Through the Looking Glass

A CAGW SPECIAL REPORT

ARE YOU GETTING YOUR MONEY'S WORTH FROM NONPROFIT HOSPITALS?

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Introduction

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Many people do not realize their local "benevolent" hospitals may pay little or no taxes to the community, to the state, or to the federal government. In exchange for their tax exemption, these nonprofit hospitals are supposed to provide community benefits, such as charity care for the indigent and health promotion/education, to the citizens in the hospital's service area. However, several exposés have shown that a number of nonprofit hospitals are providing little to no charity care and few community benefits to justify their tax exemption.[1] This report explains the need for states and municipalities to demand, at minimum, standards for defining "community benefits" provided by nonprofit hospitals.

There are, according to a 1995 report, some 1.1 million nonprofit organizations in the United States. They include the "classic" charitable organizations, that provide assistance to the poor and hungry; such as the Red Cross and the Salvation Army, cultural organizations, such as museums; and advocacy groups, such as the American Association for Retired Persons (AARP), the National Rifle Association (NRA) and Citizens Against Government Waste (CAGW). These organizations (excluding churches) produce about $1.1 trillion in revenue each year and control about $1.475 trillion in assets. Although hospitals make up only 1 percent of all nonprofit organizations, they generate about 40 percent of total nonprofit revenue. At the same time, it is estimated that nonprofit healthcare organizations save at least $15 billion through their exemption from federal, state, and local taxes.[2]

Often the difference between a for-profit organization and a nonprofit can be difficult to determine. Most state statutes define a nonprofit as an organization focused on a goal other than the bottom line; rather, nonprofits are supposed to provide a public service. This "other" goal affects the decisions made by the nonprofit's management.[3]

A for-profit management team usually makes decisions designed to increase, or at least maintain, its company's profits. The success of the team is judged by the company's profitability. A nonprofit's management team, on the other hand, makes decisions that result in providing more of the organization's specialized "service" with its available resources. The management team's success is judged upon the benefits provided to and goodwill generated among the public.

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[1] "Serving the Community? A Financial Analysis of Selected Maine Nonprofit Hospitals 1990-1994," Community Catalyst, et al., 1997, Boston; Monica Langley, "Nonprofit Hospitals Sometimes Are That in Little but Name," The *Wall Street Journal*, July 14, 1997; "Big HMO Mergers Spark Call to Review Tax-exempt Status," The *Sacramento Bee*, July 28, 1997; Michael Morrisey, Gerald Wedig, Mahmud Hassan, "Do Nonprofit Hospitals Pay Their Way?" *Health Affairs*, Vol. 15, Number 4, Winter 1996, pp. 132-143; "Tax Exempt," *U.S. News and World Report*, Oct. 2, 1995, pp. 36-46.

[2] Edward T. Pound, Gary Cohen and Penny Loeb, "Tax Exempt," *U.S. News and World Report*, Oct. 2, 1995, pp. 36-46.

[3] Robert N. Anthony and David W. Young, "Characteristics of Nonprofit Organizations," *The Nonprofit Organization*, ed. Giles, Ott and Shafritz, Belmont, Calif., 1990, pp. 216-217.

Although this is a simplistic definition for both types of organizations, it establishes basic differences between the two.[4]

Background

"What has become clear in the years since the IRS ruling is that there are no absolutes that determine the kind and amount of community benefits nonprofit hospitals must provide to justify their tax-exempt status."

Prior to the beginning of the 20th century, hospitals primarily served the poor and obtained most of their funding through philanthropy. People who could afford healthcare avoided hospitals and preferred to be treated in their doctors' offices or in their homes. Furthermore, hospital care was not any better than what could be provided in a home setting, so there was no incentive to go to a hospital. The number of hospital visits began to increase with advances in medical technology such as anesthesia, improved surgical techniques, and the ability to control sepsis. Soon, the non-poor began to demand care in hospitals. Insurance plans were developed and offered complete hospital coverage by the 1930s.[5] In 1946, Congress passed the Hill-Burton Act to stimulate capital investment in and the modernization of hospitals, both of which were stifled during World War II. The Act provided grants to nonprofit hospitals and greatly aided the growth of the nonprofit hospital industry. In return for the grants, nonprofit hospitals had to provide care at reduced fees or at no cost to persons unable to pay for treatment.

