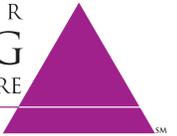


Hospital Tax Exemption: How Did We Get Here?

REPRINT OF *INQUIRY* ARTICLE, FALL 2012

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Nonprofit organizations,¹ including nonprofit hospitals, have been exempt from federal income taxation since their inception in the early 20th century, when these organizations accounted for a small portion of the U.S. economy. Nearly all hospitals were organized as nonprofit at that time, affiliated with either religious groups or foundations, and they served families who could not afford to pay a doctor to visit their home. Providing public benefits without question, these hospitals depended heavily on charitable gifts to finance their operations and earned little, if any, net income.

Over the ensuing 100 years, drastic changes in medical technology have transformed hospitals from places where the poor seek primary care and comfort to places where everyone goes to get various types of care when needed. The growth in the last century of private health insurance and government financing of care for the elderly and poor has played a major role in stimulating the development and adoption of that medical technology, and has made it feasible for nonprofit hospitals to finance most, if not all, of their operations through patient revenues (Gentry and Penrod 1994). At the same time, however, it fueled the emergence and growth over the past 50 years of for-profit, investor-owned hospitals. Today, some nonprofit hospitals have expanded their roles further by undertaking programs to promote healthy lifestyles or otherwise prevent illness.

Beginning in the mid-1950s, and extending until 1969, the Internal Revenue Service (IRS) required a hospital seeking exemption under Section 501(c)(3) to be “operated to the extent of its financial ability for those unable to pay for the services rendered.” In 1969, however, the IRS issued Revenue Ruling 69–545, which eliminated this charity care standard in favor of a broad “community benefit” standard, where “promotion of health” for the general benefit of the community would now be considered a charitable purpose.

As part of that ruling, the IRS set forth several factors for demonstrating a community benefit: an emergency room (ER) open to all; a board of directors drawn from the community; an open medical staff policy; treatment of Medicare, Medicaid, and other government program patients; use of surplus funds to improve facilities, equipment, and patient care; and provision of medical training, education, and research.

Revenue Ruling 69–545 was requested by the hospital field itself, believing that the Medicare and Medicaid programs, in combination with employer-based private insurance coverage, would by and large eliminate the need for charity care. This ruling has now been intact for more than 40 years, with one modification made 14 years after inception. That change, Revenue Ruling 83–157, states that although the operation of an ER open to all patients is a strong indicator of community benefit, the presence of other significant factors would warrant tax exemption if a state or local health planning agency determined that an ER was unnecessary and duplicative (Crossley 2007).

The breadth of the standard, “promotion of health,” continues to this day to generate considerable confusion and debate both within and outside the nonprofit hospital sector.

From 1988 through the early 1990s, a national demonstration project, The Hospital Community Benefit Standards Program, was created with funding by the W.K. Kellogg Foundation. Based at the Robert F. Wagner School of Public Service at New York University and spearheaded by Robert Sigmond, National Steering Committee chairman, Anthony Kovner, project director, and Paul Haddis, project deputy director, the program developed and field-tested such standards, with the ultimate intent of having them adopted and applied by the Joint Commission on the Accreditation of Hospitals (now called the Joint Commission). These standards, process-

oriented in nature, focused on community benefit governance, planning, management, and reporting and emphasized hospital collaboration with other community stakeholders.² The Joint Commission declined to adopt those standards.

Also during the 1990s, three states established specific standards related to community benefit, including the following quantitative thresholds, for nonprofit hospital property tax exemptions:

- Utah (1990): The total “gift” to the community must exceed on an annual basis a hospital’s property tax liability for that year.³
- Texas (1993): Charity care and other community benefits must in total be equal to at least 5 percent of the hospital’s or system’s net patient revenues, provided that charity care and government-sponsored indigent health care program losses are equal to at least 4 percent of net patient revenues.⁴
- Pennsylvania (1997): Uncompensated services⁵ must equal at least 75 percent of the hospital’s net operating income and at least 5 percent of its operating expenses; or at least 20 percent of patients pay no fee or a fee lower than cost, and at least 10 percent of patients receive reduced fees of at least 10 percent of costs; or wholly free care is provided to at least 5 percent of its patients; or financial assistance is provided to at least 20 percent of patients, with at least half of those patients paying no fees or fees discounted by at least 10 percent; or uncompensated services equal at least 5 percent of the hospital’s costs.

