increasingly are unable to afford the insurance that they have (Schorsch, 2020). Consuelo Vargas, an employee at Stroger for nearly six years, describes that "Nurses are burnt out like never before. Sometimes after you've worked 12 hours doing the job of two and three people, the next day you have nothing to give … That's when you're going to make a medication error … a charting error, and someone's going to get hurt" (Ibid). Budgeting and staffing issues have plagued Cook County Health's system, yet greater numbers of patients are being forced to go to County's hospitals. This is largely due to a practice known as patient dumping.

Patient Dumping. In the early 1980s, the number of patients who were being transferred to County from other hospitals began to increase, from roughly 100 patients brought via ambulance to the ER each month to more than 600 per month just ten years later (Kosuth, n.d.). This trend coincided with the growing number of uninsured individuals in Illinois, as well as the limit placed on payments by the State of Illinois for patients with public aid (Ibid). The Stroger Hospital has, today, the busiest emergency room in Illinois (Schorsch, 2020). Three decades ago, Dr. David Ansell conducted a study to expose patient dumping in Chicago. With the help of several colleagues, Dr. Ansell's study followed 500 acutely ill patients who were being transferred from private hospitals to Cook County Health hospitals. Most of these patients had common medical conditions, such as pneumonia, and women in active labor (Kosuth, n.d.). They were being transferred nonetheless, due to the fact that private hospitals did not want to treat these individuals who could not afford to pay for their care. Therefore, these transfers delayed treatment not for clinical, but for financial reasons (Ibid). This practice was coined "patient dumping."

Patient dumping exploded in the early 1980s when Illinois and the federal government restricted the budget for healthcare spending (Graham, 2011). Public hospitals in Atlanta, Dallas, Washington, and Los Angeles reported similar experiences, indicating an issue of national concern (Ibid). The publication of Dr. Ansell's paper yielded an immediate reaction: "The paper exposed the ugly side of the Reagan 'boom' and upset many inside the County system and out. Because of this publication and other reports of patient dumping, Congress passed the Emergency Medical Treatment and Active Labor Act that same year" (Kosuth, n.d.). This act requires medical centers nationally to evaluate and stabilize all patients who arrive at their emergency room, regardless of insurance status (Graham, 2011). Unfortunately, this act alone was not enough to balance to scales of disproportionate charity care provision between Cook County Health and other private hospitals in Illinois. According to former Cook County Health CEO Dr. Jay Shannon, patient dumping continues to happen nearly every day (Schorsch, 2020).

Charity Care. According to Illinois law, as of the 2016 Eligibility Guidelines, most hospitals in the state are required to provide free and reduced cost emergency room care for uninsured and underinsured (Communities United, 2016). This is regardless of immigration status, and a social security number is not needed in order to receive "charity care," which refers to the aforementioned forms of financial assistance (Ibid). Two other components exist that are necessary to understand the issue at hand: firstly, "bad debt," or an expense incurred at a hospital by a patient who, for whatever reason, does not pay for the services they are charged (O'Donnell & Martire, 2006). Second is "uncompensated care," which is an umbrella term encompassing charity care and bad debt (Ibid). Bad debt is separate and distinct from charity care.

In exchange for charity care provision, non-profit hospitals are exempt from property taxation, so long as the amount of charity care equals or exceeds the value of the property taxes

that they would otherwise pay (Cahill, 2019). This preferential tax treatment includes not only property tax exemptions, but also exclusion from paying federal and state taxes, eligibility to receive charitable contributions, which are tax-deductible for donors, and eligibility to receive tax-exempt bond financing (O'Donnell & Martire, 2006). The standards regarding what qualifies a non-profit hospital for tax exemptions varies based on whether the taxes are those of federal and state income taxes, state sales taxes, or local property taxes (Ibid). This further complicates the debate over non-profit hospital tax exemptions (Ibid). The underlying rationale for providing these tax exemptions is the belief that the non-profit hospitals are, through their charity care, relieving the government of an obligation the public sector would otherwise be assuming (Ibid). In order to qualify for 100% free care, one's household income must be at or below 200% of the Federal Poverty Guidelines (Communities United, 2016). This is covered under the Hospital Uninsured Patient Discount Act, which was originally enacted in 2009 but amended in 2012 to include 100% discounts for uninsured patients at certain income levels (Illinois Health and Hospital Association [IHA], 2012). Additionally, one's family size dictates the amount of charity care that one is able to receive from hospitals.

