Tax Exemption and Public Accountability

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IN 1990, THE OFFICE OF the Attorney General brought suit against Methodist Hospital in Houston for its failure to provide charity care in accordance with its charitable purposes and status as a tax-exempt institution. This summer the Attorney General's Office supported landmark legislation in the Texas Legislature which effectively settled the questions contained in the suit. Senate Bill 427 was passed by the Senate and House in April and May, respectively, signed by Governor Richards in June, and took effect on September 1 of this year.

S.B. 427 is model legislation. For the first time in the nation, tax-exempt, nonprofit hospitals will be held accountable to the public for the level of charity services provided. As a result, they must plan for, report, and provide or fund specified levels of charity care to their respective communities. The Attorney General's Office has already received a number of inquiries from legislators in other states considering similar legislation.

Under the new law, Methodist Hospital will provide 4% of its net patient revenue, approximately $19 million, in charity care annually. This is an increase of about $14 million over previous years, and is equal to about 100% of their state tax benefits from last year. Furthermore, Methodist has made grants to the hospital district and established a charity care endowment fund.

It is important to understand that the suit against Methodist, and therefore the impetus behind this bill, was based on the fundamental belief that community need should drive health care decisions for nonprofit hospitals. In other words, that competition, profits and marketing should not be the prime motivation behind such decisions. Instead, the issue is one of public accountability, with a focus on the relationship between a hospital's tax-exempt status and its decisions regarding the provision of charitable care.

POLICY CONCERNS

This issue has, of course, been phrased many ways. But the simplest way to phrase it is to ask the question: What are nonprofit hospitals required to do in exchange for their tax-exempt status?

The Utah Supreme Court was the first in recent history to address the issue head-on. In *Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985), the Utah Supreme Court examined a modern nonprofit hospital, questioned the services it was providing in exchange for its tax-exempt status, and found the given Utah hospital lacking.

Government bodies in a dozen or more states have addressed the issue, approaching it differently in just about every state. One approach is based upon an underlying and prevalent policy theme which is revenue-driven: the recognition that taxing districts forego millions of dollars every year in the form of tax-exempt benefits to nonprofit hospitals. Tax exemption is viewed as a direct appropriation of government dollars; the nonprofit is held accountable, and therefore must answer to the state for the use of those dollars.

On the other hand, there is an alternative policy theme which is not revenue-driven, but rather service-driven. This theme considers the nonprofit director's role, and subsequent fiduciary duty, in providing health care to its community. Thus, the policy is still one of accountability, but it is an accountability for serving the community's needs. Undoubtedly, community needs are thought to encompass the neediest aspects of the community, that is, the uninsured or "charity" patients.

In practice, these two policy themes merge and provide the driving force behind attempts to clarify the duties of tax-exempt, nonprofit hospitals. Accordingly, revenue-strapped taxing

authorities enhance their scrutiny of nonprofits, as they look for the means to increase revenue. At the same time, governmental entities concerned with health care policy search for innovative ways to use existing resources to combat a frightful and growing health care crisis.

The Texas Attorney General's approach to the charity care issue has been to focus on accountability primarily from a service, or health policy, standpoint. On the whole, actions have not been revenue-driven, though government accountability for millions of dollars in state tax-exempt benefits was surely a factor in the successful passage of S.B. 427. Thus, accountability has been considered from the standpoint of responding to and serving the community's needs, particularly the needs of the uninsured or charity patients.

Why? Because accountability in serving the community is implicit in a nonprofit hospital's charitable mission, and the director's duty in carrying out that mission.

All nonprofit hospitals are charities, by definition. Consequently, the directors of tax-exempt, nonprofit hospitals have a fiduciary duty to use the hospital's resources for its charitable purposes. This fiduciary duty means that hospital directors have a special relationship to the community. Essentially, they hold assets in trust for the public and are responsible for managing them for the public benefit and in accordance with their charitable mission. And this public benefit and charitable mission includes serving the uninsured or charity patient. Thus, in order to carry out their purposes effectively, directors must assess and respond to the needs of the public they serve.

Accountability may sound like one of those onerous words that to some translates into "government interference." But it really is an opportunity and a challenge for nonprofit hospitals to repond to the communities they were created to serve. It is the service providers, like hospitals, that are confronted on a daily basis with the very real, tough, and seemingly insurmountable health care problems facing the community. The current health care crisis presents an opportunity for nonprofit hospitals to refocus attention on their communities at a grass-roots level, to grapple with some of the most serious issues facing our citizenry today, and to play a part in finding solutions for these issues.

Senate Bill 427 provides the necessary framework for hospitals to use in finding creative answers to these community needs. In so doing, it reflects the policy belief that hospitals should respond to community needs, including the needs of those less fortunate, by requiring community benefits planning and by setting forth minimum levels of charity care. Community benefits planning provides a method to assess community health care needs, and subsequently, to direct hospital resources where they can be most effective. While nonprofit hospitals cannot, and should not, be expected to solve all the health care problems existing in their vicinity, community benefits planning does offer a way for hospitals to be more creative and effective in those health care services that they can provide.