Over the past two decades, programs have been established in many additional states wherein: 1) nonprofit hospitals are required to meet certain requirements regarding billing and collection practices for low-income and/or uninsured patients; and/or 2) on an annual basis, nonprofit hospitals voluntarily report to their state hospital association, or are required to report to a state agency, on the community benefits they provide. Currently 18 states (including Utah, Texas, and Pennsylvania) have one or more community benefit-related requirements, and 34 states have voluntary community benefit reporting programs.⁶

The definitions of community benefit differ across the state reporting programs, but over the past two decades the Catholic Health Association of the U.S. (CHA), in collaboration with VHA, Inc. (formerly “Voluntary Hospitals of America”),

has promoted uniformity in the definition of community benefit—what should be counted and how it should be counted. More recently, CHA has been working with VHA, Inc., to develop and give guidance through manuals and educational conferences (the latter involving faculty of St. Louis University) on evaluating the results/outcomes of various types of community benefit programs, as well as on assessing and addressing community health needs.

Between October 2002 and November 2004, three major nonprofit hospital systems and three independent nonprofit hospitals, variously located in California, Texas, Arizona, and Nevada, launched a major demonstration project to build upon the community benefit guidance available at that time from CHA and VHA, Inc. The intent was to develop a new set of tools that would move community benefit thinking and action from free and discounted ER-based and inpatient care to primary care delivered in settings close to concentrations of low-income and uninsured people, and to strategies that encourage healthy behaviors. In other words, the goal of community benefit would be to improve health status and quality of life and thus reduce the demand for high-cost ER and inpatient care by people with preventable health problems, and to do so in a sustainable manner. This project, funded by several private foundations, was aptly named Advancing the State of the Art of Community Benefit (ASACB). Led by the Public Health Institute in California and Kevin Barnett, its principal investigator, the project produced an ASACB User's Guide,⁷ which recommends seven core community benefit principles, six organizational policies and practices, and eight management practices. It also includes several templates and other tools for carrying out those practices.

In 2007, the IRS undertook a major redesign of Form 990, which all tax-exempt organizations must file annually. As part of the redesign, the IRS developed a new Schedule H for nonprofit hospitals that requires them to report in detail on their community benefit-related activities and programs. The definitions of community benefit contained in Part I of Schedule H are generally consistent with the CHA's definitions of community benefit but it does not include "community building activities," such as housing development and workplace development. Instead, hospitals are permitted to report on those activities in Part II of Schedule H. Consistent with the CHA's definition, Part I does not include Medicare payment shortfalls or bad debts; however, hospitals are

permitted to report in Part III what portion of those payment shortfalls and bad debts they consider to be community benefits. The IRS has given no indication as to when it might reassess whether any or all of the Part II or Part III items should be moved to Part I. Hospitals were required to file Schedule H beginning in tax year 2009.

A second significant development in 2007 at the federal level was the release of a report, "Tax-Exempt Hospitals: Discussion Draft," by the Senate Committee on Finance Minority Staff, led by Senator Charles Grassley (R-Iowa). While the document stated that it was not proposed legislation, it suggested various alternatives that should be considered in drafting legislation to reform nonprofit hospital tax exemptions. The staff proposal recommended several specific standards, the most noteworthy being:

- Adoption and wide publication of a charity care policy;
- Limitation on charges billed to the uninsured;
- Curtailment of unfair billing and collection practices;
- Requirement for the conduct of a community health needs assessment every three years;
- Quantitative minimum for charity care for section 501(c)(3) hospitals—5 percent of annual patient operating expenses or revenues, whichever is greater—and a quantitative minimum for total community benefits for section 501(c)(4) hospital organizations—5 percent of annual patient operating expenses or revenues, whichever is greater;
- Requirements for joint ventures between nonprofit hospitals and for-profit entities;
- Requirements for board composition, executive compensation, and other governance practices; and
- Restrictions on conversions.

