Criteria to Counter Tax-Exemption Threats

The CHA Board of Trustees Recommends Not-for-Profit Facilities Adopt Voluntary Community Benefit Standards

In April 1991 the Catholic Health Association (CHA) Board of Trustees established a task force on tax exemption to examine the debate on tax exemption of not-for-profit healthcare facilities and to consider the advisability of more explicit criteria for community benefit. After considerable study, deliberation, and consultation within and outside of CHA, the task force formulated a set of voluntary community service standards for not-for-profit healthcare facilities. The CHA board approved the standards in April 1992 and called on all CHA members to adopt them.

The task force also recommended that CHA work with other national organizations to promote the adoption of voluntary community benefit standards by the nation's not-for-profit healthcare facilities. The task force hopes widespread adoption of community benefit standards will address many of the issues fueling the tax-exemption debate, but it recommended that CHA continue to study other voluntary, administrative, or legislative activity in response to public concerns about healthcare facility tax exemption.

Following is a synopsis of the report and recommendations of the CHA Task Force on Tax Exemption.

Catholic healthcare facilities were founded, often at the cost of great hardship and sacrifice, to care for the frail, sick, and injured in their communities. Like other healthcare institutions established in the Judeo-Christian tradition, their service is motivated by the values of justice and compassion. Thus Catholic healthcare facilities have traditionally provided service that promotes human dignity and concern for the community, especially its most vulnerable members, the poor and disadvantaged.

Maintaining a commitment to the healthcare ministry and responding to communities' most

Summary Not-for-profit hospitals' response to an increasingly competitive environment has damaged the relationship between the facilities and those they were established to serve—their communities. Since the mid-1980s, governmental scrutiny at federal, state, and local levels has focused on tax-exempt organizations' income-producing activities, competition with small businesses, and financing.

The debate over tax exemption has been fueled by three factors: budget cuts to state and local programs, concern over the growing number of uninsured and underinsured, and the commercial behavior of healthcare facilities, particularly hospitals.

Challenges to tax exemption could diminish Catholic healthcare facilities' identity as charitable, mission-driven organizations. They also threaten facilities with the loss of valuable resources to fulfill their mission. And these challenges threaten the flexibility of Catholic facilities to respond to locally defined needs.

The CHA Task Force on Tax Exemption has identified voluntary community benefit standards for not-for-profit healthcare organizations. CHA believes adherence to these standards would demonstrate that community well-being continues to be the foremost concern of Catholic healthcare facilities.

The standards include requirements for mission statements and philosophy reflecting a commitment to community benefit, the implementation of a community benefit plan, and the dissemination of an annual community benefit report.

crucial needs are becoming increasingly difficult, however. Competitive forces, commercial values, and government and other cutbacks are prompting many healthcare facilities, even those with a strong tradition of community service, to deemphasize community healthcare needs and priorities. External forces have caused a change in the mentality and behavior within healthcare facilities. Planning mechanisms, language, organizational charts, and compensation formulas make many not-for-profit healthcare facilities appear more commercial in orientation.

Not-for-profit healthcare facilities appear more commercial today.

Not-for-profit hospitals' response to an increasingly competitive environment has damaged the relationship between the facilities and those they were established to serve—their communities. Many are questioning whether these hospitals have the commitment to identify and to meet their communities' most pressing needs. This charge is clearly manifested in recent challenges to hospital tax exemption, which are symptomatic of growing public sentiment that many not-for-profit healthcare facilities are being operated more like commercially oriented businesses than the community service organizations they were chartered to be.

Legislative proposals to change the criteria for hospital tax exemption and other challenges to the tax exemption of not-for-profit healthcare facilities have led CHA to reexamine its members' community service role and the community benefit standard for federal tax exemption.

An Evolving Definition

Section 501(c)(3) of the tax code provides for the exemption of categories of not-for-profit organizations that meet certain requirements, including having religious, scientific, educational, or charitable purposes. Most healthcare facilities derive their exemption from the category of charitable purpose organizations.

The definition of "charitable" has evolved throughout the history of tax exemption from a narrow view of charity as relief of poverty or service to the poor to a broader "community benefit" standard. In 1969 the Internal Revenue Service stated that a charitable hospital would be considered to benefit the community and qualify for exemption if it operated a full-time emergency room open to all persons without regard to their ability to pay and if it provided hospital care for everyone able to pay the cost of care either by themselves or through private insurance or public programs such as Medicare and Medicaid.

Challenges to Tax Exemption

Since the mid-1980s, numerous threats to healthcare facility tax exemption have taken many different forms.

Congressional investigations have looked at whether tax-exempt organizations' commercial and other income-producing activities were adequately dealt with through existing unrelated business income tax laws. In this debate, hospitals were characterized as large, multilayered, and multipurpose organizations, focusing less on healthcare than on trying to generate revenue through for-profit subsidiaries.

