

BUILDING A BETTER FUTURE TOGETHER



CLU | COMMUNITY
LABOR
UNITED

The NonProfit City: The Impact of Boston's Teaching Hospitals on Our Community

A PUBLICATION OF COMMUNITY LABOR UNITED

8 Beacon Street
Second Floor
Boston, Massachusetts 02108

www.massclu.org

The NonProfit City: The Impact of Boston's Teaching Hospitals on Our Community

A PUBLICATION OF COMMUNITY LABOR UNITED

Community Labor United

Community Labor United (CLU) is a coalition of community and labor organizations that run joint campaigns to counteract the growing gap between rich and poor, while highlighting the connections between jobs and community issues. Our mission is to protect and promote the interests of working class communities in the Greater Boston region. CLU unites many of the strongest community organizations and unions in our region to drive forward policies that promote quality jobs, secure healthcare, affordable housing, job access, and environmental justice for the area's low and moderate-income people. Through collaborative research, leadership development and organizing, CLU unites our organizations and communities around a common vision and plan of action.

CLU carries out two types of research: campaign research that helps to frame and support our campaigns, and policy research on other issues of concern to working class communities in our region. In 2006, we published *The Hourglass Challenge: Creating a More Equitable Economy for Greater Boston*, which examines a range of policy and organizing opportunities for stemming this region's rapidly growing economic and racial inequality.

Community Labor United



Board of Directors

Chair: Richard Rogers, *Secretary-Treasurer, Greater Boston Labor Council*
Treasurer: Lauren Jacobs, *Organizing Director, SEIU Local 615*
Clerk: Tom Callahan, *Executive Director, Massachusetts Affordable Housing Alliance*
Fausto DaRocha *Executive Director, Brazilian Immigrant Center*
Enid Eckstein *Vice-President, 1199 SEIU*
Tom Flynn *Political Director, NE Council of Carpenters*
Penn Loh *Executive Director, Alternatives for Community & Environment*
Roxan McKinnon *Executive Director, City Life/Vida Urbana*
Warren Peppicelli, *Manager/Vice-President UNITE HERE*
Naemi Ramos *Head Organizer, ACORN*
Jim Snow, *Director of Organizing, Painters & Allied Trades DC35*

Strategy Committee

Alternatives for Community and Environment (ACE)
Associations of Community Organizations for Reform Now (ACORN)
Boston Teacher's Union (BTU)
Brazilian Immigrant Center (BIC)
Chelsea Collaborative
Chinese Progressive Association (CPA)
City Life/Vida Urbana (CLVU)
Greater Boston Labor Council (GBLC)
Massachusetts Affordable Housing Alliance (MAHA)
New England Council of Carpenters (NERCC)
Painters and Allied Trades, DC 35 (IUPAT)
Project RIGHT
Service Employees International Union (SEIU) Local 615
1199 Service Employees International Union (SEIU)
UNITE HERE
Union of Food and Commercial Workers (UFCW) Local 1445

CLU Staff

Lisa Clauson, *Executive Director*
Darlene Lombos, *Organizing Director*
Kalila Barnett, *Senior Organizer*
Mary Jo Connelly, *Research Director*

The Nonprofit City: The Impact of Boston's Teaching Hospitals on Our Community

Table of Contents

Table of Contents	3
Acronyms and Abbreviations Used in this Report	5
Executive Summary	6
I. INTRODUCTION	10
Hospitals As Profit Generators.....	12
II. PAYING THEIR FAIR SHARE? MUNICIPAL IMPACTS OF AMCs	14
Twin Problems: Overburdened Taxpayers, Underfunded Municipalities.....	14
PILOT: A Policy Tool to Address Nonprofit Tax Exemption	16
The Country's Most Pro-Active PILOT Program	16
Fair Share Taxation.....	17
Efforts to Legislate PILOTs.....	18
Property Tax Impact of Boston Medical Facilities.....	19
The PILOT Gap	20
What Difference Could The Additional Revenue Make?.....	22
III. PROVIDING GOOD JOBS AT GOOD WAGES?.....	23
What would an equitable labor market look like?	23
Troubling Aspects of Boston's Hospital Labor Market.....	25
Racially Diverse Workforce Only in the Lower-Paid Positions.....	25
Few Training and Advancement Opportunities for Lower-Wage Workers	25
Wages in Boston's AMCs: Don't Meet Basic Needs for Two-Thirds of Employees.....	26
CEO Compensation	30
No Health Care for Many Hospital Workers.....	30
IV. CHARITY CARE.....	33
Uncompensated Charity Care Contributions.....	35
V. CONCLUSION.....	37
Appendix: Methodology	39
Endnotes.....	42

Acknowledgements

We would like to thank the many individuals who contributed to this report.

Researchers & Data Analysts:

Principal Investigator and Author: Robb Smith, former CLU Research Director

Contributing researchers: Elisabeth Daley, John Doherty, Amanda Montgomery, Jeremy B. Thompson, Mary Jo Connelly

Boston University student research interns: Adel al-Zaharani, Faisal Farhat, Jill Passano and Akanimo Udo

Reviewers:

Anneta Argyres, University of Massachusetts Boston Labor Resource Center

James Jennings, Tufts University Professor of Urban and Environmental Policy and Planning

Stephanie Luce, Associate Professor, University of Massachusetts Amherst Labor Center

Karl Seidman, Senior Lecturer, MIT Departments of Urban Studies and Planning

Editors:

Amy Gluckman and Chris Sturr of *Dollars and Sense*

Layout:

Audubon Dougherty

Julie Decedue

Foundations Supporting CLU's Work

Anonymous Foundation

Discount Foundation

Jewish Funds for Justice

Hyams Foundation

Herman and Frieda L. Miller Foundation

Needmor Fund

Public Welfare Foundation

Solidago Foundation

Unitarian Universalist Veatch Program at Shelter Rock

Acronyms and Abbreviations Used in this Report

AMC	Academic Medical Center
BIDMC	Beth Israel Deaconess Medical Center
BWH	Brigham and Women's Hospital
BMC	Boston Medical Center
CEO	Chief Executive Officer
CHB	Children's Hospital Boston
COBTH	Conference of Boston Teaching Hospitals
DFCI	Dana Farber Cancer Institute
ER	Emergency Room
FESS	Family Economic Self-Sufficiency
FY	Fiscal Year
MH	MassHealth
MGH	Massachusetts General Hospital
PILOT	Payment in Lieu of Taxes
St E	St. Elizabeth's Medical Center
TMC	Tufts Medical Center
UCP	Uncompensated Care Pool

EXECUTIVE SUMMARY

Boston's health care industry comprises a unique cluster of world-class academic medical centers (AMCs) that train the nation's doctors and serve patients from across the country and around the world. These institutions are among the City's largest employers and are generally regarded positively, as an economic engine. At the same time, the tax-exemption AMCs enjoy on their extensive land holdings, along with their continued expansion, add to the pressures on Boston's working families. Community Labor United is a coalition of community and labor groups whose mission is to protect and promote the interests of working class communities in the Greater Boston region. We believe that it is reasonable to ask whether the pressures of providing extensive tax exemptions to these institutions are balanced by the benefits a prosperous health care industry is bringing to Boston's residents—whether the industry makes a fair contribution to the people of Boston in return.

In this study, Community Labor United examines whether or not Boston's academic medical centers (AMCs), the core of the hospital sector, make a fair contribution to the City, its workers and its residents. Analyzing a range of information including property tax valuations, hospital financial filings, and employment data in Boston's health-care sector, this report addresses the following questions:

- 1. Are AMCs paying a fair share of revenue to the City of Boston?**
- 2. Are AMCs providing their workers with good jobs at good wages?**
- 3. Are AMCs providing an adequate level of charity care?**

Our detailed examination of a wide range of data leads us to conclude that the answer to all three of these questions is 'No.' We present evidence that the AMCs fail on all three criteria for contributing adequately to the City of Boston and its residents.

As a group, the Boston AMCs paid barely half of their fair share of the cost of essential municipal services—and this share represents only a fraction of what residential and commercial taxpayers must pay. Further, the area labor market for hospitals and the health care sector in general is significantly inequitable, with almost two-thirds of the sector's occupations failing to pay wages high enough to provide for workers' basic self-sufficiency.

Finally, Boston's AMCs do not even provide an adequate level of charity care to the poor, one of the core purposes underpinning their non-profit tax-exemption. They fall well below the proposed federal standard of directing 5% of their revenues to provide uncompensated charity care for low-income patients. These

failures cannot be attributed to a lack of resources: in 2006, Boston's AMCs had profits—which they call operating surpluses—ranging from \$10 million to \$294 million, and own assets worth hundreds of millions of dollars. The property tax exemption AMCs enjoy as nonprofit institutions represents additional millions of dollars in public subsidies they receive every year in the form of tax exemptions. Ironically, this adds to the AMCs' capacity to buy more land and buildings, which takes even more land off the tax rolls and to increases traffic and other burdens on adjoining neighborhoods.

1. Failure to Pay Fair Share Contribution Strains the Local Tax Base

Boston is home to a large number of medical institutions, nearly all of which are nonprofits. In Fiscal Year (FY) 2007, the 30 largest nonprofit medical institutions together owned properties with an assessed value of just over \$2.4 billion. From that, the City collected just under \$1.5 million in taxes; yet, if these medical institutions' properties were taxed at the commercial rate paid by other businesses, they would bring in just over \$65 million. Subtracting a small amount of taxes collected for commercial activity on these properties, as well as the 'payments in lieu of taxes' (PILOT) that some of these institutions pay voluntarily, because these properties were exempt from property taxes, the **City of Boston lost \$59.7 million in revenue for 2007 alone. Boston's large teaching hospitals, known as Academic Medical Centers (AMCs) accounted for most of this revenue loss, \$45.5 million.**

Although they are tax-exempt, as large employers and owners of extensive properties, AMCs use significant amounts of essential city services—fire, police, and public works—and we believe that they should at the very least pay their fair share of the cost of providing these services. This assumption also governs the City's PILOT guidelines, which suggest that these nonprofit institutions should pay 25% of the commercial property tax obligation on their properties, since essential services represent approximately 25% of the City's budget. The City of Boston, under Mayor Menino's leadership, has earned a well-deserved reputation for the "most proactive PILOT program in the country."² Between 1993 and 2008, Mayor Menino succeeded in more than doubling total PILOT payments, bringing many new institutions into the PILOT program and significantly increasing the contributions of other institutions. However, the City is constrained by the fact that it cannot require PILOTs: a state statute dating back to 1830 grants these institutions tax-exempt status, and to date numerous attempts to amend this statute have failed.

Despite the City's intense efforts, the AMCs as a group fail to pay even half of the sum Mayor Menino and the City have designated as their fair-share contribution to the costs of essential municipal services. This amount, in turn, represents

only a fraction of what residential and commercial property-owners who are not tax-exempt must pay. Assuming that large nonprofit institutions should pay 25% of the commercial property tax obligation on their properties to cover the cost of essential services, Boston nonprofit medical institutions as a group should pay \$16.25 million in PILOT payments to cover the essential services the City provides, and the AMCs should pay \$12.7 million of this. **In FY07, the AMCs paid just over \$3.9 million in voluntary PILOT payments. If you add to these PILOT payments the \$1.25 million in taxes these institutions paid on for-profit uses in their facilities, the AMCs paid less than half of the PILOT goal—41%—and just 10% of what the tax revenue would have been if the Academic Medical Centers were not exempted from taxation.** This gap is even larger if you include all nonprofit medical institutions.