In early 2009, the Alliance for Advancing Nonprofit Health Care, representing all types of nonprofit health care providers as well as nonprofit health insurers, released a position paper, "Maximizing Community Benefit: A six-point program."⁸ The paper recommended for the long term a national voluntary program that would independently certify the community benefit practices of nonprofit health care organizations in accord with the best practices in the field. However, for the more immediate term, the paper urged that all nonprofit hospitals and other nonprofit health care

organizations adopt what the Alliance considers to be the six best practices in community benefit, which draw heavily upon the ASACB principles and practices: 1) board or board-level committee oversight of community benefit planning and performance; 2) incorporation of community benefit into the CEO's job description responsibilities, performance goals, and appraisal, and any incentive payment arrangement; 3) operational accountability for community benefit placed in one individual who reports to the CEO or to a senior manager reporting to the CEO; 4) integrating community benefit into the organization's overall planning and budgeting; 5) including two key priorities in the organization's ongoing community benefit goals (i.e., reducing the needs of uninsured and low-income people for preventable, costly emergency room care, inpatient admissions, and readmissions and helping to protect one or more of the region's health care safety-net organizations); and 6) joining with all key stakeholders in the community in an organized coalition to plan, implement, and evaluate community benefit programs.

As a result of the Patient Protection and Affordable Care Act (ACA), enacted in March 2010, nonprofit hospitals now must meet additional federal tax exemption requirements related to the first four proposals noted previously in the Senate Finance Committee Minority Staff Discussion Draft. Consequently, the IRS has proposed a new Part V.B in Schedule H for nonprofit hospitals to report on these new requirements beginning in tax year 2011, although the community health needs assessment portion of Part V.B is optional until tax year 2012. Also under the ACA, the IRS is required to report to key congressional committees every three years on charity care and other information derived from Schedule H, and to compare nonprofit hospitals' performance in that regard to that of for-profit hospitals. The fact that a quantitative minimum for charity care was never even considered for inclusion in the ACA may well have been due to the groundbreaking work in the ASACB demonstration project, which emphasized primary care and prevention activities and programs to reduce free and discounted care.

In early 2012, the American Hospital Association (AHA) released a report that it had commissioned Ernst & Young to prepare on community benefits based on the Schedule H filings of about 30 percent of nonprofit hospitals for tax year 2009. The report indicated that these hospitals spent, on average, 11.3 percent of their total expenses on community benefits (including Medicare

payment shortfalls averaging 2.4 percent) and 5.7 percent on "direct benefits to patients in financial need" (which was defined to include charity care and Medicaid payment shortfalls). The report included breakdowns of these average percentages by type of nonprofit hospital, but did not present any data on variances in these percentages. In releasing the report, the AHA argued that "communities themselves are in the best position to determine whether the benefits provided by their local hospitals match their needs and aspirations."

A second argument has been made by some hospital groups that oppose establishment of any quantitative standard or threshold for federal income tax exemption: If it doesn't make sense to measure a hospital's quality performance in terms of the resources invested in quality rather than in terms of quality results, why should assessment of community benefit performance be any different?

A third argument suggests that a quantitative standard or threshold would tend to reduce community benefit to an accounting exercise, distracting nonprofit hospitals from the critical work of continuously improving how they plan, implement, and evaluate the progress and results of their community benefit programs.

And a fourth argument notes that a quantitative standard or floor for tax exemption would likely become, in practice, the ceiling for many or most nonprofit hospitals.

As of this writing, no leader in the U.S. Congress has expressed any interest in legislating a more specific standard or set of standards for hospital federal tax exemption. Nor does the IRS's 2012 annual work plan make any mention of establishing and applying a more specific screen or set of screens for nonprofit hospital desk reviews, compliance checks, or field audits.

However, it is noteworthy that in late May of this year, the Illinois legislature passed a bill establishing a quantitative threshold for hospital property tax exemption, requiring each nonprofit hospital or system to demonstrate that its community benefits (the law uses different terminology) in the prior year, or on average for the prior three years, equaled or exceeded the estimated value of its property taxes if assessed. Community benefits were defined to include free and discounted care for low-income patients, Medicaid losses, and a portion (percentage of revenues associated with care to indigent patients) of subsidies for unprofitable services,

medical education, and research. In addition, the law provides tax credits to for-profit hospitals whose free and discounted care under a financial assistance policy exceeds the estimated value of their assessed property taxes.