The healthcare industry began to change again when Medicaid and Medicare were implemented. The poor and elderly now had health insurance, and by the late 1960s, hospitals received about 90 percent of their revenue from private and government-funded insurance payments. By 1984, only 5 percent of the total amount spent on nonprofit hospital construction was funded by philanthropists.[6]

In 1969, the Internal Revenue Service (IRS) expanded its definition of "charitable services" and eliminated the specific requirement of free or below cost care, except for care provided in hospital emergency rooms. It established a "community benefit" standard; in other words, the IRS would weigh several factors that would provide services to the community as a whole. These factors can include "promotion of health" and the "advancement of medical education."[7]

In 1983, the IRS extended the tax exemption to a hospital that did not have an emergency room because the responsible state health agency had determined that such a facility would provide duplicative and unnecessary services. With this action, the IRS modified its "charitable" requirement even further.[8]

What has become clear in the years since the IRS ruling is that there are no absolutes that determine the kind and amount of community benefits nonprofit hospitals must provide to justify their tax-exempt status. Because of this vagueness, several states are beginning to look at what their nonprofit hospitals provide in the way of community benefits and to design set goals for the hospitals

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[4] Ibid.

[5] Sloan, Hoerger, Morrisey, and Hassan, "The Demise of Hospital Philanthropy," *Economic Inquiry*, Vol. 23, October 1990, p. 725.

[6] Ibid.

[7] U.S. General Accounting Office, "Nonprofit Hospitals: Better Standards are Needed for Tax Exemption," (GAO/HRD-90-84), May 1990, pp. 2, 47.

[8] Ibid., p. 47.

to meet. In fact, some states have already established standards in an effort to hold nonprofit hospitals more accountable for their tax-free status.

States Demand Accountability

During the early 1980s, states looking for new sources of revenue began to reconsider the tax-exempt status of their nonprofit hospitals. The first state to take a closer look at the tax exemption of hospitals was Utah in 1985; the next was Pennsylvania. Since then, more than 30 states have considered legislation that would affect the tax treatment of nonprofit hospitals.[9] For example, California enacted SB 697 in 1994, a statute that requires private, nonprofit hospitals to complete community needs assessments and to adopt community benefits plans. The hospitals must report information to the Office of Statewide Health Planning and Development on the benefits they are providing to the community. These benefits should be designed to encourage disease prevention and an improvement of health status in the hospitals' service areas.[10]

"Cities and states are strapped for money, and government officials are beginning to realize many of their community hospitals may not be providing the level of community services necessary to justify the huge tax exemptions they are granted."

The state of Texas passed legislation in 1993 that redefined the tax-exempt status of its nonprofit hospitals. In Texas, hospitals must now choose from four standards to maintain their tax exemptions, and only the *unreimbursed* costs of providing community benefits, charity care, and government-sponsored indigent healthcare may apply in order to comply with the standards. The hospital must: (1) provide charity and government-sponsored indigent healthcare at a level that is reasonable in relation to community needs as determined by the community needs assessment, the available resources of the hospital, and the tax-exempt benefits received; (2) provide charity care and government-sponsored care equal to 4 percent of the net patient revenue; (3) provide charity care and government-sponsored indigent healthcare in an amount equal to 100 percent of the hospital's tax-exempt benefits, excluding federal income tax; or (4) provide charity care and community benefits in a combined amount that is equal to at least 5 percent of the hospital's net revenue, of which charity care and government-sponsored indigent care are provided in an amount equal to 4 percent of the hospital's net patient revenue.[11]

Charity care is no longer the main mission of hospitals, so states are likely to continue to examine just what community benefits are provided by nonprofit hospitals and to set definite standards and goals for such services. Cities and states are strapped for money, and government officials are beginning to realize many of their community hospitals may not be providing the level of community services necessary to justify the huge tax exemptions they are granted. After all, for-profit hospitals pay local property taxes and other state taxes, which certainly provide clear means to measure the benefits they are furnishing to communities, such as funding for schools, roads, and libraries.