Nonpayment of taxes by the AMCs puts additional pressure on residential taxpayers to pay increased taxes, at the same time restricting the City's ability to provide services. In a city where more than half of the land is tax-exempt, this contributes significantly to the financial difficulties facing Boston and pressures on residential and commercial property taxes. Because of restrictions arising from Proposition 2 ½, and as a matter of political reality, the City of Boston cannot simply raise property tax rates as much as is needed to pay for essential—and other—services. As a result, wealthy nonprofit hospitals sitting on valuable real estate create a squeeze on City taxes and services.

2. Inadequate Hospital Wages Point to an Inequitable Labor Market and Shifting Employee Health Care Cost Burdens Taxpayers

The hospital labor market is not an equitable one. **Nearly two-thirds of its occupations, and all but three entry-level occupations fail to pay a “self-sufficiency wage”**—the wage a Boston family needs simply to pay for its basic needs, approximately \$58,133.³ This figure is very close to the ‘mean income’ for 85 hospital occupations. If incomes were clustered around this mean, it would represent an ‘equitable’ labor market; but unfortunately a mapping of the City’s hospital labor market shows that its occupations are NOT clustered around this mid-point. The hospital labor market is significantly inequitable and growing more so. Executive salaries reflect this: in 2006, each of the AMC Chief Executive Officers (CEOs) was paid \$1 million or more in compensation: about 50 times the median income for the AMCs lowest-paid full-time occupations and 14 times the average salary for registered nurses. Low wages are exacerbated by other troubling features: a lack of training and advancement opportunities for lower-wage workers, and racial diversity found.

Perhaps most disturbing, we also found that many AMC employees and their dependents themselves relied on charity care through the Uncompensated Care

Pool and MassHealth, because they either did not receive or could not afford employer-sponsored health insurance. **In FY06, Massachusetts taxpayers absorbed the cost of health care for 2,028 Boston AMC employees and their dependents, a total of more than \$8.6 million.** We do not believe that this kind of ‘cost shifting’ is acceptable from the AMCs, which are making tens and often hundreds millions of dollars in profit, institutions that are already subsidized by millions of dollars in tax exemptions.

3.Under-serving Poor Patients Creates a Strain on the Poor and on Taxpayers

One public benefit that most people expect from tax-exempt hospitals is that they provide adequate (or better) free care to the poor. **The proposed federal standard is that a nonprofit hospital should spend a sum equal to at least 5% of its annual patient revenues or operating expenses—whichever is more—on uncompensated charity care.⁴ The Boston AMCs do not come close to meeting this proposed standard: together, Boston AMCs provide less than half that level of charity care.** Not providing free healthcare to the needy creates a strain on poor people seeking health care, forces the government to pay more in health care costs, and ultimately imposes a burden on working families whose city and state tax dollars cover these costs.

Conclusion

There is no credible evidence that the academic medical centers cannot afford to pay more equitable and self-sustaining wages for their workers and to provide more generous uncompensated charity care, just as there is no credible evidence that they cannot better support a fair share of essential municipal services. The tax exemptions that Boston is required to grant institutions such as the AMCs rest on an assumption that the exempt nonprofit institution is indeed fulfilling its exempt purpose in the activities that take place at each of its exempt properties. As the AMCs have grown into physically huge, legally complex, multi-billion dollar enterprises, new questions arise about whether this is in fact the case. The time may have come to reexamine this issue.

Community Labor United believes that our economy is shaped as much by creative public policy and broad civic participation as it is by the specific types of economic activity located here. The shift from a manufacturing-based economy to a service-based economy need not condemn us to low wages, high unemployment and shrinking public services. As in the past, organized communities, organized workers and innovative leadership can lead our region towards an economy where working people can support their families, where cities have the funds to pay for necessary services, and where residents and intuitions share the revenue burden. Community Labor United is hopeful that Boston’s academic medical centers can play a positive role in helping us to move in this direction.

I. INTRODUCTION

Health care is one of the most important sectors in the Boston economy. The City's health care industry comprises a unique cluster of world-class academic medical centers that train the nation's doctors and serve patients from across the country and around the world. These institutions are among the largest employers in the City and own significant amounts of land. The property tax exemption they enjoy as nonprofit institutions represents millions of dollars in public subsidies for them every year—yet these “nonprofits” make millions of dollars of profit (in “operating surpluses”) and own assets worth hundreds of millions of dollars. Nearly two-thirds of their workers do not make a wage sufficient to support a family in the City. And, perhaps most disappointing, they do not even provide an adequate level of charity care to the poor. Despite their importance to the Boston economy, Community Labor United is very concerned that these institutions do not make a fair contribution to the City or its workers.

Much has been written about the large nonprofit hospital sector in the Greater Boston region.⁵ The research on this sector has largely examined the nonprofit hospitals from the traditional economic growth perspective. From this perspective, any job creation is considered to constitute a plus for the community, as well as a justification for continued public subsidies to large nonprofit employers. This economic growth perspective, however, fails to consider such issues as the quality of the jobs created, the impact of the subsidies that property tax exemption provides on the operation of the City of Boston, and the impact of the institutions' physical growth on surrounding neighborhoods. These are all important considerations for working people in Boston. The large hospitals accumulate a lot of wealth, yet they maintain inequitable wage scales in which executive and professional staff take home hundreds of thousands of dollars while workers struggle to earn self-sustaining wages. Community Labor United asks: “Don't we expect better from our nonprofit hospitals?”

In CLU's 2006 report *The Hourglass Challenge*, we recognized the importance of the nonprofit sector to the Greater Boston economy and to the region's employment landscape, with health care representing a significant piece of the nonprofit sector. Six out of every ten Boston workers are employed in the health care sector.⁶ In Greater Boston there are over 1,600 health care establishments employing more than 100,000 people, with a combined annual payroll of over \$4.6 billion. Taken together, twenty-one nonprofit hospitals have an annual payroll of over \$2.7 billion and employ over 60,000 people. The Greater Boston Chamber of Commerce found that Healthcare and Life Sciences is the largest employment sector in the region (252,000 employees), followed by Banking and Financial Services (132,500), High Technology (112,000), and Higher Education (85,900).

In 2006, of the forty-eight largest employers in Boston (all of which have more than 1,000 workers), fifteen were medical facilities.⁷

This first report from Community Labor United's *Nonprofit City* research project focuses specifically on the City's large teaching hospitals, called Academic Medical Centers (AMCs). According to the Conference of Boston Teaching Hospitals (COBTH), the AMCs employ nearly 30,000 workers in the City itself and nearly 90,000 in Suffolk County and the adjacent counties of Middlesex, and Norfolk. Here we focus on seven of the leading teaching hospitals in Boston: Beth Israel Deaconess Medical Center (BIDMC); Boston Medical Center (BMC); Brigham & Women's Hospital (BWH); Children's Hospital Boston (CHB); Massachusetts General Hospital (MGH); St. Elizabeth's Hospital (StE); and Tufts Medical Center (TMC). Six of these seven AMCs are among the top ten largest employers in Boston.

Top Ten Largest Employers in Boston, 2007 (hospitals are bolded)

- 1. Massachusetts General Hospital**
 - 2. Brigham and Women's Hospital**
 - 3. Beth Israel Deaconess Medical Center**
 4. Boston University
 5. Fidelity
 - 6. Tufts Medical Center**
 7. Northeastern University
 - 8. Boston Medical Center**
 - 9. Children's Hospital Boston**
 10. Harvard University
- Source: COBTH report

We focus on the Academic Medical Centers because they are the largest hospitals in Boston. They can be more easily compared (as a type) because they are all acute care facilities with active emergency rooms. Moreover, their relationships with universities, also nonprofit entities, suggest an even deeper public obligation. (Note, however, that for the employment analysis we had to rely on data about the Boston-area healthcare sector as a whole, as the individual hospitals do not provide independent public reports on their actual occupations, wage rates, and related data.)

Analyzing such data as property tax valuation, hospital financial filings, and employment and occupational data about the healthcare sector, the report asks whether the AMCs make a fair contribution to the City, its workers, and its residents. First, we examine the profit-making capacity of the AMCs. Then, we look in detail at the AMCs contribution in three areas:

- (1)** Are AMCs paying enough to the City of Boston to cover their fair share of the cost of essential municipal services?
- (2)** Are AMCs providing their workers with good jobs at good wages and helping to create an equitable labor market in the healthcare sector?
and
- (3)** Are AMCs providing an adequate level of charity care for the poor? In all three areas, the evidence leads us to conclude that Boston's large teaching hospitals are currently failing to meet even modest standards for a fair contribution to the city they call home.

Hospitals As Profit Generators

Nonprofit hospitals are legally classified as charitable institutions, and this is one of the primary reasons that the AMCs are exempt from taxation.⁸ The exemption is given to allow the hospitals to operate and to perform their public mission. It can be surprising to learn, then, that these institutions can and do make profits. Nonprofit organizations can legally make a profit, but there are limitations on what they can do with it. For instance, nonprofits cannot pay out profits to individual owners or shareholders, as for-profit institutions do; but they can accumulate profit and use it in a variety of ways, including land purchase and facilities expansion. It might seem counter-intuitive that nonprofit hospitals would make any significant profit, but, they can and do. Boston’s seven AMCs each made over \$10 million in profit in fiscal year 2006. This profit is the amount by which their revenues exceed their costs. While the hospitals’ accountants often refer to it as a “surplus,” we refer to it by its more common name: profit.

Children’s Hospital Boston (Children’s) provides a useful illustration of how significant an AMC’s profit can be. Children’s is tax exempt, but made a voluntary ‘payment in lieu of taxes’ (PILOT) to the City of Boston totaling \$515,000 in fiscal year 2007 (FY07).⁹ That amount represents about half of the City’s PILOT goal for Children’s (and only about one eighth of what would be the hospital’s tax obligation were there no exemption at all). While half a million dollars is a very small amount to pay if you consider the assessed value of Children’s properties, it nevertheless compares favorably to other PILOT-paying institutions. Children’s also paid just under \$16,000 in taxes that year on property that was not exempt. If it had been taxed on the almost \$148 million worth of its real property that year, it would have paid an additional \$3.95 million in property taxes. This means that Children’s Hospital received almost \$4 million in property tax relief in that one year—essentially, a \$4 million subsidy from the City of Boston and its’ taxpayers.

In FY07, Children’s Hospital made a profit of just over \$100 million. In other words, after accounting for the entire cost of the hospital’s community benefit, community

Total Profit for 7 Boston AMCs, FY03-FY06

Hospital	FY03	FY04	FY05	FY06
Beth Israel Deaconess Medical Center	\$17,805,000	\$40,813,000	\$51,765,000	\$64,609,000
Boston Medical Center	\$3,606,410	\$21,112,762	\$54,219,000	\$45,792,397
Brigham and Women’s Hospital	\$35,669,000	\$42,708,000	\$93,568,000	\$68,070,000
Children’s Hospital Boston	\$69,012,000	\$69,956,000	\$110,133,000	\$101,465,000
Massachusetts General Hospital	\$77,596,000	\$153,470,000	\$245,415,000	\$294,917,000
Tufts Medical Center	-\$25,950,000	-\$21,260,000	\$13,584,000	\$10,099,000
St. Elizabeth’s Medical Center	\$5,133,613	\$317,504	\$10,488,482	\$10,139,424

service, and charity care programs, and after paying its PILOT and whatever taxes it may have owed that year for for-profit uses of its property (such as a leased food-service facility), and after covering all operating expenses, Children's still had over \$100 million left over for the year. The \$4 million subsidy from the City of Boston, then, represents a mere 4% of Children's *profit*.¹⁰

There is nothing illegal or even inherently inappropriate about the AMCs making a surplus, or profit. But the magnitude of their profits does tell us something about the ability of these institutions to pay their fair share for essential city services, to provide their workers with good wages, and to provide charity care to the poor. We see in the next section that these profits are being generated at a time when their host city could certainly use additional revenue.