Unfortunately, a standard does not yet exist in Illinois regarding how much charity care hospitals are to provide. In a personal interview, Margie Schaps, Executive Director of Health & Medicine Policy Research Group, shared that "No one wants to put a dollar amount or percentage on it … Not many states have done so either, so there is not a precedent in [charity care standards]" (Schaps, 2020). Additionally, powerful lobbying in Springfield can hinder the passage of legislation that could hold hospitals to a strict guideline (Ibid). According to the Illinois Health and Hospital Association (IHA), Illinois hospitals contribute $805 million in charity care annually, and have undergone an 88% increase in charity care since 2004—however,

the latter statistic is only based upon hospitals that report their charity care (Ibid). Hospitals are required to report to the state Attorney General summaries of so-called "community benefits" they provide, which include charity care, language services, education, and research (IHA, n.d.a). Filing these reports is mandated under the Illinois Community Benefits Act, but public hospitals, rural hospitals outside of Metropolitan Statistical Area, and small hospitals of 100 beds or less are exempt from filing (n.d.b). Annual reports are to be filed within six months of the close of a hospital's fiscal year (Ibid). However, unfortunately, the amount that hospitals provide, on average, in charity care and other community benefits does not truly correspond with the amount that they are being relieved via tax exemptions and property taxes.

Many hospitals claim to be contributing their portion of community benefits via services such as health screenings, medical research, and programs to help patients pay for prescription drugs (Cahill, 2019). These additional numbers are largely unquantified, leading many to question whether hospitals are doing their due diligence. According to the Health & Medicine Policy Research Group, in 2009, Illinois forewent almost $490 million in revenue because of hospital tax exemptions, yet Illinois tax-exempt hospitals provided only $176 million in Charity Care (Chapman, 2013, slide 6). Stroger Hospital provided $324.6 million in Charity Care in 2018, equaling 54% of its revenue (Cahill, 2019). This amount is nearly twice the *combined* Charity Care of the nine largest non-profit hospitals, which generally ranges from 1 to 2% of revenue (Ibid). Additionally, in 2017, Stroger provided $281 million in charity care, approximately 51% of all the charity care provided by hospitals in Cook County that year (Schorsch, 2019). A visualization of Cook County Health's charity care provision as compared to all other hospitals in Illinois is provided below:

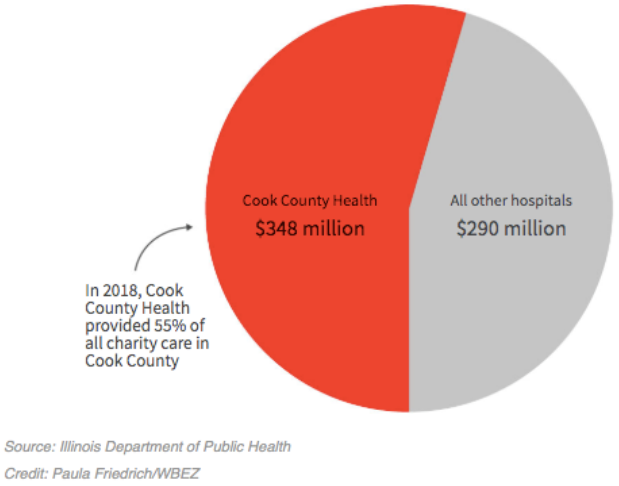

Figure 1: Cook County Health charity care (Schorsch, 2019).