As mentioned earlier, S.B. 427 is the first legislation in the country holding tax-exempt, nonprofit hospitals accountable to the public for charity care, and it covers four major areas: (1) Charity Care; (2) Community Benefits Planning; (3) Uniform Reporting; and (4) Tax Exemption.

It has been suggested that S.B. 427 would likely require amendment in the wake of the Clinton Health Care Plan. Certain provisions might need to be reviewed at the point that universal coverage becomes a reality and the charity care needs of communities have been solved. Until that time, however, the bill's charity care formulas remain appropriate and needed.

Further, the basic accountability policy behind S.B. 427 is consistent with health care reforms. Refocussing on community need through community benefits planning and reporting to the public are basic requirements for nonprofit hospitals to serve the public.

A more fundamental question — that may require even more attention as uncompensated care is eliminated for

hospitals — is the basic question of what separates nonprofits who get tax exemption from for-profits that don't. If it is not charity care, is it community benefits in general? Or, as some would argue, simply the provision of medical care through the nonprofit form which prohibits the distribution of profits to private individuals?

CHARITY CARE

Charity care is designed to cover only those without the resources to pay for care, as these are the people who have the most difficulty accessing health care services. As a result, its definition is necessarily limited to those falling into two distinct categories: the "financially indigent" and the "medically indigent." Charity care is strictly defined and does not include bad debt, contractual allowances or Medicare contractuals.

The "financially indigent" appellation basically refers to the uninsured or underinsured low-income person, while "medically indigent" covers insured persons who have depleted their financial resources due to catastrophic illness. Essentially, the bill allows charity care to be provided in either of two ways: by the hospital itself, to inpatients or outpatients, or by its funding of other entities that provide care to those in the financially indigent category. This provision merely recognizes that services outside the hospital setting, e.g., preventive care, are often the most effective use of hospital resources for the community. Either way, the hospital is credited for its help in meeting community needs.

Senate Bill 427 also defines community benefits in recognition of the fact that hospitals provide services in addition to charity care that also benefit the community. Community benefits are used in the bill in three ways: (1) through reporting to the Health Department; (2) through community benefits planning, which includes planning for other community benefits, as well as charity care; and (3) through the counting of community benefits toward satisfying one of the charity care standards. "Community benefits" is thus used as an umbrella term of which charity care is but one subset.

Community benefits include charity care, Medicaid, donations, education, Medicare, research, and subsidized health services like neonatal intensive care and trauma care. While S.B. 427 defines these community benefits as precisely as possible, the definitions are necessarily fairly broad. This is due to the policy rationale behind this section of the bill — to capture as much information as possible about how hospitals provide services. As a result, hospitals will now report this data by categories which should render a much clearer picture of what is being provided.

Under S.B. 427, charity care and other community benefits will be calculated and reported at cost, using Medicare cost to charge ratios. Costs will be reduced by reimbursements, however, with unreimbursed costs defined as a hospital's costs after subtracting payments *from any source* for such service.

The definition of charity care also includes a method for identifying charity patients. Under Senate Bill 427, hospitals will calculate charity care by categorizing patients as financially or medically indigent. This will require hospitals to establish "hospital eligibility systems" to determine whether or not a patient falls into either category. While the bill sets out a framework for such a system, it allows the hospital to decide exactly how to establish a system within the framework. The framework includes a determination of income levels in addition to means testing indexed to the federal poverty guidelines.

S.B. 427 furthermore establishes a bracket for the financially indigent. As a result, the income level for charity care eligibility cannot be higher than 200% of the federally defined poverty income or lower than the level required of counties under the Indigent Health Care Act, that is, the income level required by Medicaid. Finally, charity care eligibility does not have to be determined at the time of admission, but may be determined after services are provided. However, the Attorney General's Office does not interpret this to allow a charity care determination after a collection action has begun. Instead, collection activity is inter-

preted as an indicator of bad debt, not charity care.

Perhaps the most controversial section of the bill is that which sets the standards for charity care, that is, the inclusion of formulas to determine the level of charity care required. It should be noted that the bill allows hospitals to count the unreimbursed cost of government sponsored indigent care programs, i.e., Medicaid, toward satisfying the charity care formula. Because these programs are based on financial need, they are not actually included in the definition of charity care.

S.B. 427 had no formulas in its original form. Instead, only a standard of reasonableness was included, based on the legal principle that the fiduciary duties of nonprofit hospital directors would require them to exercise prudent business judgment in setting charity care budgets, by considering factors such as community need, hospital resources, and tax-exempt benefits.

S.B. 427 still includes this reasonableness standard. But it also contains more specific formulas, added at the request of those hospitals who wanted more certainty in the process. These formulas are based on percentages of two different numbers: the value of tax-exempt benefits and net patient revenue. These standards are intended to be minimum floors, not ceilings. The legislative intent is clear that these formulas should not be viewed as caps.