The debate also focused on whether organizations were using their tax-exempt status unfairly to compete with small, tax-paying businesses. Hospitals were portrayed as capitalizing on their "halo" as not-for-profit tax-exempt organizations, thus harming community businesses engaged in hearing aid services, rental and sale of medical equipment, and laboratory testing.

Later, the debate shifted to tax-exempt financing of homes for the aged, as well as of hospitals. Some members of Congress questioned the appropriateness of tax-exempt financing for projects that did not appear to be community service oriented. They criticized luxurious apartments for the elderly, sometimes sponsored by tax-exempt hospitals and long-term care facilities, and extravagant facility expansions in affluent suburbs.

In 1991 two bills introduced in the House of Representatives sought to specify new community benefit criteria for hospital tax exemption. H.R. 790, introduced by Rep. Edward Roybal, D-CA, would require hospitals to provide (1) an

amount of charity care equal to at least 50 percent of the economic benefit of their tax exemption and (2) other community benefits in amounts equal to at least 35 percent of the value of the exemption.

The second bill, H.R. 1374, introduced by Rep. Brian Donnelly, D-MA, would grant federal tax exemption only to those hospitals which operate an emergency room for all members of the community; have a Medicaid provider agreement and nondiscriminatory policies with respect to Medicaid beneficiaries; and provide service to a broad spectrum of the community in one of several ways, including devoting 5 percent of gross revenue to charity care or 10 percent of gross revenue to qualified community benefits and services.

> Loss of tax exemption would diminish institutions' identity as charitable.

The Likelihood of Change

The likelihood of a significant change in the federal requirements for hospital tax exemption is uncertain. Neither bill before Congress had cosponsors. Healthcare facility tax exemption has not been an issue in the Senate, and the subject has not arisen during the debate on this year's tax legislation. The Bush administration has not supported changing the criteria for tax exemption, although it has recommended developing interim penalties for relatively minor tax code violations.

For the past five years, however, congressional interest in hospital tax exemption has escalated. In 1991 the full House Ways and Means Committee held a hearing on the hospital community benefit standard for tax exemption. Most members of this tax-writing committee attended, many with personal and constituent accounts of hospitals that did not demonstrate charitable behavior. Also, the House Energy and Commerce Committee has asked the Office of the Inspector General to conduct in-depth hospital administration audits to look for violations related to financial reporting and tax exemption.

In addition, hospitals are well advised to examine the history of Blue Cross/Blue Shield tax exemption. The 1986 Tax Reform Act removed the tax exemption of Blue Cross/Blue Shield organizations. This occurred despite opposition in the Senate and little support, except for one determined member, within the House. Before this surprise move, the plans recognized the opportunity to develop criteria for tax exemption. The industry rejected this option, which would have retained the exemption of community-oriented plans.

State and local threats to hospital tax exemption are more imminent, with legal or legislative challenges under way in nearly half the states. The debate on long-term care facility tax exemption has taken place predominantly at the state and local levels, with continuing care residential communities especially targeted as serving only the most affluent.

Roots of the Debate

Three factors have fueled challenges to tax exemption. During the past decade, federal budget cuts to state and local programs have forced government agencies and their revenue officials to seek new financial sources. The search for increasingly scarce revenue to finance needed services has focused attention on healthcare facility tax exemption.

Concern over the growing numbers of uninsured and underinsured has also fueled the tax-exemption debate. Lawmakers, frustrated by budget deficits and hesitant to raise taxes, have suggested that federal funding lost through "subsidies" to tax-exempt organizations could help meet the growing needs of the uninsured and underinsured.

Finally, the commercial behavior of healthcare facilities, particularly hospitals, is jeopardizing tax exemption. Hospitals operate in a competitive environment where business and financial success is seen as an end rather than a means of providing healthcare services. Not-for-profit facilities, contending with both for-profit competitors and mounting financial pressures, have responded by adopting more commercial marketing practices and by entering into complex business relationships with physicians to attract and retain medical staff. In many cases, this competitive behavior has

been fostered by governmental programs designed to reduce government healthcare spending.

Adding to this image problem were atypically high hospital margins in the mid-1980s (partially caused by drastic shifts in government payment policies), juxtaposed with press reports of patient "dumping." Newspapers and other media accused hospitals of apparent disregard for the uninsured and other community health needs because of margin-focused behavior. Given these circumstances, it is not surprising a 1988 poll by Arthur D. Little, Inc., showed that an overwhelming number of community members see hospitals as business enterprises rather than social service organizations.

These perceived trends should be balanced with the record of hospital performance within the communities they serve. Nationwide, hospitals have been doing an increasing amount of community service and uncompensated care.