Cook County Health's tab of uncompensated care, the majority of which being charity care, is projected to reach nearly $600 million in 2020, which would be nearly double the amount in 2014 (Ibid). Former CEO of Cook County Health Dr. Jay Shannon implored other hospitals to make their proper contributions to charity care so that the county's government-run hospitals do not have to shoulder the financial burden on their own (Ibid). The inequity of charity care provision has worsened, as Cook County anticipates providing about $590 million of uncompensated care this year—an 88% jump in the last six years since the boost to finances provided by Illinois Medicaid expansion with a federal waiver in 2013 (Ibid). Charity care makes up the largest portion of that $590 million estimate, followed by uncollected bills. Paradoxically, other hospitals are providing less charity care, and therefore enjoying large profits from property tax breaks (Ibid). One estimate indicates that medical centers and their affiliates are receiving at least $390 million in tax relief each year (Ibid). However, a lack of available data is the principal difficulty posed for lawmakers comparing hospitals' tax exemptions and charity care provision

(O'Donnell & Martire, 2006). The true amount of tax exemptions hospitals receive has been historically difficult to quantify.

Attempts to Address Property Tax Exemptions

Approximately three-fourths of Illinois' 200+ hospitals are non-for-profit, including some of Chicago's biggest hospitals, such as Advocate Aurora Health, Northwestern Memorial Hospital, University of Chicago Medical Center, and Northshore University HealthSystem, among others (Schencker, 2018). Some individuals, such as A.J Wilhelmi, President and CEO of the Illinois Health and Hospital Association, say that tax exemptions allow Illinois hospitals to better serve their communities (Ibid). Wilhelmi claims that "Taxing nonprofit hospitals would hurt the communities they serve by diverting dollars that are better used to take care of patients and to upgrade equipment, modernize facilities, and hire needed staff" (Ibid). Others disagree, arguing that "… [giving] these hospitals a pass on paying real estate taxes [forces] people within the counties where the hospitals are located … make it up" (Ibid). These words come from Edward Joyce, lawyer for Constance Oswald, the Cook County taxpayer who filed a lawsuit against the Illinois Department of Revenue in 2012.

Oswald wanted to challenge the constitutionality of the charitable property tax exemption for non-profit hospitals, and was rejected by initial circuit courts in his argument that exemptions were issued regardless of compliance with constitutional requirements (*Oswald v. Beard*, 2018). According to the background of the court case, Article IX, section 6 of the 1970 Illinois Constitution authorizes the General Assembly the right to grant tax exemptions for various kinds of properties, and the ability of non-profit hospitals to qualify for charitable property tax exemptions was established more than a century previous (Ibid). However, "… the absence of any standards for the amount of charity care or other types of charitable activities needed to

qualify for property tax exemption created uncertainty and confusion" (Ibid). This confusion remains, and regulation appears to be minimal, if at all, given that, according to a Service Employees International Union (SEIU) analysis, only 23% of hospitals in Cook County filed disclosure forms with the state to justify their tax exemptions (Ollove, 2020). This number rose to 48% in 2016, and then 58% in 2017 (Ibid). Although these figures demonstrate improvement, the fact stands that hospitals are not regularly filing required forms to justify their exemption status, and are nonetheless receiving said exemptions.

In the culmination of *Oswald v. Beard*, the Illinois Supreme Court upheld the constitutionality of the state's hospital property tax exemption law (IHA, 2018). The same year, Illinois legislators, the IHA lobbying group and others implemented a law amending the property tax code, which became part of Public Act 97-688 (Post, 2020). They brokered a deal in which non-profit hospitals were allowed to "pick from a broad menu of 'community benefits' that are worth at least as much as what their estimated property tax bills would be" (Schorsch, 2020). For better or worse, many of the community benefits listed were actions that hospitals were already taking, such as conducting medical research. Important to note also is the fact that the law determined that hospitals were able to assess the value of *their own property*. In a personal interview, Sharon Post shared that although hospitals were to be held accountable for the tax exemptions they calculated and subsequent care provided, the restrictions and guidelines were not strict, and the law made it very difficult for hospitals to lose their tax exemption status (Post, 2020). This was, in Post's words, "A huge disappointment" (Ibid). The law did not yield an absolute threshold that hospitals were to meet in charity care.