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[9] Thomas Buchmueller and Paul Feldstein, "Hospital Community Benefits Other Than Charity Care; Implication for Tax Exemption and Public Policy," *Hospital & Health Services Administration*, Vol. 41, Issue 4, Dec. 1, 1996, pp. 461-462.

[10] Community Benefits Program (SB 697), California Office of Statewide Health Planning and Development.

[11] Texas Hospital Trustees and Texas Hospital Association's Manual on S. 427.

A Place to Start: The Form 990

All nonprofit organizations, including CAGW, are required to submit a Form 990 to the IRS on a yearly basis. The 990 looks like most tax returns and is used to support an organization's tax-exempt status. It is one way to get a picture of where and how nonprofit organizations obtain and spend their tax-exempt funds. Few people realize that all nonprofit organizations must allow the public to *inspect* their last three 990s during regular working hours at the organization's principal office and at any regional office that has three employees or more. In addition, on July 30, 1996, President Clinton signed the "Taxpayer Bill of Rights II" into law. Now, organizations must provide a copy of their 990 to anyone who asks for one either in person or in writing. Regulations were written that provided clear direction on how organizations should comply with the law and at the same time avoid harassment campaigns (i.e., someone who requests an inordinate number of copies).[12]

The 990 provides information about revenue, expenses, and net assets. It is required to provide information on program accomplishments, the purpose for the tax exemption, and the benefits provided to the community that justify the tax exemption. Unfortunately, hospitals vary greatly in how much they reveal about community benefits and charity care on their 990s. For example, many hospitals claim their 24-hour emergency service is a community benefit. Although emergency rooms certainly benefit the community and are very expensive to run, *all* hospitals with emergency rooms must provide screening and emergency care if needed, regardless of the patient's ability to pay, under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). The patients cannot be transferred until they are stabilized. Other hospitals claim that their pamphlets giving basic health information, such as services provided at the facility, are a community benefit. In reality, such pamphlets may be nothing more than promotional pieces.

"Several of the Washington area hospitals examined had huge fund balances, or accumulated earnings over the years, ranging between $29 million to $216 million."

CAGW reviewed the 990s of randomly selected nonprofit hospitals in the Washington, D.C., area. Although all of the 990s requested were eventually produced, to say there was some resistance would be an understatement. Some requests were refused outright at first; others obscured information such as the salaries of their highest paid employees. This is against the law.

Several of the Washington area hospitals that CAGW examined had huge fund balances, or accumulated earnings over the years, ranging between $29 million and $216 million. An organization's fund balance represents its assets minus liabilities; assets include items such as cash reserves, land and securities (stocks and bonds) investments. Their investments in stocks and bonds ranged from $5 million to $145 million. In addition, many of the hospitals owned affiliated organizations that are for-profit as well as nonprofit, which were not investigated. Exactly how they provide income to the hospital's bottom line was not determined.

