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Hospital Tax Exemption: Where Do We Go From Here?

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Whether most or all nonprofit hospitals can survive without various tax exemptions is a key question.

As discussed in the report "Hospital Tax Exemption: How Did We Get Here?" (located on the Alliance website and also as a reprint of an article in the fall issue of *Inquiry*), to this day there is no agreement among states, local government units, and the federal government—nor among national and state hospital trade associations—on what nonprofit hospital activities and programs besides charity care should be included or counted as community benefits. Nor is there any agreement on whether—and if so, how—a quantitative floor or threshold test should be applied by government to determine whether various types of tax exemptions should continue to be granted in full, in part, or at all.

Are there forces in the environment (e.g., negative press, high unemployment, high levels of uninsurance, government budget deficits) likely to generate any significant government interest in setting a more specific standard for hospital tax exemption? Do nonprofit hospital leaders need to be proactive in telling their story to their various publics? Do nonprofit health care leaders need to be proactive in developing and promoting a more specific standard for tax exemption, either along the lines of the approach recently enacted in Illinois or something else?

These are among the questions explored in the following discussion, another in *Inquiry's* ongoing Dialogue series, cosponsored by the Alliance for Advancing Nonprofit Health Care, to provide a variety of voices on timely nonprofit health care issues. The panelists for this discussion, held on June 1, 2012, were: John Koster, M.D., president and CEO of Providence Health & Services, based in Seattle, Wash.; Myles P. Lash, president emeritus (and founder) of Provenance Health Partners of Doswell, Va.; and Wayne M. Lerner, D.P.H., FACHE, president and CEO of Holy Cross Hospital in Chicago, Ill. Bruce McPherson, Alliance president and CEO, who authored this issue's McNerney Forum, moderated the discussion.

Bruce McPherson: *Let's start with a basic question. How important are the various types of tax exemptions to nonprofit hospitals?*

Myles Lash: The chief executive officer of almost every hospital in the country probably has a back-of-the-envelope calculation on what each type of exemption is worth to his or her hospital. How you determine which ones are more important than others depends on where you sit. If you are doing very well at the moment, the income tax exemption will take on more weight. If you have big capital needs, access to tax-exempt bonds and/or philanthropy may be vital.

In just about every C-suite—executive suite—a simple comparison has probably been made between the total value of the hospital's tax benefits to its margin, bringing home the point that the financial viability of the institution would be in question if those tax benefits were to be lost.

Wayne Lerner: Most of the institutions in which I have worked have seen access to tax-exempt bonds and philanthropy as critically important. Maintaining these exemptions is usually linked to an organization's strategic and capital plans. We need to bear in mind that by providing more charity care or other programs benefiting the community, thereby reducing any earnings, the loss of any income tax exemptions becomes less of an issue.

John Koster: Providence, with total revenue of about $8 billion, operates in five states. We have estimated that, across all our communities, our federal, state, and local exemptions have a combined value of $340 million. This is significant, yet it is just over half of the $651 million total community benefits we provide.

As Wayne said, which exemptions are most important depends on your own circumstances. For instance, tax-exempt bond financing is very important to us, but not everywhere.

McPherson: *Are you seeing or do you foresee greater public scrutiny of and challenges to hospital tax exemptions?*

Koster: I foresee that federal, state, and local governments will expand their scrutiny of existing exemptions, as well as take other actions. The reality is that hospital balance sheets are on the radar screen of every unit of government. In fact, a governor in one of our states has referred to the balance sheets of nonprofit hospitals and health plans as "trapped community assets."

If you, as a legislator, are looking for the path of least resistance, that's going to be the introduction of new taxes. Taxes can take many direct and indirect forms, including unreasonable payment reductions in serving various population groups such as we are experiencing under a number of state Medicaid programs. A path of high resistance would be changing the rules around access to tax-exempt bond financing, where the investment banks and other stakeholders would also be impacted.

Unfortunately, some of our colleagues just don't get it. They are operating very much like for-profit entities in terms of profit levels, executive compensation, and other practices. My biggest fear is that in imposing various direct and indirect taxes, government will set aside market forces—which could reward well-managed hospitals. Instead, they could dictate which hospitals will survive and which won't based on other factors, including political influence.

Lerner: Like John's, our field is entering a firestorm of never-ending threats from government to get us to pay more and more of the public tax bill.