Critics of this Illinois law claim feel that the legislation was heavily influenced by the hospital association, and provides too many loopholes enabling non-profit hospitals to receive

and maintain their exemptions without delivering the necessary amount of community benefits and charity care (Ollove, 2020). Haider Warraich, MD, a physician and researcher at Brigham and Women's Hospital, is intimately familiar with hospital tax exemptions. He says that "… I don't think this whole area has been regulated much … It's largely left to hospitals to regulate themselves. I think the government needs to step in" (Ibid). While it is clear more governmental authority is needed, an additional concern is the fact that theoretical tax exemptions are difficult to calculate.

A 2009 report by the Center for Tax and Budget Accountability estimates that the property tax exemptions of 47 Chicago non-profit hospitals was roughly $279 million annually (Schencker, 2020). Based upon 2012 data, researchers Herring et al. (2018) demonstrate why those numbers may be inaccurate. In a Johns Hopkins study, Herring and colleagues use data from the IRS Form 990, Centers for Medicare and Medicaid Services (CMS) Hospital Cost Reports, and the American Hospital Association (AHA)'s Annual Survey in order to quantitatively compare community benefits accrued with tax exemptions (Herring et al., 2018). The researchers assumed a federal tax rate of 33%, because the Tax Foundation reported that healthcare and social assistance corporations paid approximately 33% from 2003 to 2008, and also calculated their estimates based on the presumption that the state corporate tax exemption is the amount the non-profit would pay if it were a for-profit (Ibid). Herring et al. approximated the tax exemption to be equal to the state tax rate multiplied by the hospital's net income, or 0 if the hospital reported a negative net income, and to do so, applied the state corporate tax rate as reported by the Tax Foundation (Ibid). After accounting for several other factors, the researchers found "Considerable variation across hospitals in terms of community benefits, tax exemption, and difference between the two amounts," so they decided to explore how much of the variation

between the two amounts could be explained by either hospital-level or market-level characteristics—hospital-level being bed size, system ownership, church affiliation, teaching status, and more, and market-level being rural versus urban, percent non-white patients, percent of patients in poverty, percent uninsured, and more (Ibid). Although there was substantial variation hospital to hospital, Herring et al. found that, on average, tax exemptions saved each non-profit hospital nearly 6% of total expenses, or about $11.3 million per hospital. Given that the researchers examined 47 different hospitals, this would equate to roughly $531.1 million for all hospitals, which is almost twice the amount aforementioned that was approximated by the Center for Tax and Budget Accountability, $279 million. Herring et al.'s study, while thorough, demonstrates the vast number of characteristics and nuances that must be taken into consideration with each hospital in order to determine property tax exemptions, and even then, the final number is only a rough approximation. One woman whose calculations made a substantial impact is Heather O'Donnell, J.D.

O'Donnell, currently an employee of Thresholds, previously worked at the Center for Tax and Budget Accountability. O'Donnell and Ralph Martire wrote the first estimate of property tax values for hospitals of Cook County. Previous to their work, "… to date, no independent review of the value of tax expenditures provided non-profit hospitals in Illinois versus the value of charity care they provide in return [had] been completed" (O'Donnell ^ Martire, 2006). O'Donnell and Martire's publication discusses qualifications for federal corporate tax exemption, qualifications for state and local tax exemptions, bad debt, and estimates the value of non-profit hospital tax exemptions and charity care. They conducted a study analyzing 21 Cook County non-profit hospitals and hospital networks, referred to as "Hospitals Studied." They did so utilizing a model developed by Drs. Nancy Kane and William

Wubbenhorst of Harvard School of Public Health to estimate the value of tax exemptions of hospitals, chosen because of the model's national respect as well as its ability to closely approximate the actual value of property tax exemptions in other states (Ibid). Although hospitals receive numerous tax benefits at the federal, state, and local levels, they found that Illinois state and local tax exemptions accounted for 96% of the tax benefits of the Hospitals Studied, with property tax exemptions being the most valuable accounting for $209.1 million (Ibid). Two significant findings of particular importance are firstly that the Hospitals Studied reported a total bad debt cost of $181.8 million (Ibid). Notably, O'Donnell and Martire write that:

