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Community(-specific) benefit

Tax-exemption rules must allow hospitals the flexibility to meet local needs

Just north of Lebanon, Kan., sits a picnic table where visitors come to contemplate their surroundings. There is nothing unique about Lebanon except that it sits squarely in the geographic center of the contiguous U.S. If members of Congress and other policymakers visited this pasture, they would see that in any direction they looked storm clouds are gathering for America's 3,000 not-for-profit hospitals.

East to Washington lies proposed new regulations aimed at limiting charitable deductions. If passed by Congress, not-for-profit hospitals could lose more than \$1 billion in donations annually, according to the Association for Healthcare Philanthropy.

To the west lies California, where tax-exempt financing has dried up, donors are re-evaluating portfolios and nagging unemployment is pushing uncompensated care to an all-time high. The conditions Californians face are emblematic of what is occurring from coast to coast.

Looking south is an influx of immigrants who continue to challenge our nation's not-for-profit hospitals through language barriers and inadequate health insurance. Sadly, health reform ignores this reality, just as it fails to address the need to focus on prevention and primary care for those who don't have traditional health coverage.

Most troubling is north, in Iowa, the home state of Republican Sen. Chuck Grassley, who advocates for new methodologies for demonstrating community benefit. These proposals threaten the existence of tax-exempt status and the ability of not-for-profit hospitals to provide charity care or invest in education, preventive services or other community programs.

Not-for-profit hospitals are the backbone of our nation's healthcare system. The Internal Revenue Service introduced the 501(c)(3) status specifically to guarantee that not-for-profits could continue to fulfill their mission without the financial burden of tax liabilities. The Supreme Court has agreed, saying that because charitable organizations already provide public resources and services that the government—and ultimately the taxpayers—would otherwise be forced to finance, such organizations should not have to contribute additional money to the government.

While all hospitals may look the same from the outside, there are significant differences in operating philosophies. Not-for-profit hospitals are subject to non-distribution constraints that demand they invest all surplus revenue into operations that benefit the community. This distinction provides the resources needed to fund necessary, yet often unprofitable, services. They are the exact kind of programs for-profits usually don't offer, given their pressures to manage quarterly earnings and shareholder demands.

Their organized efforts of giving back to the community include:

- Charity care for those patients unable to pay. Charity care also includes the hospital absorbing the differences between the actual cost of the care and the amount of money received for patients covered by Medicare and/or Medicaid. Even under healthcare reform, there will still be uninsured or underinsured patients.

- Health research, education and training including clinical research, graduate medical education programs, scholarships and continuing education in nursing and many



Locally differing needs and a changing healthcare system require loosely written IRS rules.

other disciplines. National research has shown that hospitals where such programs exist produce improved patient outcomes.

- Benefits directed at vulnerable populations and the community-at-large, such as seniors, ethnic minorities and those suffering from specific diseases. It also includes health screenings, community health fairs, flu shots and charitable donations to others doing preventive care.

Beyond these formal measures, many not-for-profit hospitals continue to provide critically important—yet money-draining—services that would otherwise be absent from the community. These “unduplicated services” may include trauma care, geriatric psychiatric services or pediatric care.

Grassley wants to establish a universal representation of what should constitute a not-for-profit hospital, threatening to revoke the tax-exempt status of those who don't qualify under the new metric.

We have nothing against accountability and support the American Hospital Association's call for hospitals to “voluntarily, publicly and proactively report to their communities on the

full value of benefits” they provide. But let's remember that the IRS intentionally made the requirements vague to allow not-for-profit hospitals to meet the demands of not only their local communities but of a changing healthcare system. It is this very attribute of ultimate local accountability—to be nimble without the involvement of Washington or bureaucratic machinery—that allows not-for-profits to do the most good for the most people.

It is everyone's role to keep the spirit of not-for-profit healthcare alive. For some, that means volunteering at their local institution or getting involved with board governance. Others contribute by advocating to their elected officials on the hospital's behalf or by giving financially. All of this is needed.

In the final analysis, not-for-profit hospitals do more than provide state-of-the-art healthcare. They make a difference in their communities while remaining true to their mission and basic principles. Regardless of weather, they forge ahead, and that's a quality that everyone—including those sitting on that bench in Kansas—should work hard to preserve, protect and defend. <<

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