The City of Chicago has begun to focus on nonprofits paying water and sewer charges. The State of Illinois, which has a massive pension liability and historically has underfunded its Medicaid program, has just enacted a series of laws establishing quantitative tests for hospital exemption from property and state sales taxes. Look at what is happening in New York, where the governor has dictated that state payments to nonprofit health care providers and payers will be reduced if their executive compensation and other administrative costs exceed thresholds he has unilaterally set.

As John noted, in part, we may be paying for sins of some of our brethren who are reporting big profits. Luckily, in the last legislative session, safety-net hospitals were exempted from a massive Medicaid payment cut. Remarkably, under this legislation, hospitals that would not otherwise meet the property tax exemption test can do so by making financial or in-kind donations to other affiliated or unaffiliated not-for-profit hospitals like mine or other community agencies. In this way, what one can count towards maintaining one's exemptions are contributions or investments that relieve government's burden of providing goods or services to low-income individuals.

This option could prove to be very important to our safety-net institutions. We have tried, without success, for the almost six years I have been here to find a partner with whom we can share resources, conserve capital, and generate revenue—all in the name of better serving a community with great need. We are the only provider in six zip codes, a four-mile radius, that houses about 450,000 residents. Many of the surrounding not-for-profits—independents and systems, Catholic and non-Catholic—are sitting on rather strong balance sheets, with relatively small charity care and Medicaid patient loads. Maybe it is time to consider different kinds of partners and leverage this groundbreaking legislation.

Lash: Here again I think every C-suite knows that these challenges are coming, at all government levels where the budget issues are front and center. The approaches with each governmental entity and the C-suite will differ, of course, depending on the politics.

Some states and local governments have gone the route of fees and assessments to help cover some of their costs. When you're the largest or the second- or third-largest entity in your community, you can understand why they would want help for things like fire and police protection.

McPherson: *Two of you have alluded to the phenomenon of "a few bad apples spoiling the barrel." To help counter attacks on tax exemptions, do nonprofit hospital leaders who are doing the right thing need to challenge those who aren't?*

Lerner: If I were to question another organization's profits, executive pay, or other practices, they would simply tell me to mind my own business. It's a nonstarter. In any case, these are really governance issues, as governing boards ultimately define, narrowly or broadly, what their community is and what their organization's contributions to the community will be. In the end, it is not the strength of one's balance sheet that is important, but how one uses those resources to change the health and physical status of one's community.

Lash: I agree that it is ultimately a governance issue. For example, how much time does the board spend on community benefit issues versus financial statements? But it gets complicated, because if you are on the board of a nonprofit hospital in the suburbs, you aren't likely to accept that what is going on in a big city 20 miles away has any relevance to your responsibilities and those of your hospital.

Koster: Calling out a colleague or another organization, whether publicly or privately, just doesn't work. It's like the old adage, "No good deed goes unpunished." They won't see that there's a problem and will tell you to mind your own business. Those doing better or paying better than others will claim that it is due to better governance or management.

McPherson: *To help counter attacks on tax exemptions, do nonprofit hospital leaders need to be doing a better job of getting their story out to their various publics about their unique role and value, with support from national groups like mine with nonprofit hospital constituencies?*

Lerner: In designing a communications campaign, or before you can have an intelligent conversation about tax exemption reforms, you need to define community benefit. The best definition I have seen comes from the Catholic Health Association. But it is a complicated concept and I worry about whether it will make a difference to the general public, the media, and legislators. In the metro Chicago area, the communications challenge is especially daunting because there is a hospital construction boom under way, which delivers a totally different message.

Koster: The ability to communicate any of this to the general public is incredibly difficult, as it is with many legislators and their staffs. Communicating it to our own boards, medical staff, and employees is moderately difficult. You have to be very clear on your audience, be crisp in your terminology and message, and prioritize how you are going to get the message across. Billboards about nonprofit health care will get a "so what" response. Most people won't even see newspaper ads.

Instead, you better make sure that your board members know that they're representing their local community to help justify your organization's existence as a not-for-profit, tax-exempt entity. Board members have a responsibility to ensure that senior management performance objectives include community benefit and delivering value back for any tax exemption. You also need to communicate internally to your physicians and employees so they also can go out and share your story to the community.