> It is estimated that currently 50% of hospital bad debt is owed by individuals who qualify for charity care and hence should not have been subjected to billing in the first place, but should have received free or discounted services. If this estimate is accurate, then by simply doing a better job of identifying individuals who qualify for charity care prior to initiation of the billing process, the Hospitals Studied could have increased the amount of charity care provided by $90.9 million, for a potential charity care total of $196.1 million. This would effectively eliminate 41% of the gap that currently exists between the value of tax breaks received and charity care provided, at no additional cost to the Hospitals Studied (O'Donnell & Martire, 2006).

As discussed previously, bad debt and charity care are separate and distinct. However, if hospitals were to better identify individuals who qualify for charity care, and subsequently provide said care, then it is possible that hospitals could both eliminate a significant portion of bad debt as well as increase their provision of charity care. This solution would be, as stated, at no additional cost to hospitals, but rather would re-categorize unpaid expenses. A second valuable finding from O'Donnell and Martire's report is that, as of the 2006 publication, the most recent annual value of all tax exemptions provided to the Cook County non-profit Hospitals Studied was estimated to be $325.6 million (Ibid). This is more than three times greater than the amount of charity care the same hospitals reported providing—only $105.2 million (Ibid).

Understandably, the implications of this analysis were met with resistance by the hospital industry.

Upon the report's completion, the publication received a significant response. Post recalls that hospital associations "tore it apart and claimed it was invalid" (Post, 2020). O'Donnell shared that there was a lot of pushback. She explained "Any time you challenge a powerful interest, even if it's the right thing to do, [you] will encounter a lot of brick walls" (O'Donnell, 2020). Hospitals are indeed a very powerful interest group, especially in Springfield, as there is a hospital in every legislator's district (Ibid). Fortunately, the report did change hospital behavior, but a notable gap continues to exist between the sum of a non-profit hospital's charity care and the tax exemptions they receive. Accordingly, the following section provides an analysis of charity care provided based upon more recent data.

Charity Care Data Analysis

Extensive charity care data has been provided by employees of Illinois Coalition for Immigrant and Refugee Rights (ICIRR). Their research details inpatient and outpatient charity care expenditures for 68 hospitals in Illinois, segmented by Cook County Health (CCH) hospitals and non-CCH for the year 2017. To create a comparison of these expenditures, the property tax exemption estimates as calculated by O'Donnell and Martire must be estimated for 2017. It would be extremely difficult to provide estimates of exemptions updated to increases in area property taxes over the decade. However, a conservative estimate can be achieved by utilizing the Consumer Price Index, or CPI, to inflate the 2006 exemption estimates for the Hospitals Studied in their report. According to the U.S. Bureau of Labor Statistics, the CPI is "a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services" (U.S. Bureau of Labor Statistics, n.d.). Taxes that are included in

the calculation of the CPI may fall under the following categories: Transportation (toll charges, parking fees), admissions (entry to national parks), and owners' equivalent rent (property taxes) (U.S. Bureau of Labor Statistics, 2020). Of the 21 hospitals whose state and local tax exemptions O'Donnell and Martire calculated, ICIRR provided charity care data for 19 of those hospitals. For sake of comparison, the two hospitals for which ICIRR did not log charity care data, Resurrection Health Care and St. James Hospital, were not included in the analysis below.

In order to calculate the value of O'Donnell and Martire's 2006 tax exemptions as they would be valued in the year 2017, the Illinois CPI as provided by the U.S. Bureau of Labor and Statistics was applied each year from 2006 through 2017. Due to the fact that the CPI was represented as a percent change, with a positive number indicating a net positive CPI change and a negative number indicating a net negative CPI change, the estimated tax exemptions were calculated as follows: To use the example of Advocate Health Care Network, O'Donnell and Martire estimated their tax exemptions to be $79,032,570 in 2006. In the year 2007, the CPI percent change was 4.7. Therefore, Advocate's tax exemption value would be approximately $79,032,570 + $79,032,570*0.047, or $79,032,570*1.047. This calculation was applied to each of the 19 hospitals, and then was computed for each year as the CPI changed annually from 2006 to 2017. These computations yielded the data below.