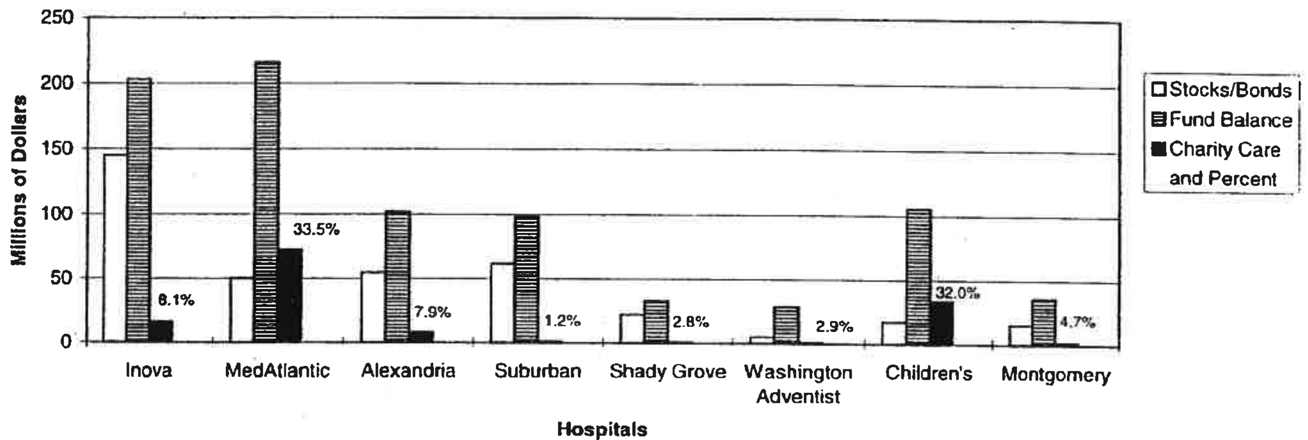
CAGW compared each hospital's fund balance or net worth, which can be found on line 21 of the 990 and calculated the respective charity care (usually described

[12] *Federal Register*, Sept. 26, 1997, (proposed rules) pp. 50533-50541.

in an attachment to the 990 or in annual reports) as a percentage of each hospital's net worth. Charity care is not equated with uncompensated care, although many hospitals combine the two. Uncompensated care can include the costs of individuals simply refusing to pay their bills. All businesses face that problem; it's a cost of doing business. In addition, some of the hospitals included "community benefits" as part of charity care.

There was quite a range in the amount of charity care that was provided, from 1.2 percent to 33.5 percent of the fund balance. The hospital with the lowest percentage of charity care, Suburban (Bethesda, Md.), claimed that providing "lifeline rentals," emergency alert systems for patients who may be unable to use phones, was a community benefit, yet the hospital claims it charged its costs for these rentals, a total of $245,739. Considering that Suburban had reported $61 million in securities, it could afford to give the lifelines away as real charity.

Charity as Percentage of Fund Balance



[Stocks/Bonds (part of Fund Balance) separated out because they are among the most "liquid" assets.]

All of the hospitals investigated by CAGW paid their chief executive officers (CEOs) very well (according to Part V of their 990s). CEO salaries ranged from $122,000 to $600,000 per year, with an average salary of $380,000. Many CEOs received generous benefit packages in addition to their salaries. Total compensation rivaled that found in the for-profit sector.

Considering that the main mission of a nonprofit hospital is to provide healthcare and related services throughout its community, CAGW was surprised that so many of the hospitals had such large fund balances including substantial investments yet spent so little on charity care. In the case of hospitals that drew a distinction between charity care and community benefits, even if community benefits are added to the equation, less than 50 percent of the hospitals' accumulated wealth was returned to the community.

Conclusion

CAGW believes that it is prudent for a nonprofit organization to make wise investments, to accumulate wealth, and to garner reserves. But it is far from clear that communities are getting their money's worth in return for releasing huge, wealthy nonprofit hospitals from their tax obligations. Medicaid reimburses hospitals for large portions of their losses on indigent care, and Medicare also subsidizes hospitals' revenue. It is now the government and private health insurers that provide most of the funding to nonprofit hospitals, not philanthropists as in years past.

"Many recent studies, such as those by Project Hope and the Medicare Prospective Payment Commission, have shown there is little difference between what tax-exempt hospitals and taxpaying hospitals provide in the way of uncompensated care and benefits to the community."