I think that national groups like yours can be helpful in the communications effort, recognizing that it's largely internal communications that yield external communications.

Lash: John's comments are right on. Board members need to understand their role and responsibilities vis-a-vis tax exemption and community service, and they along with senior management need to be informing the inside communities so that they can also be outside advocates. I also agree that national groups like yours and others can provide useful advocacy tools to members. The biggest communication challenges and risks will be for those that don't have a good, credible story to tell. Let's hope they are in the minority.

McPherson: *Should nonprofit hospital leaders be proactive in designing and promoting publicly a more specific standard for tax exemption, whether along the lines of what was legislated in Illinois or something else?*

Koster: I think we ultimately will. But there's some wariness right now that adoption of a fairness test for tax exemption linked to community benefit, which would or could lead to some redistribution of income among institutions, could open the door for even greater government interventions to redistribute income. There's no doubt that the tax exemption issue will be front and center in a couple years or even sooner in some places as governments continue to struggle to balance their budgets and address unfunded liabilities. But you're going to get many of the traditional trade associations to take this issue on proactively.

And how is a smaller cadre of nonprofit health care organizations going to have any credibility? And could they, if their boards view themselves as stewards of the assets of their organizations? If their organizations were to be sold, the proceeds would go to foundations located in and serving the people in their communities, however defined geographically. In that context, the board's job is not to look out for the greater welfare of the state, county, or region outside its defined community. The board's goal is to be a steward of the community asset. So it can get sticky promoting a public policy that could be at odds with this stewardship responsibility.

Lash: Some of my colleagues and I have been intrigued by a "cap and trade" approach, which I guess is what you could call the Illinois tax exemption law that Wayne cited earlier, where a nonprofit hospital that couldn't otherwise meet the community benefit test could do so by volunteering to help out others with financial or in-kind contributions. That approach keeps the resources in the nonprofit health sector, rather than have some disappear into general government coffers for political redistribution elsewhere.

I think that leaders in our sector will ultimately come to this same conclusion, but it's difficult to get folks to focus on that issue given all the other challenges of the day. And as John said, there's the stewardship issue.

It could prove very unfortunate if government took the lead on this by default. Perhaps as a first step, some highly respected public policy people within or outside academia could be encouraged to articulate and have published in a major newspaper or journal, the pros and cons of an approach like Illinois'.

Lerner: I, too, would like to see our field's leaders step up to the plate and design an approach where we are in effect helping ourselves by helping others—along the lines of the Illinois legislation. Remember, in Illinois' case, there was no voluntary effort. We had the threat of government coming in and demanding property taxes. Our hospital association did a great job of working with our elected leaders to lobby for the legislation, which subsequently passed. Not only is it groundbreaking, but it included the potential for safety-nets like mine to get help from others. I'm not saying we couldn't do it on a voluntary basis. I just haven't seen the kind of statesmanship coming out of our field's executives and board leaders that I recall being extant 30–40 years ago to drive such a societal change across a market or geographic area.

McPherson: *Do you have any final comments that you would like to make?*

Lash: The future is becoming increasingly unclear in a whole variety of respects. We are in a major transition, but to what end exactly? Tax exemption is just one example, and it is uncertain whether and/or how that fits with the melding of provider and insurer roles that we are now seeing more frequently.

Lerner: I agree about all the uncertainties that lie ahead, Myles, and about the melding of provider and insurer roles. Whether under ACO [accountable care organization] arrangements, modified HMOs, or other new structures, our incentives will become more and more pronounced to prevent illnesses, treat patients innovatively in primary care through post-acute care settings, and keep them out of hospital ERs and inpatient beds.

We need to balance changes in delivery and financing with the continuing attention to the societal gaps that will continue to exist. In this way, we will remain accountable for community benefit as the means by which we can justify our tax exemptions.

Koster: Here's just one example of our complex environment. The governor of Oregon just received a special federal grant to assist in the establishment of coordinated care organizations throughout the state, which will initially serve Medicaid enrollees. Over the next year, we are projecting the health plan we own in Oregon to have its Medicaid enrollment trebled. Other hospitals and systems that don't own their own health plans will also be taking on more risk—with no experience in doing so.

How are we to remain financially sustainable under all of the uncertainties and changes out there—even without thinking about tax-exemption reforms?