Hospital	Estimated Value of State & Local Tax Exemptions (2006)	Estimated Value of State & Local Tax Exemptions (2017)
Advocate Health Care Network	$79,032,570	$93,652,092.32
Alexian Brothers Hospital Network	$22,837,112	$27,061,543.38
Evanston Northwestern Healthcare	$22,980,617	$27,231,594.07
Gottlieb Memorial Hospital	$4,289,045	$5,082,436.75
Holy Cross Hospital	$4,018,838	$4,762,246.60
Jackson Park Hospital	$1,188,516	$1,408,368.86
Little Company of Mary Hospital	$8,736,578	$10,352,678.77
Loyola University Medical Center	$20,297,147	$24,051,733.16
Mercy Hospital & Medical Center	$3,781,966	$4,481,557.78
Mount Sinai Hospital	$2,852,605	$3,380,282.67
Palos Community Hospital	$7,792,176	$9,233,580.36
Roseland Community Hospital	$528,846	$626,672.45
Rush North Shore Medical Center	$5,533,584	$6,557,191.80
Rush University Medical Center & Rush Oak Park	$22,425,246	$26,573,490.00
Saint Anthony Hospital	$4,468,575	$5,295,176.39
St. Bernard Hospital	$1,740,025	$2,061,896.53
South Shore Hospital	$721,170	$854,572.73
Thorek Hospital	$3,277,231	$3,883,456.40
University of Chicago Hospitals	$38,395,267	$45,497,661.15
TOTAL	$254,897,114	$302,048,232.17

Figure 2: State and local tax exemptions as calculated in 2006 compared to their values in 2017.

These state and local tax exemptions were then compared to the charity care provision estimates as provided by ICIRR:

Hospital	Estimated Value of State & Local Tax Exemptions (2017)	Charity Care Provided
Advocate Health Care Network	$93,652,092.32	$31,603,000
Alexian Brothers Hospital Network	$27,061,543.38	$4,722,348
Evanston Northwestern Healthcare	$27,231,594.07	$7,060,591
Gottlieb Memorial Hospital	$5,082,436.75	$1,219,656
Holy Cross Hospital	$4,762,246.60	$11,128,821
Jackson Park Hospital	$1,408,368.86	$2,602,539
Little Company of Mary Hospital	$10,352,678.77	$5,566,952
Loyola University Medical Center	$24,051,733.16	$9,695,769
Mercy Hospital & Medical Center	$4,481,557.78	$4,408,423
Mount Sinai Hospital	$3,380,282.67	$22,431,338
Palos Community Hospital	$9,233,580.36	$2,151,441
Roseland Community Hospital	$626,672.45	$669,300
Rush North Shore Medical Center	$6,557,191.80	$21,603,793
Rush University Medical Center & Rush Oak Park	$26,573,490.00	$2,796,890
Saint Anthony Hospital	$5,295,176.39	$4,048,765
St. Bernard Hospital	$2,061,896.53	$3,267,671
South Shore Hospital	$854,572.73	$1,203,811
Thorek Hospital	$3,883,456.40	$422,131
University of Chicago Hospitals	$45,497,661.15	$17,581,627
TOTAL	$302,048,232.17	$154,184,866

According to these estimates, the difference between state and local tax exemptions 19 for non-profit hospitals and the charity care 19 these hospitals provided in the year 2017 was **$147,863,366**. This number represents only a small portion of the money that non-profit hospitals may be profiting from these tax exemptions, as the current analysis examined only 19 hospitals. ICIRR data examined 68 hospitals, approximating a total revenue of $18,324,575,515.16 and a charity care total of $554,193,743.65. This represents a $17,770,381,772 deficit.