Recently, the *Wall Street Journal* reported on the Daughters of Charity, a nationwide healthcare chain with 49 hospitals in 12 states, which ranks among the top five hospital systems in the country. Dubbed the "Daughters of Currency," the system has cash and investments valued at $2 billion, owns a subsidiary in the Cayman Islands and receives top ratings for its tax-exempt bonds. The system receives about $6 billion annually in revenue and gets its biggest savings from selling unprofitable hospitals. With its investment income tax free, the Daughters of Charity is believed to have the largest reserves of any nonprofit hospital system in the country. Although its representatives claim to maintain their charitable mission, some critics argue otherwise. The system serves fewer than the national average of Medicaid patients, and its key hospitals are located in affluent suburbs, not inner-city slums where one would expect a religious order to focus its efforts. A Boston clinic owned by the Daughters was featured in videos about the order's commitment to the poor. The clinic eventually left the Daughters' system in 1995 because it was overrun with patients, and the clinic's administrators felt they were not getting the financial support they needed to expand their space and buy new equipment. Eventually, the clinic aligned with another medical center and got the funding it desperately needed.[13] How the Daughters of Charity can claim to be "different" from for-profit hospitals and deserve a tax exemption is a mystery.

Many citizens are witnessing investor-owned, or for-profit, hospitals entering their communities. Investors buy a nonprofit hospital that is old, losing money and often about to close its doors. Those opposed to for-profit hospitals rattle their sabers and raise the alarm in the community that somehow this investment will be bad for the community. Yet, the for-profit company injects precious capital that allows the hospital to purchase new technology, upgrade facilities, and introduce management techniques that reduce administrative costs. Plus, the taxes these hospitals pay provide community benefits that can be quantified.

Many recent studies, such as those by Project Hope and the Medicare Prospective Payment Commission, have shown there is little difference between what tax-exempt hospitals and taxpaying hospitals provide in the way of uncompensated care and benefits to the community.[14] The commission compared uncompensated care as a percentage of total costs.[15] In both 1996 and 1997, it found that

[13] Monica Langley, "Nun's Zeal for Profits Shapes Hospital Chain, Wins Wall Street Fans," The *Wall Street Journal*, Jan. 7, 1998, page A1.
[14] Project Hope, "The Community Impact of Hospital Mergers," Bethesda, Md., May 1997.
[15] NOTE: This is a different methodology than CAGW used in this report.

proprietary (for-profit) hospitals gave 4.0 and 4.1 percent in uncompensated care, respectively. Voluntary (nonprofit) hospitals gave an average of 4.5 percent for both years.[16]

"Before citizens rise in indignation over a for-profit hospital moving into their community, they must understand the nostalgic image of "charity" at hospitals is no longer relevant in an age of massive government and private insurance support."

Before citizens rise in indignation over a for-profit hospital moving into their community, they must understand the nostalgic image of "charity" at hospitals is no longer relevant in an age of massive government and private insurance support. Robert Anthony and David Young, experts in nonprofit management, stated with regard to nonprofit healthcare organizations, "Hospitals, nursing homes, health maintenance organizations, clinics, and similar healthcare organizations closely resemble for-profit organizations. Indeed, were it not for the difference in objectives -- service rather than profit -- their management control problems would be similar to those of their for-profit counterparts. There are few differences between a voluntary [nonprofit] and proprietary [for-profit] hospital."[17] CAGW would add that if a for-profit organization, particularly a for-profit hospital, did not provide promised services to its customers, it would be a relatively short time before profit margins would suffer and stockholders would demand change. Ultimately, it is customer service that determines whether a business survives.

A more recent General Accounting Office (GAO) report confirmed our assessment that the acquisition of nonprofit hospitals by investor owned healthcare companies do not have a negative impact on the community. The report, requested by Representatives Pete Stark (D-Calif.) and William Coyne (D-Pa.), reviewed the process that some nonprofit hospitals have used in converting to for-profit status. Rep. Stark, a sharp critic of for-profit hospitals, said earlier this year, "The for-profits' allegiance is to their shareholder, not the community -- and certainly not the uninsured or poor. The for-profit hospital chains have the minds of piranha fish and the hearts of Doberman pinschers."[18] Much to his chagrin, however, the report did not prove these specious allegations.

