Bond Case Briefs

Municipal Finance Law Since 1971

Commentary: Significant Tax Exemption Concerns Arise for the Health Care Industry.

An unmistakable theme arising from the Tax Cuts and Jobs Act is increasing Congressional skepticism that nonprofit hospitals and health systems deserve the benefits associated with tax exempt status under Section 501(c)(3) of the Internal Revenue Code. This skepticism is reflected not only in the final exempt organization provisions of the Act, but also in several significant proposals that surfaced in, but did not ultimately withstand, the full legislative process.

This theme, and the long-term sustainability of tax exemption benefits, present significant planning concerns for advisors and counsel (e.g., underwriters' counsel, bond counsel, borrower's counsel, borrower's general counsel) in the municipal bond sector as they relate to debt issued by tax exempt hospitals and health systems. These concerns exist notwithstanding the fact that the final version of the Act preserved tax exemption for interest on private activity bonds. Greater organizational effort will need to be expended in the future to support continued claims to overall tax exempt status. This includes a governing board that will be more engaged in assuring operation for charitable purposes.

Many provisions of the Act are punitive to tax exempt health care. They begin with the elimination of advance refunding bonds (i.e., bonds issued to refinance existing bonds that are not callable within 90 days of the related issuance). They continue with provisions that may increase organizational unrelated business income tax (UBIT) exposure through the new prohibition against offsetting profits and losses from various unrelated enterprises, and provisions that subject tax exempt employers to UBIT on the value of certain employee entertainment, club dues, qualified transportation and a variety of other fringe benefits. And they accelerate with the new excise tax on compensation in excess of $1 million to "covered employees". The new excise tax applies not only to current compensation but also to all forms of deferred compensation and to "excess parachute payments."

Individually and collectively, these new provisions present significant tax planning challenges for tax exempt health care systems. As it relates to compensation in particular, these provisions place such systems at a significant disadvantage compared to privately-held, for-profit competitors in connection with executive level talent recruitment and retention.

But equally instructive were the series of punitive proposals made at some point in the legislative process but not included in the final bill. In many ways these are more illustrative of the mood of Congress towards the tax exempt hospital sector.

Most prominent among these was the provision of the House bill that served to eliminate the tax exemption for interest on private activity bonds, which alarmed, appropriately, the nonprofit sector. If enacted, it would have served to deny to tax exempt hospitals a traditional and critical vehicle for financing major capital expenditures. The House bill would also have increased UBIT exposure with respect to certain types of research conducted by tax exempt organizations.

Other proposals (beyond the excise tax as enacted) related to the manner in which tax exempt

hospitals compensate their highest paid executives. The Senate Finance Committee "Chairman's Mark" proposed sweeping changes to the tax rules relating to nonqualified deferred compensation under Code Section 457. The Finance Committee attempted to essentially eviscerate the "Rebuttable Presumption of Reasonableness" guidelines under the intermediate sanctions rules of Code Section 4958.

Proposed changes to the intermediate sanctions regime included not only the elimination of the "RPR", but also provisions that would have (i) increased the personal financial exposure of "organizational managers" who approve excess benefit transactions; (ii) removed as an affirmative defense to excise tax liability the reliance on professional advice; (iii) added new categories of "disqualified persons" subject to intermediate sanctions; and (iv) imposed an additional excise tax on the exempt organization itself in the case of an excess benefit transaction (contrary to the historic policy of the intermediate sanctions regime).

In many respects, the concerns expressed in the recent legislative process are consistent with those expressed in the past by senior IRS Exempt Organizations officials and longstanding legislative concerns that the nonprofit health care sector is inexorably drifting towards the purely commercial sector (and thus should be taxed accordingly). These concerns have included the consistency of exempt status with several factors: e.g., (i) the emergence of the "nation-sized" nonprofits—organizations that are national (or even global) in scope and scale; (ii) the blurring of the line between tax exempt and commercial health care; and (iii) highly complex, lucrative executive compensation arrangements. Many of these concerns—and their compatibility with the community benefit standard— remain relevant today.

To be clear, the sky is not in imminent danger of falling. Despite the troubling theme that emerged during the tax reform process, tax exempt financing and the nonprofit health care sector remain alive and well. Yet the message from the Act is clear, and the unprecedented revocation of two hospitals' tax exemptions by the IRS in a single year,[1] sends a parallel message. Both the governing board and executive leadership of health systems must invest greater effort toward communicating—for both internal and external audiences—how the delivery of health care services through a tax exempt, non-profit model is distinguishable from the delivery of such services through a proprietary model.

Such efforts can be highlighted through tangible steps: e.g., emphasizing the achievement of charitable purposes through the strategic plan; including language in board resolutions about how specific board actions reflect the intention that those actions serve charitable purposes; highlighting research and education; confirming that the compliance officer monitors compliance with the various Section 501(r) requirements for charitable hospitals; and negotiating provisions in key service agreements, joint venture agreements and major transaction documents that preserve the tax exempt organization's control over exempt purposes and prevent unreasonable benefits to private parties.

Advisors who work with tax exempt hospitals and health systems on private activity bond issuances should anticipate the need to focus on the strength of the borrower's underlying claim to tax exempt status much more than in the past. Borrowers must not wait until a pending bond issuance to review and strengthen their documentation and operations with respect to these key issues.

The Bond Buyer

By Michael W. Peregrine & Erika Mayshar

January 16, 2018

[1] See Priv. Ltr. Ruls. 201731014 (Feb. 14, 2017) and 201744019 (Aug. 7, 2017).

The authors wish to thank their partner, Lisa Kaderabek, for her assistance in preparing this article.

Michael W. Peregrine is a partner at the law firm of McDermott Will & Emery.