II. PAYING THEIR FAIR SHARE?

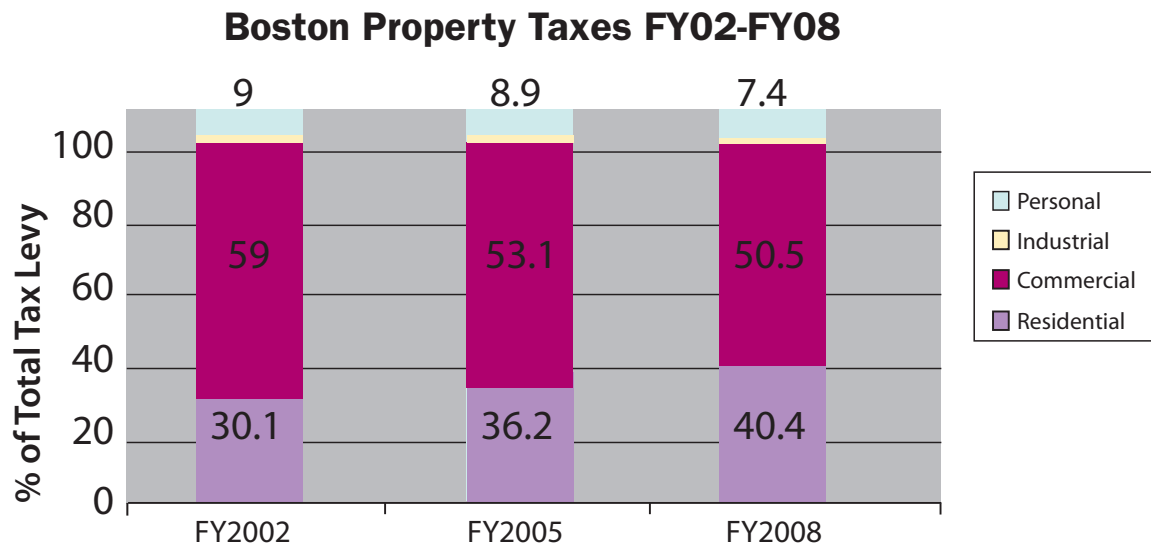
Local government depends on property taxes to provide the essential services on which residents and businesses rely every day. Police protection, fire and rescue services, trash pick-up, road maintenance and schools are functions of city government. Residents and businesses pay local taxes, primarily the property tax, to ensure that the City can function properly. AMCs do not. Yet, as one official noted, “When the fire alarm rings at a college or hospital, the firefighters don’t check to see if the institution is paying a PILOT.”¹¹

Twin Problems: Overburdened Taxpayers, Underfunded Municipalities

The financial stress on Massachusetts’ cities and towns is reaching critical proportions, and their fiscal difficulties are well documented.¹² A recent report from the Massachusetts Budget and Policy Center shows that while property tax collection has not changed much in fifteen years, overall state tax rates and receipts have fallen, meaning that the property tax represents an increasing share of total taxes paid.

“ . . .three factors may be contributing to heightened public concerns about property taxes: (i) property taxes, as a share of income, declined in the late 1990s, but began to climb due to local aid cuts beginning in FY 2002[;] (ii) there has been a trend towards greater reliance on residential property taxes relative to those from commercial and industrial sources; and (iii) income growth has been concentrated among high-income households in recent years, meaning that low-and moderate-income families’ ability to pay their property taxes may not have risen at the same rate as those taxes.”

Residential taxpayers are shouldering an increasing share of the tax burden. This problem has been compounded by rising property value assessments,

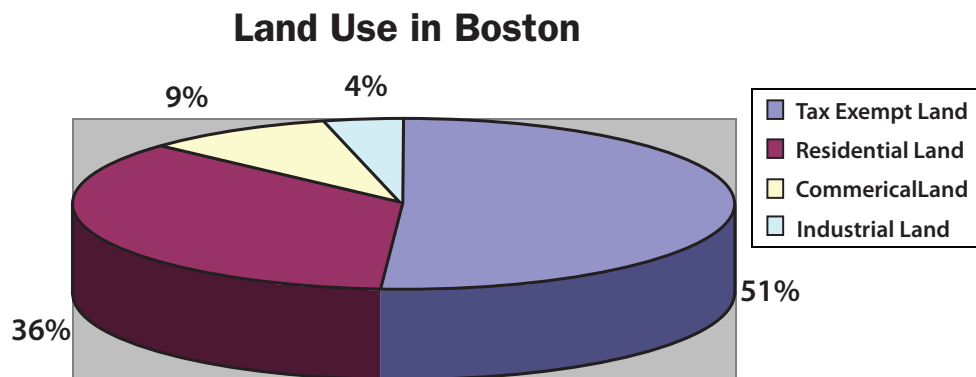


Data Source: City of Boston Property Tax Facts and Figures FY 2008

coupled with tax breaks for commercial and industrial uses.¹⁴ This creates two problems—one for residents and one for municipalities. The problem for residents is evident: residential property taxes increase almost every year to support the annually increasing cost of providing the same, or even a lower level of government services, whether or not residents’ incomes have increased.

For municipalities, the corresponding problem is inadequate revenue. Proposition 2 1/2 limits the amount of revenue a city or town may raise, or levy, from local property taxes each year to fund municipal operations. First implemented in fiscal year 1982, Proposition 2 1/2 limits the total levy a city or town can collect to no more than 2.5 percent of the total full cash value of all taxable property in the community. In addition, in a given fiscal year the total levy may increase no more than 2.5 percent. Massachusetts cities and towns are up against a revenue ceiling: the Proposition 2 ½ tax cap. Their only way out of this is to have rising property values, to attract new construction, or to win state permission to enact new local taxes such as a meal tax. The Proposition 2 ½ tax cap puts increasing pressure on municipal officials to make land use decisions—for example, permitting new construction—for purely fiscal reasons, regardless of whether the uses are appropriate or reflect community desires. This “fiscalization” of land use decision-making has dire consequences for neighborhoods as pressure for increasing gentrification becomes a *de facto* municipal policy.

In Boston, one important squeeze on the City’s ability to raise revenue is the fact that so much of its land is off the tax rolls. A total of 51% of Boston’s land is tax exempt. Most of this land is used for open space; schools, government facilities and other public uses; and religious institutions. A small but significant amount of Boston land is owned by large tax-exempt nonprofit hospitals and universities. In 2005, tax-exempt nonprofit hospitals and universities owned 5.4% of all the land in Boston, which translated into almost \$160 million of lost tax revenue.¹⁶ This is equal to 8% of the entire City budget or one-third of the City’s total state aid for that year.



Data Source: Perez, Yolanda et al, Residential Land Use in Boston, Boston Redevelopment Authority, 2/1/2004, p. 1.

PILOT: A Policy Tool to Address Nonprofit Tax Exemption

Although the Boston AMCs are exempt from corporate income tax under federal IRS law, it is state statute that grants them exemption from local property taxes. In 1830, Massachusetts granted tax-exempt status to land used for charitable purposes.¹⁷ Most states have similar laws. Given this state law, the City of Boston cannot legally require these institutions to pay property taxes on any property that is correctly used for their exempt purpose.

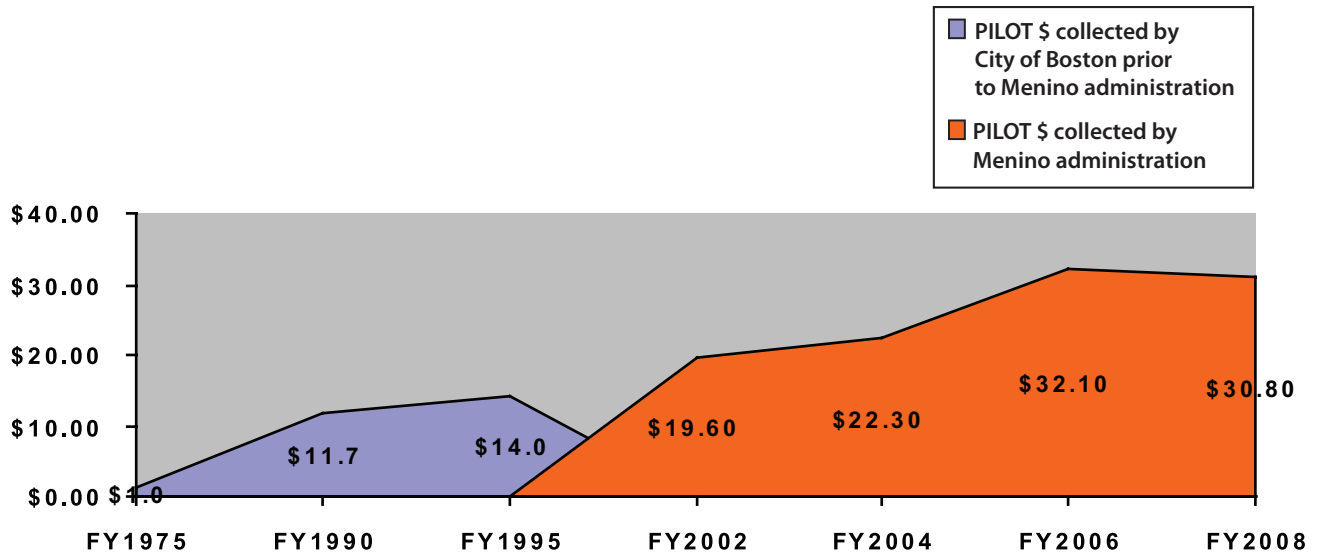
With mandated caps and political limits to residential property tax increases, the slim array of local revenue options, and the absence of available land for new development, Massachusetts municipalities are looking to large property-owning nonprofit institutions, such as the AMCs, to pay their fair share for essential local public services.¹⁸ A PILOT is a *payment in lieu of taxes*: any voluntary, but contractual, payment made to a public agency instead of or supplementary to tax payments. PILOT agreements are used with nonprofit organizations or other governmental entities that are exempt from paying taxes to a local government. To this end, in 1985 the City created a program to persuade nonprofit institutions to make *payments in lieu of taxes*, or PILOTS, to cover their fair share of the costs of essential city services.