CHA's *A Community Benefits Report on Catholic Healthcare Providers* (1991) showed that although hospital margins have continued to decline since the mid-1980s, services to the poor and other needy groups have risen considerably. Nearly three-fourths of CHA members responding to a survey indicated that since 1985, they have increased their volume of free or discounted services to low-income populations and their services to other populations with special needs, such as the elderly, persons with AIDS, or the homeless. CHA's *1991 Assessment of the Catholic Institutional Healthcare Ministry, Its Community Context, and Sponsorship Structures* found that the level of services was particularly high in poor areas.

Data released in October 1991 by the Prospective Payment Assessment Commission (ProPAC) reveal that from 1980 to 1989 uncompensated care by hospitals increased 12 percent per year, more than tripling in that eight-year period. ProPAC also reported that the burden of providing uncompensated care is being shared by many hospitals, as opposed to being borne by a relatively small group of public and inner-city teaching hospitals, as was previously the case.

The Impact of Tax-Exemption Loss

Challenges to tax exemption are of particular concern to Catholic healthcare facilities. First, the loss of exemption would diminish the institutions' identity as charitable, mission-driven organizations. Service to the poor and sick is at the heart of the identity of Catholic facilities. Tax exemption represents a public recognition of that identity. If the facilities are no longer publicly recognized as charitable organizations, questions

CHA'S SOCIAL ACCOUNTABILITY RESOURCES

- *Evaluative Criteria for Catholic Health Care Facilities* (1980) helps Catholic facilities distinguish themselves as Catholic and speaks to the responsibility of CHA members to put into practice the Gospel values of compassion, love, and justice.
- The report of CHA's Task Force on Health Care of the Poor, *No Room in the Marketplace* (1986), makes specific recommendations for Catholic health facilities to ensure their decisions and activities give priority to the needs of the healthcare poor.
- *A Time to Be Old, a Time to Flourish: The Special Needs of the Elderly at Risk* (1988), the report of CHA's Task Force on Long Term Care Policy, reinforces the special concern for frail elderly persons and calls on Catholic facilities to renew their long-professed goal of focusing on the needs of the patient, client, and community.
- *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint* (1989) is a set of tools for assessing the needs of the community, especially the poor and vulnerable; for planning and budgeting to meet those needs; and for reporting the community benefits that Catholic facilities provide.
- *Agenda for Advocacy* (1991) is a summary of CHA's public policy goals and priorities and describes the values that animate CHA's public policy agenda: promotion of human dignity, protection of human rights, a conviction that healthcare is a social good, and a preferential concern for the poor and disadvantaged.
- *Ethical Issues in Healthcare Marketing* (1990) gives recommendations for organizing healthcare on the basis of community need rather than market competition.
- *Physician-Hospital Joint Ventures: Ethical Issues* (1991) includes an ethical risk-benefit analysis model.
- *Setting Relations Right: A Working Proposal for Systemic Healthcare Reform* (1992) is anchored in values that challenge the overtly commercial orientation of today's healthcare system. It discusses how community service may be countercultural to contemporary healthcare, since competitive success depends on a provider's ability to exclude the poor and sick.

may arise about whether Catholic healthcare continues to be a ministry of the Church, and sponsors of the facilities may be compelled to discontinue their sponsorship.

Second, the potential loss of tax exemption threatens Catholic healthcare facilities with the loss of valuable resources needed to fulfill their mission. Tax exemption is economically valuable, allowing CHA members to carry on the types of programs and services essential to their mission of service to the community and to the poor and frail elderly. Philanthropy, for example, which is encouraged by tax exemption, is expected to be an increasingly important factor in the future. In addition, loss of access to tax-exempt financing would severely limit the ability to replace or add needed equipment, services, and programs.

Third, loss of tax exemption or significant curtailment through rigid new requirements would threaten the flexibility of Catholic healthcare facilities to respond to locally defined needs. Each community's healthcare needs are unique and require a different response. It is important for Catholic facilities to respond creatively to those needs. Some proposals for changing hospital tax exemption would inappropriately direct facility services into a single, national mode.

The Foundation for Standards

The mission and values of Catholic healthcare facilities lead them to a high level of responsiveness to community need, especially the healthcare needs of the poor, frail elderly, and disadvantaged. Catholic healthcare facilities should meet a high standard of community benefit and social accountability.

CHA has developed a number of programs and publications that define the values of Catholic healthcare and help CHA members clarify their mission to address community needs (see **Box**, p. 53).

But Catholic healthcare facilities are not alone in holding themselves to a high standard of responsiveness to community need and charitable orientation. Not-for-profit healthcare facilities continue the voluntary charitable tradition of private organizations in the public service. Not-for-profit health facilities value that tradition and strive to adhere to a strong set of values which flow from their missions.