Significant limitations of this analysis exist. These estimates do not factor in increases in property tax rates or land and building acquisitions on these hospitals' campuses. The CPI values

provided by the U.S. Bureau of Labor Statistics approximates price changes across Illinois, Indiana, and Wisconsin cumulatively. Region-specific CPIs could vary widely, especially when comparing Chicago, one of the largest cities in the country, to rural Wisconsin. With this consideration, the property tax values may indeed be higher than represented, as taxes are significantly higher in downtown Chicago, for example for Northwestern Memorial in Streeterville, than in rural areas of Wisconsin and Indiana. Therefore, the local and state tax exemption values for 2017 are likely significant underestimates.

Discussion

It is evident that hospitals are not providing as much charity care as they benefit from their tax exempt status, which includes access to lower interest bond markets. While this paper primarily focuses on the discrepancy between CCH and non-CCH charity care, delivering free or discounted care to under- and uninsured individuals is an issue at the national scale. O'Donnell and Martire write, "… there is considerable debate at both the national and state levels over which hospital services constitute the type of public benefits that justify the tax breaks received, and how much, in terms of hospital costs, non-profit hospitals should devote to providing such services to warrant the forgone tax revenue" (O'Donnell & Martire, 2006). Property tax exemption laws similar to Illinois' has led to lawsuits in other states (Schencker, 2018). For example, in 2013, Pittsburgh's Mayor sued the University of Pittsburgh Medical center in an effort to challenge its exemption status (Ollove, 2020). In 2015, a New Jersey judge ruled that the Morristown Medical Center was not fulfilling its obligations for receiving tax exemptions, and therefore its property tax requirements were reinstated (Ibid). In 2017, the Internal Revenue Services (IRS) revoked the tax-exempt status of an "undisclosed hospital" (Ibid). Illinois would do well to learn from other states' best practices in order to ameliorate its own care provision.

One state that has demonstrated significant progress in the past few years is Oregon. Oregon stiffened requirements in 2019, mandating that non-profit hospitals provide free care to all individuals with incomes under 200% of FPL (federal poverty level), or $43,500 for a family of three (Ollove, 2020). The state also requires hospitals to provide discounts to people making between 200% and 400% of FPL (Ibid). Additionally, HB3076 was passed in May of 2019 aimed at preventing medical debt by establishing the following: 1. A requirement for non-profit hospitals to establish financial assistance policies required to reduce charges to low-income patients; and 2. A minimum amount these hospitals and hospital systems must spend on activities that improve their surrounding communities (Gentzler, 2019). This bill makes Oregon the first state in the country to set such a minimum, and has been called a "landmark piece of legislation years in the making" (Glucklich, 2019). Oregon's 60 nonprofit hospitals are now required to meet spending floors in consultation with the Oregon Health Authority, which are to be set every two years based upon analyses of hospitals' annual profits, current level of community benefit spending, as well as community needs (Ibid). Finally, medical debt is prohibited from being passed to family members, interest rates are capped on the amount hospitals and debt collectors can charge of medical debt, and hospitals are required to provide information and application paperwork for their Charity Care policies before sending them to a debt collector (Ibid). Encouragingly, Oregon hospitals collectively provided more than $522 million in Charity Care, $207 million more than in 2015 (Hayes, 2020). Executive Vice President of the Oregon Hospital association claims that "While we have done a tremendous amount to increase access to coverage in this state, these increases in charity care show that some coverage is not adequate" (Ibid). Nonetheless, Oregon has taken tremendous strides.

In her interview, Schaps highlighted Texas as a state worth investigating. Texas Tax Code § 11.1801, Charity Care and Community Benefits Requirements for Charitable Hospital, states that:

> To qualify as a charitable organization … a non-profit hospital or hospital system must provide charity care and community benefits as follows:
> (1) charity care … must be provided at a level that is reasonable in relation to the community needs, as determined through the community needs assessment …;
> (2) charity care … must be provided in an amount equal to at least four percent of the hospital's or hospital system's net patient revenue;
> (3) charity care … must be provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax … (FindLaw, n.d.).