The Country's Most Pro-active PILOT Program

Mayor Menino and the City of Boston have earned a well-deserved reputation for the “most proactive PILOT program in the country.”²⁰ Boston has an explicit PILOT policy and actively seeks out participation, which is unusual for a U.S. city. PILOT payments come from three major sources: 1) state and other government agencies (e.g. for open space); 2) Massachusetts Port Authority (Massport), which owns Logan Airport and other land; and 3) large tax-exempt nonprofit hospitals and universities. The City's largest PILOT agreement, \$15 Million in FY07 or almost half of the PILOT total is with Massport. Massport's PILOT agreement was mandated in 1978 by state legislation, and the City periodically re-negotiates the terms. In addition to efforts to get non-profit institutions to contribute to the cost of their own City services through PILOT payments, the City has also worked to get non-profit colleges, universities and hospitals to directly address the needs of low-income residents by filling medical, educational or affordable housing service gaps.²¹

Between 1993 and 2008, Mayor Menino succeeded in more than doubling total PILOT payments. The City reports that growth in PILOTs comes from three sources: new PILOT agreements, contract escalations that adjust the payments for inflation, or re-negotiation of a current contract.²² Mayor Menino succeeded in negotiating PILOT agreements with many colleges, universities, hospitals and

Boston Revenues From PILOTs FY1974-FY2008



Data Sources: City of Boston Assessor's Office and Boston Globe articles as cited ²⁴

cultural institutions that had not previously paid, increasing the number of PILOT agreements from a dozen in the early 1990s to 44 in FY2006.²³

Boston's "Fair Share Taxation" Approach

When the City learns that a large nonprofit property owner has acquired new property, or plans new construction or other expansion, the City attempts to negotiate a PILOT that will compensate the City for up to 25% of the lost taxes on that parcel.²⁵ The PILOT agreement also typically includes an escalator clause to keep up with inflation. The City does not currently ask nonprofits to pay a PILOT on property already off the tax roles as of 1985, the date of the policy's adoption. PILOT negotiations are accomplished either through the Boston Redevelopment Authority's permitting process, in which case the Mayor's Budget Office takes the lead; or through a change in tax status on a parcel, in which case the City Assessor's Office takes the lead.

The City of Boston's policy of seeking voluntary PILOT payments from nonprofits to the city incorporates a fair share methodology. The PILOT goal of 25% of lost revenue is based on the idea that all property owners should cover their share of the cost of "essential services," defined as police, fire, and public works, which together make up about 25% of the City budget. (For the purpose of setting PILOT goals, schools are not defined as an 'essential service.')

The assumption is that this 25% essential services cost is shared relatively equally among all taxpayers. This is a fundamental principle of 'fair share' taxation, the method used for determining residential and commercial, as well as institutional, charges.²⁶ (See sidebar.) There is no provision for hospitals, individually or collectively, to claim that they use more or less than this level of City services, even if they supplement city services with in-house trash collection or security.

Fair Share Taxation

Businesses, like residents, pay a “fair share” of the tax burden for city services that are part of our present-day municipal “commons.” What does that mean? We do not consider it fair for property owners to opt out of paying taxes on the grounds that they use few or no city services. If we did, a wealthy childless couple living in a multimillion dollar-townhouse on Beacon Hill would pay less than a working-class family with several school-age children living in a modest Mattapan home. In fact, these two property-owners are asked to pay the same residential tax rate, although the Beacon Hill couple pays more in taxes because their property is more valuable.

Efforts to Legislate PILOT Increases

Over the past 20 years, City of Boston and state officials have tried a number of different approaches to require large non-profit institutions to pay some kinds of standardized payments to municipalities to offset the costs of providing city services to these institutions. These include:

- ▶ In 1990, former Mayor Flynn filed a bill with the state legislature that would require tax-exempt hospitals and universities to pay 25 percent of the amount they would have to pay if they were fully taxable. That bill died in the legislature in 1992.
- ▶ In 1993, Assessor Ron Rakow proposed a ‘local option public safety tax whereby all large non-profits, including hospitals, colleges and cultural institutions, would pay one-quarter the rate of businesses, to cover the cost of city services. This home rule legislation also died in the legislature.²⁷
- ▶ In 2001, in response to Harvard University’s purchase of a large commercial property in Watertown, the State legislature debated legislation that would have required schools and other nonprofit organizations to pay taxes when they bought large properties, thus removing them from the tax rolls. It would also have allow communities to assess taxes on any property worth more than 1 percent of the tax base, even if used for tax-exempt purposes. The legislation offered a local option, so that communities could decide, for example, if they wanted to tax other-wise eligible open space.²⁸
- ▶ The 2003 State budget crisis, when the City faced a \$1.75 billion budget gap due to state aid cuts, prompted Boston City Council to call for hearings to discuss charging colleges and universities a maintenance fee of \$50 - \$100 per semester for each student who lives in the city, to help defray the cost of police, fire and other services.

- In 2005, Mayor Thomas J. Menino intensified efforts to encourage tax-exempt institutions to increase their PILOTs, without waiting as the City usually did for nonprofits to come before the city for rezoning approval or other business before negotiating the voluntary payments. The Boston Globe editorial board supported the Mayor’s initiative, and added that they believed “the system needs standardization” to even out contributions: “it’s a fair bet that most nonprofits would rather work out a more rational, predictable payment system than have the Legislature do it for them.”³⁰
- In the spring of 2007 the Boston City Council held a hearing to consider reforming the PILOT program in order to collect more from large nonprofit institutions that can afford to pay more. On April 17 of this year, Councilor Stephen J. Murphy introduced a proposal to pressure colleges and universities to contribute more money to the city, asking the Legislature to end colleges’ tax-exempt status.³¹

Despite all of these efforts, the City’s non-profit institutions still fall far short of making payments in lieu of taxes that would offset the cost of the services the City of Boston provides to them. PILOT programs such as Boston’s rest on an assumption that the exempt nonprofit institution is indeed fulfilling its exempt purpose in the activities that take place at each of its exempt properties. As the AMCs have grown into physically huge, legally complex, multi-billion dollar enterprises, new questions arise about whether this is in fact the case.

Property Tax Impacts of Boston Medical Facilities

Nearly all large medical facilities in Boston are nonprofits and have tax-exempt status.³² For the City, the consequence is a loss of property tax revenue. Hence, tax exemption represents a form of public subsidy: the City forgoes collecting revenue from these institutions in order to facilitate their important charitable functions. This public subsidy implies several duties on behalf of the nonprofits. In a later section of this report we will look at whether the hospitals fulfill these charitable duties.

For its *Nonprofit City* project, CLU conducted a survey of all the parcels owned by the nonprofit hospitals and universities in the City of Boston in FY07. From this survey, we found that the FY07 Assessed Value of the 30 largest nonprofit medical facilities totaled over \$2.4 billion. **If all of this property had been taxed at the commercial rate, it would have brought over \$65 million in to the City’s coffers. In fact, the City collected just under \$1.5 million in property taxes,** primarily for the small portions of these properties used by for-profit businesses—for example, a commercial restaurant located in a hospital building. Subtracting the \$1.5 million in taxes collected and the PILOT payments made by these

institutions, **the public subsidy from the City to the hospitals for FY07 was approximately \$59.7 million.**

By far the largest share of this subsidy went to Boston's academic medical centers. (In the table below, we include Dana-Farber Cancer Institute, which is an AMC, albeit one that does not provide emergency-room services, as the others all do.) The AMCs account for **\$45.5 million** of the \$58.5 million in property-tax revenue that Boston lost in FY07 due to the tax-exempt status of its nonprofit hospitals. **As a group, the AMCs paid barely 10% of the amount they would have owed in property taxes were they not tax-exempt.**

Property Tax Subsidy FY07

All Nonprofit Medical Facilities

Total Property Value: \$2.4 billion

Commercial Taxes would be: \$65 million

25% 'PILOT' Goal would be: \$16.25 million

\$65 million minus taxes actually paid (\$1.4 million) = \$63.6 million

\$63.6 million minus PILOT payments (\$3.9 million) = \$59.7 million

Total Property Tax Subsidy to all Nonprofit Medical Facilities: \$59.7 million

Seven AMCs and Dana Farber

Total Property Value: \$1.8 billion

Commercial Taxes would be: \$50.6 million

25% 'PILOT' Goal would be: \$12.7 million

\$50.6 million minus taxes actually paid (\$1.25 million*) = \$49.5 million

\$49.35 million minus PILOT payments (\$3.9 million) = \$44.2 million

Total Property Tax Subsidy to the Seven AMCs and Dana Farber: \$45.5 million

* Note that the actual tax payments are not in the table. In FY07, the seven AMCs plus Dana Farber paid \$1,258,654 in property taxes to the City for unrelated for-profit uses.

The PILOT GAP

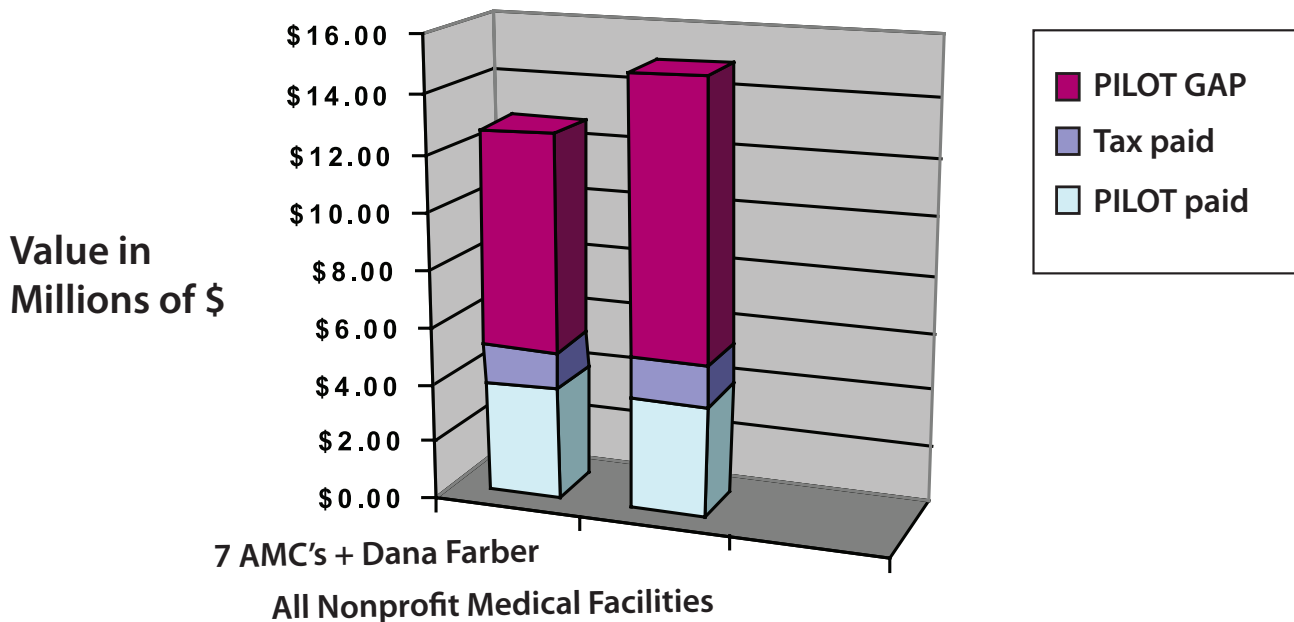
The PILOT goal is intended to compensate the City for "essential services" only, not for the full tax amount. So the PILOT goal for the AMCs would be \$12.65 million (25% of the full assessed tax value of \$50.6 million). **As the table below makes clear, however, even measured against that more limited standard the AMCs as a group paid less than half their expected contribution in FY07.** Their PILOTs, combined with their small property-tax payments on for-profit uses within their properties, totaled \$5.16 million, 40.8% of the goal of about \$12.65 million, leaving what we might call a **"PILOT gap" of about \$7.5 million.** This is the amount that would go into the City's coffers if the AMCs (including DFCCI) paid their fair share of the cost of essential city services.