In terms of reporting, hospitals are allowed to choose which standard to satisfy and report that choice to the Health Department and the taxing bodies. And while the bill does not specify any particular form which must be utilized in reporting this information, the Attorney General's Office will be working with all enforcement agencies in an effort to establish standard forms for this reporting requirement.

The starting point in setting a charity care formula was the policy that nonprofit hospitals should provide charity care equal to 100% of the tax subsidy received from the state. The value of all state taxes foregone are included — specifically property, franchise, and sales taxes — plus contributions and the value of tax-exempt bond financing. The calculation of these tax-exempt benefits can be difficult, particularly for property taxes, because appraisal districts usually do not appraise exempt property.

S.B. 427 contains an alternative formula based on net patient revenue that has the advantage of being simpler and more straightforward to calculate. Under this formula, a hospital must provide at least 4% of net patient revenue as charity care.

The bill also contains a phase-in formula which accounts for community benefits as well as charity care. This formula requires 5% of net patient revenue divided as follows: for the first two years — 3% charity, 2% community benefits; thereafter — 4% charity, 1% community benefits.

COMMUNITY BENEFITS PLANNING

S.B. 427 also requires community benefits planning, which simply means that hospitals must include planning for community needs as part of the normal planning process. The importance of such planning cannot be overemphasized. Community benefits planning holds out the promise of hospitals working in partnership with the community to improve access to health care, and potentially the health of the entire community.

Several guides to community benefits planning have been developed by the hospital industry. Perhaps the most widely known is the Catholic Healthcare Association's Social Accountability Budget, a practical, step-by-step guide for use in planning for hospital services.

The community benefits planning section of S.B. 427 is based on planning guides like the Social Accountability Budget, in addition to a New York State statute requiring such planning by its hospitals. Senate Bill 427 preserves a hospital's discretion, however, by mandating only the most basic elements of community benefits planning. The bill simply requires hospitals to develop two documents, an organizational Mission Statement and an operational Community Benefits Plan, to be based on a community-wide needs assessment. The Plan must also include such basic

elements as goals, objectives, evaluation mechanisms, and budgeting.

The rationale for requiring such plans is evident. For example, twelve public, private and nonprofit hospitals in Houston have recently joined with city and county health departments in funding a comprehensive effort to assess health care needs. This action is being viewed as a model initiative which will: (1) establish a basis for reducing unmet health needs; (2) allow the community to develop a collaborative strategy for efficient health care delivery; and (3) develop the capability for on-going community health needs assessment. The hospitals are planning to use this needs assessment data to work together in addressing these needs.

UNIFORM REPORTING

The third major subject of Senate Bill 427 is reporting, both to the community and to state agencies. Accountability is, once again, the policy consideration behind making such information about hospitals' charity care and community benefits readily available. Under the former law, all hospitals (public, private and nonprofit) were required to report financial and utilization data to the Health Department on an annual basis.

S.B. 427 amended that law to provide a uniform definition of charity care and education, and to additionally define other community benefits not formerly reported such as subsidized health services, donations, and research. Thus, all hospitals will be reporting data to the Health Department according to uniform definitions, and Texas will garner a much clearer picture of what particular hospitals provide to a community, both in terms of charity care and community benefits.

In addition, S.B. 427 reporting requirements further public accountability in two important respects. First, the bill removes the former confidentiality provision and makes all hospital financial data public from September 1987 forward.

Second, the bill contains two public disclosure requirements: (1) hospital notification to the public that the community benefits plan is available; and (2) that the hospital inform those seeking care about what the charity care program is and how to apply.

Finally, hospitals also must file a copy of their community benefits plan with the Health Department, and the Health Department may assess civil penalties for failure to report the community benefits plan.

TAX EXEMPTION

The last section of S.B. 427 to be discussed is its requirements for tax exemption. The bill's amendments to the tax code incorporate the charity care and community benefits standards, i.e., the formulas, into the exemption requirements for property, sales, and franchise taxes. Consequently, the local appraisal districts and the comptroller's office have the authority to revoke tax exemption if the charity care standards or formulas are not met.

The Attorney General's Office also has the authority to enforce S.B. 427. The bill provides that other remedies available to the state are not limited in any way. Thus, the Attorney General's Office continues to have enforcement authority through its common law responsibility for overseeing the actions of nonprofit hospitals. As a result, if a nonprofit hospital fails to satisfy any portion of the bill, it could be considered a breach of the hospital's fiduciary duty to the public, for which the Attorney General's Office could reasonably file suit.

Senate Bill 427 is an example of legislation which balances the need to refrain from too much specificity that hinders the efforts of nonprofit hospitals doing their best to serve the public, with the need to impose some meaningful requirements on those hospitals that have ignored their responsibilities. The current health care crisis has presented an opportunity for nonprofit hospitals to grapple with some of the most serious problems facing society today, and to play a role in finding solutions for them.

Senate Bill 427 provides the springboard from which nonprofit hospitals can move forward in finding more creative and efficient means of answering their communities' needs. The minimal requirements of S.B. 427 simply provide a start. The hospitals themselves must now meet the challenge. ❖