Most significant from this excerpt is the statement that hospitals and hospital systems are to provide charity care at an amount equal to at least 4% of that institution's net patient revenue. Few other states have established such a strict and clear expectation. O'Donnell mentioned that Massachusetts would also be a state Illinois could learn from, as the Affordable Care Act (ACA) was modeled from that state's healthcare system (O'Donnell, 2020). However, policymakers have not been in uniform agreement that non-profits must provide charity care corresponding to the value of their tax exemptions (Herring et al., 2018). Therefore, alternative solutions must be considered.

One potential alternative would be having non-CCH hospitals pay into a pool for CCH hospitals that are disproportionately burdened by charity care provision and supplying care for less wealthy populations. Chicago Alderwoman Jeannette Taylor has begun a movement towards that by "[introducing] a resolution that would require nonprofit hospitals in Chicago that are not part of Cook County Health to make 'payments in lieu of taxes' to the city if they are not providing sufficient community benefits" (Ollove, 2020). Schaps echoed sentiments about the desire for pooling of resources, discussing how non-CCH hospitals could combine resources to

support Cook County (Schaps, 2020). Sharon Post stated that an ideal solution moving forward would be to know what the hospitals' exemptions are in a transparent way (Post, 2020). Post called into question the current arrangement, wondering whether money that would have been provided in property taxes would be better utilized as one fund used by a public body (Ibid). She also discussed how charity care is not a comprehensive solution to supplying care for under- and uninsured populations, using the example that "[Through charity care] someone could get free care for an amputation but not for diabetes medication" (Ibid). Perhaps by creating a focal point of inpatient care, systems in place are neglecting needed outpatient care. Post continued by saying that there is, at times, a focus on hospital care when that is not where the greatest need lies, and that perhaps adjusting the hospital definition of charity care could allow for a shifting attention from inpatient care to addressing the needs of individuals before they require hospital attention. Schaps stated that she would "Love to see legislation that provides a percentage of their revenue that they need to spend on charity care," similar to Texas' 4% revenue requirement (Schaps, 2020). An additional solution could be O'Donnell and Martire's suggestion as mentioned previously, of encouraging patients to apply for charity care rather than incurring bad debt. This resolution would be at no additional cost to hospitals, given that a large number of individuals who were not paying their medical bills to the Hospitals Studied would have qualified for charity care.

Conclusion

According to the data analysis, the discrepancy between state and local tax exemptions and the charity care provided for 19 non-profit Illinois hospitals was **$147,863,366** in the year 2017. As property taxes grow each year, it is more than plausible that this number has increased.

Although the exact number will vary based on differing calculations, what remains clear is that non-profit hospitals must provide more charity care to underserved populations.

It is necessary to note that, ultimately, charity care is a Band-Aid solution. That patients are unable to afford medical care is a fault of America's healthcare system. As mentioned by O'Donnell, healthcare is not affordable for a significant portion of the US population, and although the ACA took large steps forward in covering more individuals, not everyone qualifies for public coverage (O'Donnell, 2020). O'Donnell acknowledged that charity care does play an important role, especially for lower-income individuals, but most significantly, we need a different healthcare system where citizens do not have to pay out of pocket (Ibid). The longer-term issue of how to finance public healthcare in a way that does not burden the working class must be considered. The FairTax proposal that will be voted on in November provides a potential source of revenue for public healthcare, but whether the nation at large is prepared to take such a step is unclear.

Finally, one must consider how COVID-19 may further exacerbate the burden CCH hospitals experience in caring for lower-income individuals. Margie Schaps discussed how COVID-19 will decrease the tax base because a greater number of people will be unemployed (Schaps, 2020). In turn, she underscored how it will be difficult to determine how, without raising taxes, to provide care for the uninsured. A greater rate of unemployment also signifies less people with healthcare coverage. These two factors coalesce to create a new economic landscape for healthcare as we emerge from the pandemic. Charity care will be needed, perhaps in amounts never seen before, and the healthcare system in place seems largely unprepared to handle such a responsibility.

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