Property Values and PILOTs of AMCs (including Dana Farber) FY07

	Total Assessed Value of Land & Buildings	FY07 Property Tax if institution was not exempt (hypothetical) *	FY07 PILOT payment	Taxes Paid for For-Profit Uses in Buildings	Ratio of PILOT & Taxes Paid to Non-Exempt Property Tax	Payment Ratio to PILOT Goal (25% of assessment)
BIDMC	\$279,421,323	\$7,508,050	\$141,532	\$167,682	4.1%	16.5%
BMC	\$45,256,500	\$1,216,042	\$66,240	\$55,903	10%	40.2%
BWH	\$116,342,600	\$3,126,125	\$714,708	\$8,094	23.1%	92.5%
CHB	\$147,858,100	\$3,972,947	\$515,777	\$15,988	13.4%	53.5%
DFCI	\$134,328,500	\$3,609,406	\$68,977	\$35,683	2.9%	11.6%
MGH	\$930,078,700	\$24,991,214	\$1,297,346	\$953,356	9%	36%
TMC	\$97,648,700	\$2,623,820	\$1,096,953	\$21,939	42.6%	170.6%
St.E	\$132,687,200	\$3,565,305	\$0	\$0	0%	0%
Total	\$1,883,621,623	\$50,612,913	\$3,901,533	\$1,258,654	10.2%	40.8%

Source: Boston Assessor Database FY07.
 All figures rounded to the nearest dollar amount.
 * Commercial rate \$26.87 per \$1000

PILOT Gap



In FY07, The AMCs as a group paid less than half of their PILOT goal, approximately the amount that it costs the City of Boston to provide them with essential services. They paid barely 10% of what they would have owed in property taxes if they were not tax exempt.

What Difference Could the Additional Revenue Make?

What difference would the additional revenues make? How could the City use these extra funds to support the essential public services it provides? The figure below shows, in the left hand column, how many teachers, police officers or firefighters could be hired with the \$44.2 million total property tax subsidy the AMCs receive, and in the right hand column, how many with the \$7.4 million gap between the amount that the PILOT program asks the AMCs to pay and the amount they actually do pay.

The \$7.5 million in lost revenue for essential services could pay for:

- 94 Teachers, or
- 71 Firefighters, or
- 59 Police Officers

Sources: Boston Municipal Research Bureau

The \$45.5 million in overall lost revenue opportunity could pay for:

- 571 Teachers, or
- 434 Firefighters, or
- 362 Police Officers, or
- A New Middle School

Sources: Boston Municipal Research Bureau and Boston Globe

As noted above, the burden on residential taxpayers is increasing; at the same time, municipal officials with ever-tightening budgets are proposing more Proposition 2 ½ override votes across the Commonwealth. The loss of tax revenue from valuable, otherwise taxable land in cities with few remaining undeveloped parcels puts a double squeeze on taxpayers and on consumers of public services. The addition of even \$45.5 million would help to relieve the burden borne by the City's residential taxpayers

To sum up, in FY07, Boston's non-profit hospitals as a whole made PILOT contributions that amounted to less than a quarter of their fair share obligations. The AMCs as a sub-sector did better, primarily because these institutions were responsible for seven institutional PILOT payments made in that fiscal year. In FY05 the AMCs paid only a quarter of their fair share obligation, but by FY07 that figure had risen to 41% percent due to increases in the relative payments made by two institutions—Brigham and Women's Hospital and Tufts Medical Center—for new construction that year. In other words, even in a year when two of the large teaching hospitals in Boston had the resources to undertake significant building projects, the AMCs as a group still contributed less than half of the limited sum the PILOT program asks of them, to cover essential municipal services.

It is a credit to Boston's proactive PILOT program that the City receives as much as it does from the City's large teaching hospitals. Overall, however, we can only conclude that these institutions do a poor job of meeting their obligation to contribute their fair share to the costs of the City's essential services.

III. PROVIDING GOOD JOBS AT GOOD WAGES?

So far, we have demonstrated that the Academic Medical Centers make significant profits, receive large amounts of public subsidy through tax exemption, and make up seven of the City's ten largest employers. These are wealthy, privileged, and large businesses; yet they also have very clear public missions. We would expect to see such institutions treat their workers well enough so that they could afford to live and support their families within the City. This does not seem to be an unreasonable expectation, given that the AMCs can afford it and that the public has invested heavily in them through tax exemption. When we examine their workforce, however, we see a different picture. Fully two-thirds of their workers at Boston's AMCs do not earn enough money to support even a family of three in Boston.

What Would an Equitable Labor Market Look Like?

In an equitable economy, people who go to work every day should have incomes sufficient to provide for their families' basic needs. They should also have important benefits such as health insurance. A labor market, if equitable, should see incomes distributed broadly: when mapped, it should look like a barrel or football, with incomes clustered around a mid-point and relatively few outliers. By contrast, an *inequitable* labor market maps like an hour-glass or, more commonly, a teardrop or cylindrical flask, with jobs clustered at the high and low extremes (or else just clustered at the bottom), and relatively few jobs at the mid-point. Visually mapping the labor market helps to convey how our economy is organized and who benefits from it. CLU has done that for our regional economy as a whole in *The Hourglass Challenge* (2006). Here, we do it for the local hospital economy.



equitable



inequitable



more inequitable

Hospitals and other health care and life sciences businesses are considered some of the most important employers in the so-called "knowledge economy." The knowledge economy comprises firms engaged in producing services and products that are the result of a substantial degree of research and innovation, employing highly skilled and educated engineers, medical doctors, scientists, and others. Yet the jobs in these knowledge firms are by no means all white-collar, highly skilled ones. Many of these jobs are clerical, janitorial, personal service, or security. Many require no formal training, pay low wages with low or no benefits, and offer few or no advancement opportunities.

As Community Labor United demonstrated in *The Hourglass Challenge*, the biggest problem facing most of Boston's current workforce is inadequate wages. While it is common to hear public concern about a *skills* gap, the reality is that many jobs in the growing sectors of the economy require few skills. While there are no doubt certain jobs that are difficult to fill because they require skills that are in short supply among Boston residents seeking employment, there also exists a very real *wage* gap. And this is not a gap that can be met by additional skills alone. Hundreds of thousands of relatively low-skill jobs that currently exist—and that must be done—are grossly underpaid. Skills training might help some individuals to prepare for other jobs, but it does nothing to alter the structural inequities manifested by the wage gap between occupations.

On January 1, 2008, the minimum wage for a Massachusetts worker increased to \$8.00 an hour, or \$16,640 a year for a full-time (40 hours a week) worker. How do families in Boston with one or even two minimum-wage workers fare? In an attempt to answer that question, researchers have developed the notion of a “family self-sufficiency wage,” in other words, the income a family of a particular size would need to earn simply to pay for basic necessities such as food and shelter—no frills—without receiving any public assistance. We use here the Family Economic Self-Sufficiency standard (MASSFESS), a location and family-size-specific measure that has become a widely-used benchmark.³³ For a family of four in Boston, the self-sufficiency wage has been calculated to be about \$62,000 a year. Compare that to the local median income for a family of four of about \$43,000—which means that half of Boston's families of that size earn less than \$43,000 per year, including families with two wage-earners each working 40 hours and earning the minimum wage. The unavoidable conclusion is that a significant number of Boston families who have at least one member working do not make enough money to pay for even bare-minimum living expenses. So how do people cope? Some don't pay for health care, while others make difficult and sometimes dangerous decisions about child care, forego a healthy and adequate diet, participate in the informal economy, live in substandard housing, turn to crime, or rely on public services for stopgap support when they can find and qualify for those.

Many families in Boston cannot make ends meet, yet most of them are not poor enough to qualify for an ever-shrinking welfare safety net. The best way to help these families is to ensure that every worker is paid a self-sufficiency wage. And this measure is how we will evaluate the hospitals' labor practices.

Boston's Hospital Labor Market: Troubling Features

Before we turn to look more specifically at wages in Boston's hospital sector, it is worth noting some of the general, and in some instances troubling, features of the hospital labor market.

Thirty-one percent of jobs in the City of Boston are in the field of healthcare and social assistance, and about half of these—approximately one in six jobs in the City—is in a hospital.³⁴ 1199 SEIU United Health Care Workers East—a large union that represents more than 300,000 healthcare workers and retirees in New York, Maryland, the District of Columbia and Massachusetts—has used worker surveys to identify health care workers' priority concerns. In addition to non-economic issues such as lack of respect, favoritism and the need for a voice in the workplace, there are many economic complaints, running the gamut from low pay, poor raises, the lack of high-quality, affordable health insurance, and lack of paid time off to limited promotion opportunities, overworked units and weak job security.

Racially Diverse Workforce Only in the Lower-Paid Positions

The hospital workforce in Boston is a racially and ethnically diverse one. One sign of this diversity was highlighted in a 2005 report from the Boston Redevelopment Authority, *The New Bostonians*, which noted that health and social services represents the single most common employment sector for Boston's foreign-born residents: 19% of them work in this sector. However, racial diversity in the hospital workforce declines as one moves up the skills and income ladder. Nearly all RNs in Massachusetts are white, but more than a third of nurses' aides and home health care workers are persons-of-color. Among the foreign-born workers in the lower-paid home health care sector, the largest share is Haitian. These non-white workers face significant barriers to obtaining the training and advancement opportunities that would allow them to ease the statewide shortage of RNs and shortages in other more highly skilled healthcare workforce positions.³⁵

Racial Distribution of Nursing and Nursing Aid Workforce

- 92% of all RN's in Massachusetts are white.
- 85% of all LPN's in Massachusetts are white.
- 65% of all nurses' aides and home health aides are white.

Few Training and Advancement Opportunities for Lower-Wage Workers

Given all of the public attention to the skill gap and recurrent shortages in certain more highly skilled health care occupations such as RNs, it seems reasonable to expect that Boston's large teaching

hospitals would put resources toward providing relevant occupational training. The AMCs do have training programs for some career opportunities; and residencies and fellowships for new medical doctors represent another significant investment in training. For other health care occupations, one important program is the Health Careers Training Institute (HCTI). The HCTI brings together the AMCs and community organizations such as the Jamaica Plain and Fenway Community Development Corporations to provide residents of these neighborhoods with pre-employment training in patient care, science and technology, medical administration, targeted ESOL (English for Speakers of Other Languages), and other relevant skills.

In addition, AMCs run in-house training programs for incumbent workers, but there is no publicly available information on the number of workers they serve. What is known is that these programs include mostly graduate and professional training programs along with continuing education for doctors, nurses, and other health care professionals. There do not appear to be many training opportunities for technical, service, or maintenance workers. Worker surveys conducted by 1199 SEIU report that even when training programs exist, they are not accessible to all employees; participation is often at the pleasure of supervisors.

