



The Hilltop Institute

analysis to advance the health of vulnerable populations

Nonprofit Hospitals: Earning Their Tax-Exempt Status Tying Medicaid Coverage to Tax Exemption

October 6, 2009

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NASHP Conference

Preview of Presentation

- Brief history of the relationship between tax-exempt status and insurance coverage
- Trends in insurance coverage
- Financing public insurance: potential roles for tax-exempt hospitals
- Related considerations

Brief History of the Relationship between Tax-Exempt Status and Insurance Coverage

Exemption from federal taxes always loosely tied to demand for charity care

- IRS Rev. Ruling 56-185: A hospital “must be operated to the extent of its financial ability for those not able to pay . . .”
- Medicare and Medicaid enacted in 1965, and theoretically virtually all patients presenting at tax-exempt hospitals are insured.
- IRS Rev. Ruling 69-545: “Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements related to caring for patients without charge.”
 - Other “community benefits” justify tax-exemption, such as operating an emergency room open to all; training health care professionals; and investing in public health and health promotion.
- State and local governments may set individual standards.

As the uninsured rate increased, charity care again became ascendant as a condition of tax exemption

- “Non-profit hospitals receive **billions in tax breaks** at the federal, state and local level. The public has a right to expect significant, **measurable benefits in return** . . . Let me end by saying that the GAO and the IRS have both commented that there is often little to no difference between for-profit hospitals and non-profit hospitals when it comes to charity care. . .” - Sen. Charles Grassley, September 13, 2006, Opening Statement at Senate Finance Committee hearing entitled “Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals.”
- “The **provision of charity care by tax-exempt hospitals is an important subject**. It has significant implications for both hospitals and the federal treasury. But it is also important **because it raises one of the most pressing problems facing our nation — that 46 million Americans have no health insurance. Arguably, if all Americans had health insurance, we would not be having this discussion.**” - Sen. Max Baucus, September 13, 2006, Opening Statement at the same hearing.

Trends in Insurance Coverage

In recent years, the uninsured have grown, as has the burden on Medicaid and SCHIP

Percent Change by Coverage Type, 2004-2007

Coverage Type	Children (0-18)	All Non-Elderly (0-64)
ESI	-1.5 percent	-0.8 percent
Individual Insurance	-0.1 percent	-0.1 percent
Medicaid/SCHIP	+1.1 percent	+0.3 percent
Other insurance	No change	+0.3 percent
Uninsured	+0.4 percent	+0.3 percent

Source: statehealthfacts.org

Financing Public Insurance: Potential Roles for Tax-Exempt Hospitals

Statement of Concept

- Tax-exempt hospitals enjoy significant tax breaks from state and local government, such as:
 - Property tax
 - State corporate income tax
 - State sale tax (on purchases made by the hospital)
 - Subsidized cost of borrowing capital, with tax-exempt bonds
- As a condition of enjoying exemption from state and local taxes, these hospitals could be expected to deliver charity care, serve a disproportionate volume of Medicaid and SCHIP beneficiaries, and/or contribute to the financing of public insurance programs.

1. Compliance: one-time revenue from discrete hospital to enforce community benefit standard

- Specific tax-exempt hospitals that are failing to deliver a community benefit under state and local tax exemption laws may be challenged by state tax authorities or Attorneys General
- Settlements may be directed to state or local treasury, or tax-exempt status revoked
- Example of principle: in February 2005, Pennsylvania settled with four tax-exempt Blue Cross Blue Shield health plans, resulting in \$950 million over six years

2. Budget neutral: re-direct Medicaid supplemental safety-net “charity” care fund toward coverage

- Nonprofit, tax-exempt hospitals receive a disproportionate share of supplemental safety-net provider funds in most states:
 - Disproportionate Share Hospital (DSH) fund
 - Various upper payment limit (UPL) funds
- Where tax-exempt hospitals fail to meet some threshold for charity care, make them ineligible to participate in these funds; redirect their share to the state general fund for Medicaid/SCHIP coverage
- Or, overtly redirect some portion of overall fund toward coverage, regardless of hospital behavior, on theory that coverage will reduce the burden of uncompensated care by hospitals (e.g., Massachusetts)

3. New revenue: impose a pseudo tax to finance coverage programs that benefit tax-exempt hospitals

- Maryland “taxes” nonprofit HMOs:
 - “Nonprofit health maintenance organization means a health maintenance organization . . . that is exempt from taxation under §501(c)(3) of the Internal Revenue Code. . .”
 - “Premium tax exemption value means the amount of premium taxes that a nonprofit health maintenance organization ***would have been required to pay if the nonprofit health maintenance organization were not exempt from taxation. . .***”
 - “A nonprofit health maintenance organization ***shall transfer funds in an amount equal to the premium tax exemption value of the nonprofit health maintenance organization to the Medical Assistance Program Account. . .***” *
- A similar approach could be used in states to “tax” nonprofit, tax-exempt hospitals

4. Rate alignment: adjust Medicaid reimbursement rates as coverage changes from charity to Medicaid

- In Maryland, there is an “all-payer” hospital rate-setting system, and the hospital rate-setting commission determines each hospital’s uniform reimbursement rate for all payers
- All 47 general acute care hospitals are nonprofit, tax-exempt providers
- Uncompensated care related to uninsured patients is explicitly built into each hospital’s all-payer rate (that is, explicitly cost-shifted to a uniform reimbursement rate for all payers)
- A Medicaid coverage expansion for childless adults was approved by the Legislature and Governor in 2008, and the financing largely is derived from the effect of this all-payer rate-setting system
- Accomplished in an 1115 waiver context
- Dynamic illustrated on next slide

Medicaid's reimbursement rate decreases, as the uninsured move into Medicaid

- Medicaid's unit rate decreases
- The unit rate and total cost for other payers decrease
- Medicaid's total cost increases, but half of \$410 increase is federal match (FFP)
- State needs \$205 match, and charity care burden down by \$500; get from tax-exempt hosps.?

Before Expansion

Payer	Patients	Daily Cost	Total Cost	Daily Rate	Total Revenue
Commercial	40	\$100	\$4,000	\$111	\$4,444
Medicare	30	\$100	\$3,000	\$111	\$3,333
Medicaid	20	\$100	\$2,000	\$111	\$2,222
Uninsured	10	\$100	\$1,000	NA	NA
Total	100		\$10,000		\$10,000

After Expansion

Payer	Patients	Daily Cost	Total Cost	Daily Rate	Total Revenue
Commercial	40	\$100	\$4,000	\$105.3	\$4,212
Medicare	30	\$100	\$3,000	\$105.3	\$3,159
Medicaid	25	\$100	\$2,500	\$105.3	\$2,632
Uninsured	5	\$100	\$500	NA	NA
Total	100		\$10,000		\$10,000

Related Considerations

Major Related Considerations

- Tax-exempt hospitals disproportionately serve people ineligible for coverage (undocumented aliens)
- Tax-exempt hospitals disproportionately serve people in remote and critical access areas
- Tax-exempt hospitals disproportionately provide other community benefits enumerated in Rev. Ruling 69-545

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and social outcomes of vulnerable populations. Hilltop conducts research, analysis, and evaluation on behalf of government agencies, foundations, and other non-profit organizations at the national, state, and local levels.

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