Instead, GAO found that standard industry methods were used to value the hospitals, and all the hospitals had either an independent (or self-conducted) valuation of their worth; that most of the nonprofit hospitals received multiple bids from potential buyers; and that the negotiated prices allowed the nonprofit hospitals to pay off their debts. Even more important, the negotiated terms of the sales included charity care and service provisions. In most cases, the net proceeds of the sales went to conversion foundations whose missions are to broaden health and wellness in the community, providing millions for charitable purposes. The only major concern expressed by GAO was that the conversions often occur between private boards of the selling and buying hospitals; GAO suggested that more state oversight might resolve this issue. It should be noted that GAO found that the nonprofit boards involved in the negotiations felt they represented the

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[16] Prospective Payment Assessment Commission, "Medicare and the American Health Care System, Report to Congress," June 1996, p. 84, and June 1997, p. 85.
[17] Anthony and Young, "Characteristics of Nonprofit Organizations," pp. 232-233.
[18] Rep. Pete Stark (D-Calif.), "The Pursuit of Profit: Nonprofit Hospitals Become the Big Public Giveaway of the Nineties," *U.S. House of Representatives*, Jan. 9, 1997.

community through their fiduciary responsibilities to protect the nonprofit hospitals' assets.[19]

CAGW obtained a draft of the GAO report before it was released to the public. Interestingly, the results in the November draft report, under the subtitle, "Most Hospitals Agreed to a Purchase Price That Exceeded the Valuation Estimate," showed that in "11 of the 14 cases [nonprofit to for-profit conversions] officials stated that the purchase price was greater than both the single price estimate and the highest estimate in the valuation range."[20] But the release of this draft report was delayed. According to one news source, Rep. Stark said the report would not be released until "concerns" about the data were reviewed.[21] In the final report, this section underwent some significant changes. The final report now has the subtitle, "Hospital Officials Agreed on a Negotiated Purchase Price," and there is *no mention* that the majority of the officials said that the purchase price exceeded the valuation estimate. However, Tables 4 and 6 in the December final report confirm what was stated in the draft release. GAO does mention that in "commenting on a draft of this report, two reviewers raised concerns about conclusions that might be drawn from comparing valuation estimates and the purchase prices."[22] Was pressure put on GAO to change the draft and leave the original, stronger statement out of the final version? You be the judge.

Most hospitals really are profit-making entities. CAGW's review of Washington, D.C. area tax-exempt hospitals, which make substantial "profits" and pay their executives as well as many for-profit corporations, reveals little difference between taxpaying and tax-exempt hospitals, except that one group pays taxes and the other does not. Other independent studies corroborate CAGW's findings. Taxpayers need to make sure their community hospitals are providing value for their tax exemption by following or establishing strict community benefit standards and continuing to question what tax-exempt hospitals are returning to the community in exchange for their free ride.

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[19] U.S. General Accounting Office, "Not-for-Profit Hospitals: Conversion Issues Prompt Increased State Oversight," (GAO/HEHS-98-24), December 1997.

[20] U.S. General Accounting Office, <u>DRAFT</u> "Not-for-Profit Hospitals: Conversion Issues Prompt Increased State Oversight," (GAO/HEHS-98-24), November, 1997, pp 13-14.

[21] Eric Weissenstein, A Favorable Report: GAO finds little to fault in for-profit hospital conversions," *Modern Healthcare*, November 10, 1997, pp. 2-6.

[22] U.S. General Accounting Office, "Not-for-Profit Hospitals: Conversion Issues Prompt Increased State Oversight," (GAO/HEHS-98-24), December 1997, pp 13- 14.