Moreover, other local educational institutions are providing insufficient training opportunities to help Boston health care workers move into more highly skilled jobs in the industry. In late 2005, despite widespread demand by health care workers for career ladder opportunities, over 8,500 health care jobs in greater Boston were unfilled.³⁶ Looking at just eleven hard-to-fill health care job categories³⁷, projections anticipate almost 14,000 new job openings by 2010 in the Boston area³⁹ that will require at least some form of post-secondary training.³⁹ While most of these will require at least an associate's degree, Boston-area institutions awarded only 816 associate's degrees in health care fields in 2002.⁴⁰

Wages in Boston's AMCS: Don't Meet Basic Needs for Two-Thirds of their Employees

We would have liked to perform an analysis of hospital workers' wages using data on the number and pay range of employees in each occupation from the hospitals themselves; however, none of this information is publicly available. As a result, we are forced to turn to the data that is publicly available—wage data by occupation for Greater Boston employers from the federal Bureau of Labor Statistics (BLS).⁴¹

The data on the next two pages cover 85 occupations found in hospitals. Note: occupations with a median annual income above \$100,000 are marked in Yellow. Occupations within \$10,000 of the mean occupational income of \$59,224 are marked in Grey. Occupations with a median annual income more than \$10,000 below the mean are marked in Pink.

Annual Median Income in Boston Hospital Occupations

Occupation	Annual Median Income
Oral and maxillofacial surgeons	\$145,600
Orthodontists	\$145,600
Anesthesiologists	\$145,600
Family and general practitioners	\$145,600
Internists, general	\$145,600
Obstetricians and gynecologists	\$145,600
Pediatricians, general	\$145,600
Psychiatrists	\$145,600
Surgeons	\$145,600
Podiatrists	\$145,600
Medical appliance technicians	\$145,600
Dentists, general	\$137,440
Physicians and surgeons, all other	\$128,270
Dentists, all other specialists	\$104,380
Pharmacists	\$86,890
Physician assistants	\$78,200
Veterinarians	\$76,930
Dental hygienists	\$73,640
Chiropractors	\$72,290
Radiation therapists	\$71,750
Registered nurses	\$70,340
Nuclear medicine technologists	\$68,760
Optometrists	\$68,470
Diagnostic medical sonographers	\$67,020
Occupational health and safety specialists	\$65,770
Physical therapists	\$64,240
Radiologic technologists and technicians	\$62,910
Audiologists	\$60,090
Occupational therapists	\$59,590
Speech-language pathologists	\$59,570
MEAN OCCUPATIONAL INCOME	\$59,224
Health diagnosing and treating practitioners, all other	\$57,040
Respiratory therapists	\$55,220
Respiratory therapy technicians	\$53,990
Therapists, all other	\$51,970
Medical and clinical laboratory technologists	\$51,960
Healthcare practitioners and technical workers, all other	\$50,970
Cardiovascular technologists and technicians	\$50,030
Dietitians and nutritionists	\$48,790
Licensed practical and licensed vocational nurses	\$47,930
Massage therapists	\$46,230
Orthotists and prosthetists	\$44,750

Note that for *all* occupations that have a listed median income of \$145,600, there is no actual median. The data for these occupations show \$145,600 as a *minimum* income for these occupations.

Occupational health and safety technicians	\$44,540
Executive secretaries and administrative assistants	\$44,500
Physical therapist assistants	\$43,690
Occupational therapist assistants	\$42,520
Health technologists and technicians, all other	\$42,250
Surgical technologists	\$42,190
Environmental science and protection technicians, including health	\$42,070
Opticians, dispensing	\$41,270
Athletic trainers	\$38,290
Dental assistants	\$36,390
Customer service representatives	\$35,780
Recreational therapists	\$34,760
Material moving workers, all other	\$34,670
Agricultural and food science technicians	\$34,650
Medical transcriptionists	\$34,420
Medical and clinical laboratory technicians	\$34,340
Office and administrative support occupations	\$34,030
All other information and record clerks	\$34,030
Psychiatric technicians	\$33,130
Emergency medical technicians and paramedics	\$33,030
Medical secretaries	\$32,700
Healthcare support workers, all other	\$32,000
Medical assistants	\$31,790
Veterinary technologists and technicians	\$31,480
Truck drivers, light or delivery services	\$30,450
Medical records and health information technicians	\$29,790
Medical equipment preparers	\$29,660
Psychiatric aides	\$28,660
Occupational therapist aides	\$28,090
Ambulance drivers and attendants, except emergency medical technicians	\$27,250
Nursing aides, orderlies, and attendants	\$27,010
Pharmacy technicians	\$26,710
Veterinary assistants and laboratory animal caretakers	\$26,630
Physical therapist aides	\$26,150
Janitors and cleaners, except maids and housekeeping cleaners	\$25,020
Home health aides	\$24,390
File clerks	\$23,780
Dietetic technicians	\$23,740
Personal and home care aides	\$22,770
Taxi drivers and chauffeurs	\$22,640
Personal care and service workers, all other	\$22,200
Maids and housekeeping cleaners	\$22,130
Pharmacy aides	\$21,030
Parking lot attendants	\$20,430

Bureau of Labor Statistics data, Metropolitan Area Wages by Occupation

As discussed above, Community Labor United believes that the appropriate standard by which to gauge workers' ability to escape poverty is the Family Economic Self Sufficiency (FESS) measure. In Massachusetts, this measure is published by the Crittenton Women's Union (formerly the Women's Education and Industrial Union).⁴² The FESS "calculates the income necessary for working families to meet their most basic needs without public or private supports, depending on where they live and who is in their family."⁴³ It assesses the actual minimum income a family needs in order to cover only basic needs such as housing, food, child care, and clothing. It includes no money for entertainment or other non-necessities, but at the same time it does not require families to sacrifice one need to pay for another, as the federal poverty level does. For this reason, the FESS is significantly higher than the poverty level, yet it still marks an income level at which going to the movies or eating out are excluded luxuries.

The table below shows the 2007 Boston FESS income level for three different family configurations.

The Self-Sufficiency Standard for Boston, 2007

Family Type		Boston
1 adult & 1 preschool child	Self-Sufficiency Income	\$49,797
1 adult, 1 preschool child & 1 school age child	Self-Sufficiency Income	\$58,133
2 adults, 1 preschool child & 1 school age child	Self-Sufficiency Income	\$62,095

Source: Crittenton Women's Union Self-Sufficiency Calculator
(<http://www.liveworkthrive.org/calculator.php> [October 2007])

Putting the Boston-area health care occupational wage data up against these self-sufficiency income standards reveals that ***the majority of hospital occupations do not pay a wage that can support a family of three in Boston.*** Of the 85 occupations we identified as existing in the hospitals, 56 (or 66%) have a median income below the Boston FESS income level for a family with one adult and two children: \$58,133. **This means that the typical Boston worker in nearly two-thirds of all hospital occupations cannot afford even a minimal, basic standard of living for himself or herself plus two children.**

Only Three Entry-Level Hospital Occupations Pay At or Above FESS

How do the entry-level workers in Boston's AMCs fare? Forty-one of the hospital occupations listed above are entry-level occupations, and only three pay at or above the Boston self-sufficiency wage for a family of three. This means that the typical worker in over 99% of all entry-level hospital occupations earns less than the wage level that can support a family's basic needs in Boston.

Interestingly, the Boston FESS for a three-person family is very close to the mean income of the 85 hospital occupations we identified. This confirms for us our assumption that the average wage across a wide range of occupations in a large local industry such as health care would represent an actual living wage for Boston workers. Unfortunately, a mapping of the City's hospital labor market shows that its occupations are not clustered around this mid-point income.

In fact, over 56% of these occupations have median incomes outside of and below the mid-point range, defined as a \$20,000 range centered on the mean

occupational wage. (In contrast, only 24.4% of the occupations pay a median wage above the mid-point range.) And these data are only for full-time work. Close to half the jobs in Boston's AMCs are part-time, with those workers earning less in terms of both salary and benefits.

We conclude that the internal labor markets at Boston's large nonprofit teaching hospitals resemble the hour-glass shape that we see in the regional economy as a whole. The hospital economy is not only inequitable; it has a significant degree of inequality, and that inequality is growing. Next, we turn to one more measure of the quality of the jobs Boston's teaching hospitals provide: employee health coverage.

CEO Compensation

The table above does not list the compensation that the CEOs at Boston's teaching hospitals receive. In 2006, each of the AMC CEOs made \$1 million or more in annual compensation, and CEO compensation continues to rise. To put that figure into perspective: \$1 million could cover the basic needs of 17 Boston families for an entire year. It is almost 50 times the median income of the least-compensated occupation in the hospitals, and 14 times the median income for registered nurses.

No Health Care for Many Hospital Workers

A disturbing trend among Boston's hospital workforce concerns the unaffordable high cost of health coverage for a significant number of workers. As health insurance premiums and the employee share of those premiums rise, some hospital workers have been forced to forgo coverage. The result: far too many hospital workers unable to set foot in a hospital as a patient. When they are forced to seek emergency care, many hospital workers find themselves deeply in debt, unable to pay the huge hospital bills that result. Many have seen their meager savings wiped out, and worse, their credit ratings ruined. A 2004 report stated that

half of all personal bankruptcies in the U.S. are related to medical debt.

The Commonwealth of Massachusetts has begun to address the crisis of the uninsured through its universal health care legislation. Over time, the commonwealth's unquestionably innovative policy may ease the situation. In the short run, however, low-income hospital workers may actually face more acute financial distress as the individual mandate to carry health coverage takes effect, requiring them to purchase the costly health plans offered by their hospital employers.

In the past year, Massachusetts has seen increases in both the number of hospital workers (and their dependents) who are enrolled in the commonwealth's Medicaid program of health coverage for low-income residents, known as MassHealth, and in the total cost to MassHealth and the Uncompensated Care Pool for services provided to hospital employees:

- ▶ **In FY06, Massachusetts spent approximately \$1,400 per user on MassHealth and Uncompensated Care Pool services for hospital employees and their dependents. The total cost to the state was just over \$13 million.**
- ▶ Of this amount, more than \$8.6 million was paid for health care for 2,028 employees of the Boston AMCs and their dependents.
- ▶ There were 2,817 hospital workers enrolled in MassHealth and 1,514 hospital workers who used the Uncompensated Care Pool in FY06.
- ▶ Costs to MassHealth for services received by dependents of hospital employees jumped 23% between 2005 and 2006 for the 25 hospitals that appeared in both FY05 and FY06 data. Combined total costs to MassHealth and the Uncompensated Care Pool for these same hospitals increased 8%.
- ▶ **The number of hospital workers enrolled in MassHealth increased by 8% between 2005 and 2006 at the 25 hospitals that appeared in both FY05 and FY06 data. Among the 11 Boston AMCs that appeared in both years' data, the increase was 15%. At this rate, enrollment in MassHealth among AMC workers will double within five years.**

AMC Employees Using MassHealth, 2006

Employer Name	Count of MassHealth Members (employees only) plus Uncompensated Care Pool Users
MASS GENERAL HOSPITAL	678
BETH ISRAEL DEACONESS MEDICAL CENTER	399
BRIGHAM & WOMEN'S HOSPITAL	376
BOSTON MEDICAL CENTER	235
CHILDREN'S HOSPITAL	186
TUFTS MEDICAL CENTER	154
TOTAL	2,028
<small>Note: The remaining two academic nonprofit hospitals in Boston have fewer than 50 each. Source: Massachusetts Executive Office of Health and Human Services</small>	

CLU believes that large, wealthy institutions such as Boston's teaching hospitals should be expected to provide affordable health care coverage to their own employees. On that basis, the thousands of AMC workers who are enrolled in MassHealth or utilize the Uncompensated Care Pool—and the millions of dollars the commonwealth spends on their health care—represent another taxpayer subsidy to these giant institutions.

