Health Care Reform: A Threat to Property Tax Exemptions for Hospitals?

By Michael J. Wynne

On March 22, 2010, a day before the Patient Protection and Affordable Care Act became law, the headline of a New York Times article announced “In Health Reform, Bonuses for Hospitals and Drug Makers.” The article predicted that 32 million additional paying customers in the next few years will be “better able to pay for hospital stays, doctor visits, prescription drugs, and medical devices.”

Five days prior, the Illinois Supreme Court denied a Catholic hospital a property tax exemption in Provena Covenant Medical Center v. Department of Revenue. The Court denied the exemption primarily because the amount of charity care provided by the hospital was not substantial enough to demonstrate a charitable use of the property.

However, the chilling national repercussions some portend for the Provena Covenant decision, with its inquiry into how much charity is enough to justify a property tax exemption, may ultimately be dwarfed by the repercussions of the new federal healthcare legislation. In 2014 the new healthcare law will extend coverage to households with income up to 133% of the federal poverty level, and will offer subsidies to purchase insurance from state insurance exchanges for those below 400% of the federal poverty level. With Medicaid and Medicare, this extended coverage will displace much of the charitable patient care that hospitals have traditionally dispensed, and it may undermine support for local exemption for hospital properties.

STATE EXEMPTION STATUTES

Most state property tax laws do not exempt hospital property. In many states, the general charitable exemption is applied only to property used by nonprofits to provide medical care to those unable to pay for their care. The state charitable exemption standards generally predate those used to grant federal income tax exemption under Internal Revenue Code Section 501(c)(3), often embodying a 19th-century concept of “charity” that ill-fits modern times but that is embedded in, and limits the scope of, the states constitution’s authorization for exemptions.

FEDERAL EXEMPTION STATUTE

How much free care is “enough care” for a hospital to obtain a charitable income tax exemption has long been a focus under the Internal Revenue Code, which does not include a specific exemption for hospitals and does not define an exempt purpose to include the promotion of health. In the 1950s, the IRS held that to qualify as a charitable organization a hospital must operate to the extent of its financial ability for those not able to pay for services and not exclusively for those who can and are expected to pay, and that the hospital must not ordinarily refuse to accept patients in need of care who are unable to pay.

Since the advent of Medicare and Medicaid, the IRS has used a “community benefit” standard to determine whether a nonprofit hospital is exempt. That standard has relaxed over time, but providing free or below-cost services to the poor is still a factor that may demonstrate a hospital promotes health for the benefit of the community.

POSSIBLE OUTCOMES

Beginning in 2014, as the pool of indigent patients significantly dries up or disappears, the facts will tilt more heavily in favor of local governments seeking to deny charitable exempt status to hospital property.

In a state that considers hospital property eligible for the general charitable exemption, a standard similar to the federal “community benefit” standard could be adopted by legislation. In states where the state constitution imposes limits on the types of property tax exemptions, adopting a “community benefit” standard by legislation may not be a workable solution.

Another legislative option would be to mandate a reduced assessment level for hospitals, allowing maximum flexibility for the legislature to consider factors other than charity that warrant state support of hospital operations.

Barring a proactive legislative solution, the property tax bills will be coming. Utilizing supportable data, qualified knowledgeable experts and experienced counsel, hospitals should not wait until 2014 to prepare their case for a reasonable and fair valuation of their property. Doing nothing will not be a good option.

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Is Your Ethics Committee Ready for the “Next Generation?”

By Rosa Lynn Pinkus, PhD, and Sarah Sudar

University of Pittsburgh Consortium Ethics Program

In 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now the Joint Commission, mandated that hospitals establish a “mechanism” for addressing ethical issues that arise in patient care. Hospitals were left to decide what kind of “mechanism” to use, with most forming ethics committees. The focus of these committees was essentially clinically-oriented and included ethics education, policy formation and consultation. A survey published in the American Journal of Bioethics indicates that by 2000, 95 percent of the hospitals surveyed had or were in the process of developing an ethics consultation service. Only 41 percent of the individuals who performed ethics consultations had learned to perform them with formal, direct supervision by an experienced member of an ethics consultation service.*

Over the last two years, the success of ethics committees has varied, depending on the education received by committee members and resources available to them, as well as how “well-respected” they were in the hospitals. In an effort to begin standardization of the education of ethics committee members, the American Society for Bioethics and Humanities (ASBH) developed “Core Competencies” guidelines for ethics consultation in 1998 and later revised in 2009. A consensus among professional ethics societies seems to be that these competencies must be mastered by members of committees, especially those members performing ethics consultations.

In addition to the identification of “Core Competencies” for clinical work, ethics committees may be faced with a new mandate: merging clinical and organizational ethics. Referred to as “Integrated Ethics” by the U.S. Department of Veterans Affairs, this focus includes tracking and evaluating the decisions made by ethics committee. Also, it focuses on broadening a committee’s scope in education, policy formation and consultation to reach all levels of the organization. The ASBH is considering adopting a similar model called, “Next Generation Ethics.”

In an effort to provide “cutting edge” education to the members of the Consortium Ethics Program, we have enlisted the expertise of James Sabin, MD, of Harvard Medical School, to address this new charge. Last October, Dr. Sabin spoke with members of the CEP about his 10-year work with Harvard Pilgrim Health Plan and what he learned about the transition of ethics from the “bedside to the boardroom.” He advised members of ethics committees to become knowledgeable about hospital administrative functions, cultivate links to high level administrative leadership, interview leaders about opportunities and risks in taking on organizational-level issues, broaden program/committee membership in accord with the expanded purview, create a gradual learning curve for both clinical and managerial participants, start slowly and apply a try-it-fix-it approach.

While new mandates continue to develop, the foundation of every ethics committee has remained the same: education. From basic foundations and principles of health care ethics to targeted education for ethics committees and ethics consultants, the CEP assists the ethics committees of member institutions with development, revitalization and ethics education. As the ethics needs of health care systems change, the CEP’s programming changes to meet these needs.

To learn more about the CEP or to inquire about membership, visit www.pitt.edu/~cep or call 412-647-5834.