In *Mission Matters*, a report on the future of voluntary healthcare institutions published in 1987 by the United Hospital Fund of New York, David Seay (a member of the task force) and Bruce Vladeck underscore that voluntary healthcare institutions must rearticulate their missions and recognize that perhaps not every not-for-profit organization calling itself charitable deserves to be treated as such. Because hospitals and other tax-exempt institutions do not operate in a vacuum, they must address community and public issues in pursuing their own goals and objectives. *Mission Matters* stresses that hospitals' mission mandates efforts to identify unmet community healthcare needs and to seek to meet them, both as providers of services and as community leaders.

These concepts are echoed with even more specificity in the voluntary criteria developed in 1990 by the Hospital Community Benefit Standards Program, a national demonstration project that began at the Robert F. Wagner School of Public Service at New York University, with funding from the W. K. Kellogg Foundation.

Principles underlying this program provide guidance to mission-driven facilities pursuing a high standard of community service. The principles include:

- A formal commitment to community service for a designated community
- Hospital-sponsored efforts to improve health status, to address special health problems of the poor and underserved, and to contain healthcare costs
- A leadership role within the community to address identified healthcare needs
- An internal culture of community caring that encourages hospital-wide involvement in community benefit activities

The American Association of Homes for the Aging (AAHA) has adopted a Membership Credo that speaks to the charitable roots of not-for-profit long-term care facilities and their values of accountability, compassion, and social responsibility. The credo encourages a commitment to mission and community service and demonstration of accountability through public communications and reports.

Voluntary Standards and Beyond

Building on the earlier CHA policy documents, *Mission Matters*, principles of the Hospital Community Benefit Standards Program, and the AAHA credo, the CHA Task Force on Tax Exemption has identified voluntary community benefit standards for not-for-profit healthcare organizations (see **Box**, p. 55). The CHA board calls on Catholic healthcare facilities to adopt these standards and invites other not-for-profit facilities sharing a commitment to community service to join in embracing these standards.

Not-for-profit healthcare facilities have a responsibility to function as community service organizations. CHA believes adherence to the voluntary standards would demonstrate that the commitment is genuine and that community well-being continues to be the facility's foremost concern. The CHA board believes that following the standards would enable a not-for-profit healthcare facility to serve its community in a way and in an amount that is proportionate to community need and the capacity of the institution to meet that need.

However, some may view commitment and adherence to voluntary standards as insufficient to fulfill a community service obligation. Some, including government officials and legislators, believe that to receive preferential tax status, hospitals should be held to an explicit standard of community benefit. They view the current community benefit standard as too vague and generally impossible to enforce.

The task force recommends that, as the debate on health facility tax exemption continues, CHA demonstrate its commitment to high standards of community benefit by taking a leadership role with its members and with other national groups to achieve consensus and widespread adoption of voluntary community benefit standards.

If legislative or regulatory policies are pursued to clarify hospital responsibilities for federal tax exemption, CHA should advocate that any new policy:

- Focus on total community benefit
- Center on the facility's accountability to its community
- Be flexible.

CHA's Role

The CHA Board of Trustees advocates the following policies and positions:

1. CHA should embark on an educational campaign to inform all members of the forces driving the tax-exemption debate and to call for adoption of voluntary standards on community benefits by Catholic healthcare systems and all CHA member facilities.

2. CHA should collaborate with other national organizations of not-for-profit healthcare facilities to develop consensus on the need to promote the adoption of voluntary community benefit standards.

3. CHA should continue to develop and refine proposals for legislative change in the federal criteria for tax exemption. □

STANDARDS FOR COMMUNITY BENEFIT

1. The organization should ensure that mission statements and philosophy reflect a commitment to benefit the community and that policies and practices are consistent with these documents, including:

- Consideration of operational and policy decisions in light of their impact on the community served, especially the poor, the frail elderly and the vulnerable
- Adoption of charity care policies that are made public and are consistently applied
- Incorporation of community healthcare needs into regular planning and budgeting processes

2. The governing body should adopt, make public, and implement a community benefit plan that:

- Defines the organization's mission and the community being served
- Identifies unmet healthcare needs in the community, including needs of the poor, frail elderly, minorities, and other medically underserved and disadvantaged persons
- Describes how the organization intends to take a leadership role in advocating community-wide responses to healthcare needs in the community
- Describes how the organization intends to address, directly and in collaboration with physicians, other individuals, and organizations:

—Particular or unique healthcare problems of the community

—Healthcare needs of the poor, the frail elderly, minorities, and other medically underserved and disadvantaged persons

- Describes how the organization sought the views of the community being served and how community members and other organizations were involved in identifying needs and developing the plan

3. The healthcare organization should provide community benefits to the poor and the broader community that are designed to:

- Comply with the community benefit plan
- Improve health status in the community
- Promote access to healthcare services to all persons in the community
- Contain healthcare costs

4. The organization should make available to the public an annual community benefit report that describes the scope of community benefits provided directly and in collaboration with others.