In a truly equitable economy, no full-time worker would earn less than a basic self-sufficiency income. And institutions making millions of dollars in profit, receiving millions more in publicly subsidized tax exemptions, and paying their executives millions of dollars in compensation would have a workforce in which no one is unable to afford the basic needs of life, let alone live in poverty. We can only conclude that the employment practices of Boston's large teaching hospitals render the City's labor market and economy less equitable, not more.

IV. CHARITY CARE

When we consider how corporations can give back to the community, we often look at the core businesses they are engaged in. So, banks are asked to open branches in neglected neighborhoods or make loans to underserved populations. Supermarkets are asked to donate food for community events or hire from the neighborhood.

What about hospitals? Providing free medical care to the needy is an obvious contribution closely related to their core business. But the picture is not so simple. Hospital officials typically describe their institutions' direct contributions to their local communities as falling into two categories, uncompensated care and community benefits programs. These categories can be misleading. A report by the Consumers Union explains:

A charity care discussion generally involves two opposing views with advocates arguing that charity care is an important requirement for nonprofit hospitals and the hospitals asserting that charity care is just one component of the 'uncompensated care' or 'community benefits' provided by the hospital. The problem with the term 'uncompensated care' is that because it typically includes bad debt (services provided to people who are able but refuse to pay for it), it does not accurately depict what a hospital provides to those who cannot afford to pay for their medical services. The term 'community benefits' is problematic because there are typically few restrictions on what qualifies as a 'community benefit', the term may be applied to hospital expenses that have no connection to the community's needs.

"Community benefits" is a tricky label for hospitals' contributions because the idea means different things to different people. For some, it refers to medical programs specifically created to serve neighborhoods abutting the hospital or affected by its construction or operations. For others, it means conforming their physical and programmatic development to the needs or desires of local community planning. Traditionally—and this is directly related to their tax exemption—it means providing charity care, or free care to poor people.

We use the level of uncompensated charity care as the criterion to evaluate the AMC's direct contributions to the Boston community. (We stress "uncompensated" because historically, Massachusetts hospitals have been reimbursed for portions of their charity care through the Uncompensated Care Pool.) There are three reasons for this choice of criterion. First, it is the truest measure of a hospital's voluntary service to the poor. Second, in addition to being long accepted as a duty of nonprofit hospitals, the measure is easy to quantify and compare. Finally, Congress is currently considering legislation that

would establish a minimum uncompensated charity care threshold that nonprofit hospitals must meet. This proposal represents an external benchmark to which the records of Boston’s teaching hospitals can be compared.

The table below shows uncompensated charity care spending by the seven large Boston AMCs for the years 2001 to 2006.

Annual Charity Care Expenditures for Seven Boston Academic Medical Centers 2001-2006

AMC	2001	2002	2003	2004	2005	2006
BIDMC	\$ 2,970,604	\$2,297,443	\$9,112,416	\$9,736,553	\$9,624,747	\$13,567,159
BMC	\$ 2,778,783	\$2,234,199	\$9,667,818	\$25,228,627	\$ -	\$ -
BWH	\$ 2,980,958	\$2,627,941	\$11,374,253	\$10,944,452	\$10,019,658	\$8,095,832
CHB	\$ 1,610,846	\$1,308,336	\$5,413,498	\$ -	\$ -	\$ -
MGH	\$ 3,626,383	\$3,200,479	\$13,738,245	\$24,177,467	\$20,094,204	\$19,749,641
St E	\$ 954,290	\$823,725	\$2,980,124	\$2,024,173	\$873,317	\$429,175
TMC	\$ 1,439,082	\$1,315,979	\$5,569,599	\$5,322,913	\$3,134,531	\$ -

Source: Uncompensated Charity Care Figures are taken from the amounts reported as “Shortfall Allocation” in each year’s Uncompensated Care Pool Annual Report. Blanks reflect unavailable data.

We put these dollar figures into perspective by comparing them to the proposed federal goal for nonprofit hospitals’ spending on charity care. The proposal originated in response to a June 2007 IRS report showing that a significant number of nonprofit hospitals around the country are failing in their responsibilities to the poor. The IRS found that about one-quarter of nonprofit hospitals nationwide spend less than 1% of their revenue on charity care, and half spend only 3% or less. At the other end, nearly 20% of nonprofit hospitals nationwide spend 10% or more on uncompensated charity care. However, since such a large number of institutions spend so little on charity care, federal and state officials are increasingly questioning whether nonprofit hospitals provide enough charity care to qualify as charities and justify their tax exemption.

Sen. Charles Grassley of Iowa has proposed some changes to tax law to create specific criteria hospitals must meet in order to receive tax exemptions as nonprofits. His proposal includes:

- ▶ Requiring nonprofit hospitals to spend 5% of annual patient revenues or operating expenses—whichever is more—on charity care.
- ▶ Limiting insiders on a hospital board to 25%, down from 49% today—and limiting doctors on the board and board committees to 25% as well, except for committees overseeing such matters as quality of care, credentialing, etc.
- ▶ Restricting hospitals to charging the indigent no more than either the actual cost of services or the amount the federal government would reimburse the hospital if federal coverage applied.

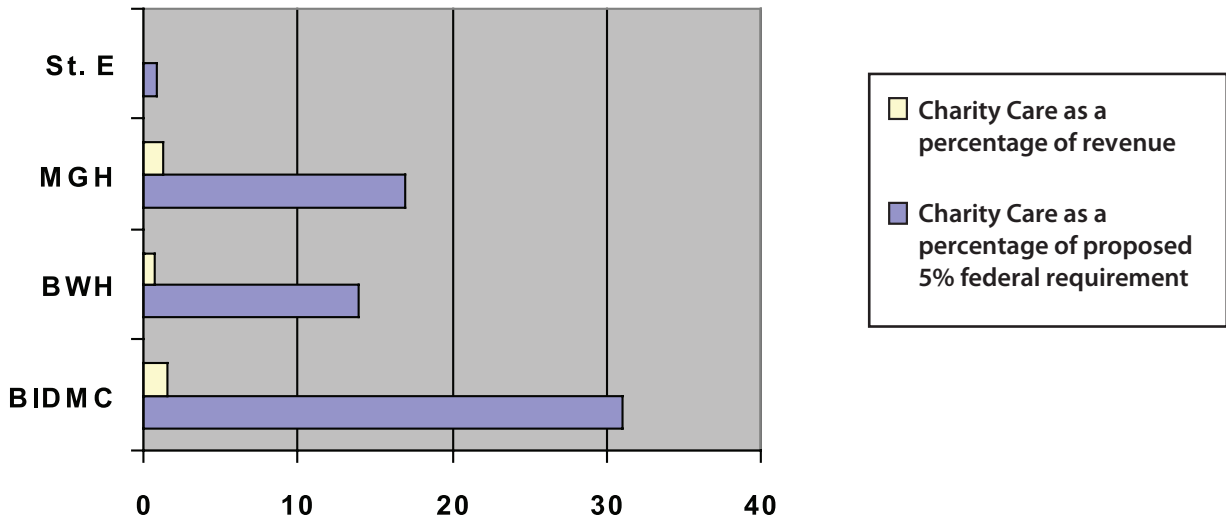
The table below shows how much Boston’s AMC’s spent in 2006 on uncompensated charity care as a percent of their revenue that year and as a percent of the federal goal. That year, none of the Boston AMC’s for which we have data spent even 2% of their revenue on uncompensated charity care. And none of them came within even 50% of the proposed federal standard; in fact, none of them came within 50% of the federal goal in any year out of the past five. The same information is illustrated on the bar chart that follows.

Boston AMC Uncompensated Charity Care as Percent of Revenue (left shaded column) and as a Percentage of Proposed Federal Goal (right shaded column)

2006	Uncompensated Charity Care (UCC)*	Net Patient Service Revenue (NPSR)	UCC as a % of Net Revenue (NPSR)	Federal UCC Goal (5% of Net Revenue (NPSR))	UCC as % of Federal Goal
BIDMC	\$13.6 M	\$879.3 M	1.5%	\$44 M	31%
BMC	0	\$733.5 M	-	\$36.7 M	0
BWH	\$8.1 M	\$1.2 M	0.7%	\$58.3 M	14%
CHB	0	\$747.1 M	-	\$37.3 M	0
MGH	\$19.7 M	\$1,486.7 M	1.3%	\$74.3 M	27%
St E	\$.4 M	\$1,058 M	0.04%	\$52.9 M	.8%
TMC	0	\$510.3 M	-	\$25.5 M	0

* Figures rounded to the nearest \$.1M. Data from UCP Reports, audited AMC financial statements

2006 AMC Charity Care Expenditures as a Percent of Revenue and as a Percentage of Proposed 5% Federal Requirement



Source: Audited AMC Financial Statements

Three of the seven Boston teaching hospitals had net charity care figures of zero for 2006. This reflects the fact that they were reimbursed by the Uncompensated Care Pool for all the costs they incurred providing free care to low-income individuals. In some instances, however, the net charity care figure, while useful, does not give a complete picture. Some hospitals with no reimbursed charity have, in fact, been providing charity care. BMC, for instance, is by far the leader in the provision of charity care in the City of Boston. No hospital receives more emergency room patients, and anecdotal evidence tells us that BMC is the hospital that low-income people turn to in order to be treated fairly and with respect when a health crisis strikes their households. With nearly twice as many ER visits as the next busiest AMC, BMC's burden of emergency care is significant and should be considered an important part of its provision of charity care. For both BMC and Children's Hospital, the legislature has made specific provisions to reimburse them for their strong provision of charity care.⁴⁸

More broadly, though, considering the amount of profit Boston's large teaching hospitals make, there appears to be no good reason they have been providing such consistently low rates of net charity care.

V. CONCLUSION: BOSTON'S NONPROFIT ACADEMIC MEDICAL CENTERS CAN—AND SHOULD—CONTRIBUTE MORE FAIRLY TO THE CITY THEY CALL HOME

This region's large health care sector is commonly portrayed as a positive economic engine. The size and expansion of Boston's health care sector is in part an outcome of public policies that allow hospital expansion and provide tax exemption. These policies unquestionably create additional economic pressures on Boston's taxpaying working families. So it is reasonable to ask whether those pressures are balanced by the benefits a prosperous health care industry is bringing to Boston's residents—whether the industry makes a fair contribution to the people of Boston in return. A detailed examination of one significant part of that sector, Boston's large academic medical centers, leads us to conclude that the answer is no.

At the outset we posed three tests:

- 1) Do the AMCs, as large property-owning institutions, pay a fair share of the cost of providing essential municipal services in the City of Boston?
- 2) As large employers that are influential in the City's labor market, do they help to make the labor market equitable and provide jobs with decent benefits and with wages that allow their workers to meet their families' basic needs?
- 3) And do they use their medical expertise and healthy financial surpluses to provide an adequate level of uncompensated charity care to poor Boston residents?

The evidence shows that Boston's AMCs fail all three of these tests.

► **NO FAIR SHARE TAX CONTRIBUTION:** Despite the City's intense efforts, the AMCs as a group fail to pay even half of the sum the Mayor Menino and the City have designated as their fair-share contribution to the costs of essential municipal services; and this amount, in turn, represents only a fraction of what residential and commercial property-owners who are not tax-exempt must pay. The nonprofit property tax exemption creates the need for higher residential and commercial property taxes to compensate for the nonprofit hospitals' share of city services.