The passage of this bill came at a time when many news stories across the country were questioning nonprofit hospitals' motives and behaviors (e.g., charity care commitments, billing practices, executive or board

compensation, profit levels, conversion to for-profit status, and use of market power). Many of these stories have been raising the fundamental question, "Is there really any difference between nonprofit and for-profit hospitals?"

One state hospital association publicly declared in June: "Hospitals must be judged by their performance, not tax status." Yet, isn't providing special benefit to the community what hospital tax exemption has been all about?*

***For a discussion on the future of hospital tax exemption, see "Hospital Tax Exemption: Where Do We Go from Here?" (located on the Alliance website and also as a reprint of an article in the fall issue of *Inquiry*).**

Notes

1. For simplicity's sake, the term "nonprofit" is used here rather than "not-for-profit" or "noninvestor-owned." Also for this discussion:

- Nonprofit hospitals are defined here to mean private nonprofit hospitals, even though government-owned hospitals are technically nonprofit as well;
- Even though the terms "nonprofit" and "tax exempt" are often used interchangeably, they are separate and distinct. An organization can be nonprofit without being tax exempt, which is the case with most Blue Cross Blue Shield health plans. In some circumstances, for-profit enterprises have been exempted from certain types of taxation; and
- "Charitable contributions," "community benefits," and "community service" are used interchangeably; "charity care" refers to only one aspect of those other terms: free or discounted care provided to low-income or uninsured patients under a hospital's financial assistance policy.

Based on the latest information available from the American Hospital Association, 2,904 (58 percent) of U.S. community hospitals are nonprofit, 1,068 (22 percent) are government-owned, and 1,013 (20 percent) are for-profit.

Nonprofit hospitals receive major tax benefits:

- Exemption from federal and state income taxes;
- Exemption from state or local property taxes;
- Exemption from state sales taxes;
- Access to tax-exempt bond financing, wherein the interest earnings are tax-exempt for the bondholders; and
- Access to private philanthropy, where the donations are tax deductible for the givers.

The overall value of these tax exemptions and other benefits has been estimated to be \$12.6 billion (Joint Committee on Taxation 2006).

Access to government grants is an additional potential benefit for tax-exempt hospitals. The relative financial benefits of several of these exemptions to nonprofit hospitals have been estimated as follows: 43 percent for property taxes, 27 percent for federal income taxes, 24 percent for state sales taxes, and 6 percent for state income taxes (Kane and Wubbenhorst 2000).

2. The program consisted of the following four overall standards with many sub-components: evidence of the hospital's formal commitment to a community

- benefit program for a designated community; the program scope includes hospital-sponsored projects for the designated community in improving health status, addressing health problems of under-served populations, and containing the growth of health care costs; the program includes activities designed to stimulate other organizations and individuals to join in carrying out a broad health agenda for the designated community; and the hospital fosters an internal environment that encourages hospital-wide involvement in the program.
3. The following quantifiable activities and services are counted as part of its total gift, and are not intended to be an exhaustive list: financial assistance to those unable to pay; unreimbursed costs of volunteer and community service, including education and research for or by the hospital; losses under Medicare, Medicaid, and other government programs; donations of time by individuals to the institution; donation of money to the institution; and the community value, rather precisely quantifiable or not, of the operation of tertiary care units or other critical services that may not otherwise be offered and/or the continuation of hospitals where costs exceed revenues, such as a primary care hospital in a rural area. Individual physician offices which are off-site and owned by the hospital are deemed not related directly to the institution's mission and are not exempt from property taxes.
 4. Other community benefits include: losses from government-sponsored indigent care programs; donations; and subsidized education, research, and patient care services. Excluded are any government taxes or assessments.
 5. Uncompensated services include: free and discounted care; subsidies for education and research; government program losses; subsidies for community services; donations to other institutions of purely public charity or to government agencies; and the reasonable value of volunteer assistance provided by its employees.
 6. Detailed information on all these state mandated and voluntary programs was collected by Catholic Health Association of America in 2010 and is available at <http://communityhlth/resources/communitybenefit.html>.
 7. This guide is available for download at www.phi.org/pdf-library/ASACB.pdf.
 8. This paper is available on the Alliance's web site at: www.nonprofithealthcare.org/reports/#.

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