► **INEQUITABLE AND INADEQUATE HOSPITAL WAGES:** On the labor side, the labor market for hospitals and health care is significantly inequitable, with the median wage in almost two-thirds of its occupations insufficient to cover the cost of very basic necessities for a family of three in the City. Almost all entry-level occupations fail to pay a self-sufficient wage. The lowest paid hospital CEO still makes enough money to support 17 Boston families for a year, while the lowest paid hospital worker will need three jobs to support her family.

► **COST SHIFTING EMPLOYEE HEALTH CARE COSTS:** Boston’s AMCs shift the costs of providing health care for many of their employees to the general public, when these uninsured employees and their dependents use taxpayer-funded MassHealth and Uncompensated Care Pool services. In FY06, Massachusetts taxpayers spent just over \$8.6 million on MassHealth and the Uncompensated Care Pool services for health care for 2,028 employees of the Boston AMCs and their dependents. The total cost for employees and dependents of all nonprofit Boston hospitals was over \$13 Million.

► **INSUFFICIENT UNCOMPENSATED CHARITY CARE:** The Boston AMCs do not begin to meet the proposed federal standard of spending 5% of their revenue on uncompensated charity care for low-income patients. Together, Boston AMCs provide less than half the level of charity care suggested by proposed federal legislation. Not providing free healthcare to needy persons creates a strain on the poor in seeking health care, forces enhanced government subsidization of health care costs, and ultimately costs the taxpaying working families whose tax dollars cover these costs.

► **HIGH AMC PROFITS:** Finally, these failures cannot be explained by a lack of resources: although they do not term them “profits,” Boston’s AMCs have annual operating surpluses totaling hundreds of millions of dollars. There is no credible evidence that the AMCs cannot afford to pay more equitable and self-sustaining wages for their workers and to provide more generous uncompensated charity care, just as there is no credible evidence that they cannot better support a fair share of essential municipal services.

The tax exemptions that Boston is required to grant institutions such as the Academic Medical Centers rest on an assumption that the institution is indeed fulfilling its exempt purpose. As the AMCs have grown into physically huge, legally complex, multi-billion dollar enterprises, new questions arise about whether this is in fact the case

Community Labor United believes that our economy is shaped as much by creative public policy and broad civic participation as it is by the specific types of economic activity located here. The shift from a manufacturing-based economy to a service-based economy need not condemn us to low wages, high unemployment and shrinking public services. As in the past, organized communities, organized workers and innovative leadership can lead our region towards an economy where working people can support their families, where cities have the funds to pay for necessary services, and where residents and intuitions share the revenue burden. Community Labor United is hopeful that Boston’s academic medical center’s can play a positive role in helping us to move in this direction.

Appendix: Methodology

Hospital Profit

The sources for the data in this section of the research brief are all publicly and readily-available. The Community Benefit, Service, and Charity Care data are from the Massachusetts Attorney General's Office. The PILOT data are from the City of Boston Assessor's Office. The asset and surplus (profit) data are from the Massachusetts Executive Office of Health and Human Services.

Municipal Finance

Using the City of Boston's Assessor's parcel database, we retrieved all practicably available parcels for 33 of the 34 nonprofit medical facilities listed by the Assessor's Office for fiscal year 2007. We omitted one facility—Mental Health Programs, Inc.—because it appeared to be a supported housing organization rather than a medical provider. For each parcel we found associated with one of the remaining 33 facilities, we collected the assessed value of the parcel (land plus building value), the net tax owed on the parcel, as well as the address, listed owner, property type, year (if any) that the parcel changed from a tax-paying type to exempt, and the parcel ID number. With this information we calculated the amount of tax that would be owed if the parcel was taxed at the FY07 commercial rate (\$26.87 per \$1,000 of assessed value). Using this number we calculated the PILOT goal (25% of the commercial tax amount). We used the commercial tax rate rather than the residential tax rate because the presumed functions on each parcel is commercial, even if it is exempt. Of course, the parcels we studied could be changed from nonprofit to residential uses, and then assume a residential tax rate, but this is speculative. The uses on these parcels right now is (almost entirely) analogous to commercial uses—the uses were they not exempt would currently be taxed at the commercial rate.

An important note about the parcels we analyzed: we cannot make any warranty that we uncovered all the parcels owned by the institutions we studied. The way in which ownership is listed varies, including through the use of limited liability subsidiaries, complicated our ability to be confident that we retrieved all the parcels. A more intensive research project could have been employed to uncover even more parcels; however, we believed that was not necessary. The results may be under-inclusive of the actual property value these institutions have; but that results in a conservative approach to the research. If one institution has a total assessment of \$100 million from our approach, we know that it has at least \$100 million of property value, but that it could have \$150 million. Even if it paid taxes on the extra \$50 million, that tax would not compensate for the lost tax revenue on the first \$100 million.

There is one area in which our research might overestimate, rather than underestimate. That is in the category of gross tax. On only a handful of parcels the property type is residential and is taxed at the lower residential rate (10.99). While we made efforts to adjust the gross tax accordingly, it is likely that there have been mistakes and the total amount is overestimated. This is problematic because this overestimation will follow to the calculations on lost revenue, but not PILOT goal. This means the PILOT goal will be overstated slightly. For the medical facilities, the number of parcels classified as residential is less than ten out of over 600. Any error here is very small and does not significantly alter any findings.

Another important caveat concerning the PILOT data: our reference to the "PILOT goal" in this research brief is to the monetary goal, not the property capture goal. Boston's PILOT criteria on property capture is that only new construction or expansion of existing construction triggers a negotiation over a PILOT agreement. However, we consider all parcels regardless of date of construction. Our task is to examine the lost revenue from tax exemption, and the property capture goal is unimportant to that task. We are not making an argument with this data that the City is not collecting enough money under its own PILOT criteria; we are showing the lost revenue on these parcels are a result of the tax exemption, taking PILOT payments into account. A final note on this point: the PILOT monetary goal is useful to note for two reasons: (1) it theoretically represents the amount of direct impact any property has on the City's "essential services" and

(2) under current policy it is the maximum the City would collect from exempt parcels assuming all construction is post-1985. This means the amount is an overestimation, not an underestimation of maximum collection; which in turn means we can conservatively estimate the lost revenue even if all parcels were subject to the maximum PILOT.

Wages and Labor Market

The research question for this section is: “Are the hospitals making a fair contribution to employment outcomes for their workers?” We approached this question by considering the following sub-questions: (1) are hospitals providing equitable labor markets? and (2) how would we know if they are?

An equitable distribution of wage data would appear visually to be barrel-shaped around a mid-point wage that afforded workers means to pay for their basic needs. We map the distribution of wages by (1) identifying a wage mid-point in the hospital labor market, (2) mapping the labor market to see how it shapes around that mid-point, and (3) comparing that mid-point with a self-sustaining wage. One of our hypotheses is that the mid-point in the labor market should track with the self-sustaining wage, and therefore the shape of the labor market is an accurate indicator of its equitable distribution.

We are limited by the data, and this presents us with some challenges. First, we cannot map the AMC wage data itself because we have no occupational income data for these institutions. Second, we cannot represent the number of employees on the map because even at the sector level, many of the occupations employed in the health care sector are not reported as health care jobs, but are reported in larger aggregates. For example, there are over 400,000 people employed in “office and administrative support occupations” in Greater Boston. These people are employed at all sorts of different kinds of workplaces, not just hospitals.

To answer the question we have posed about the shape of the hospital labor market, we had to create a methodology that would do so. Here is what we did. First, we collected median salary data on all health care occupations from the BLS for its May 2006 employment survey for the Boston-Cambridge-Quincy NECTA. This is the most recent publicly-available data at the smallest geographic area that includes the City of Boston. Second, we made some assumptions about the kinds of jobs that are employed in hospitals, but are not reported as health care occupations, and collected the same salary data as for the health care occupations. Third, because we could not make assumptions about the numbers of workers in non-health care occupations who are working in hospitals, we used the occupation (and not the worker) as the unit of observation. Fourth, we found the mid-point wage of the labor market by calculating a mean (not median) salary for all identified occupations. We used a mean because it better represents a qualitative mid-point to the market. A median, by definition, would have shown us a market in which half the occupations were higher and half lower—and, consequently, would tell us nothing of any significance about the labor market as a whole. Fifth, we made an assumption about a mean area, in which all occupations in this area, while not actually hitting the mean point, could be fairly said to be in the middle of the market. We initially calculated that area as being with ten percent of the mean salary on either side (calculated as ten percent of the mean salary). This gave us a \$12,000 area around the mean, which we then expanded to \$20,000 (\$10,000 on either side of the mean) in order to compensate for any error. This gave us a range of \$20,000, from \$49,224 to \$69,224—an area we assume is the mid-point wage of our hospital labor market.

The mean income for all 85 hospital occupations for which we had wage data is \$59,224 (note: the self-sufficiency wage is \$58,133). This is not the median income for all hospital workers, but it does tell us that the average occupational wage among all hospital workers (health care and others) is just under \$60,000 and very close to the self-sufficiency wage. From this we can see how many occupations pay a wage higher than the mean, and how many lower, and how many at it. This tells us how concentrated or non-concentrated the income distribution is.

We use the Family Economic Self-Sufficiency (FESS) measure as our self-sufficiency wage. The FESS was developed by the Crittendon Women’s Union. This measure takes into account how much

income is needed to pay for basic needs for families of certain sizes. We use the family with one adult, one preschooler, and one school-age child to better approximate the buying power of one income on a family.

Monthly Costs

Housing	\$1,304
Child Care	\$1490
Food	\$522
Transportation	\$71
Health Care	\$343
Miscellaneous	\$373
Taxes	\$1009
Earned Income Tax Credit (-)	\$0
Child Care Tax Credit (-)	\$-100
Child Tax Credit (-)	\$-167

Below are the monthly self-sufficiency standards for Norfolk County (Brookline) and Suffolk County based on 1 Adults, 1 Preschool, 1 School-age. The annual Self-Sufficiency Wage is \$58,133.

Summary of our findings:

- ▶ 24.4% of the occupations are above the mid-point wage.
- ▶ 18.8% of the occupations fall within the mid-point wage.
- ▶ 56.4% of the occupations are below the mid-point wage.
- ▶ The top tier occupations range from \$70,000 to \$145,600 (and above). This represents a range of \$75,000. About 2/3 of these top tier occupations are above \$100,000.
- ▶ The difference between the highest compensated occupation in the lower 1/3 and the lowest compensated occupation in the higher 2/3 is just under \$20,000.
- ▶ The range for the entire 48 occupations below the midpoint is about \$28,000.
- ▶ The best compensated occupation below mid-point wage is about 1/2 of the income of the best compensated occupation in just the lower 1/3 of the occupations above the mid-point wage.
- ▶ Of the 41 entry-level occupations for which we have wage data, only 3 (three) pay at or above a self-sufficient wage.
- ▶ 64.7% of occupations have a median salary below the self-sufficiency wage for Boston.

Charity Care

In this section we make a straightforward comparison between the percentage of patient-related care that is spent on uncompensated charity care and the proposed federal standard of 5%. The AMCs' actual percentage is taken from their 2006 audited financial statements. The annual charity care expenditures (actual amounts, not percentages) are taken from the amounts reported as "Shortfall Allocation" in the Uncompensated Care Pool Annual Reports for the years 2001-2006.

Endnotes

¹ Formerly known as Tufts New England Medical Center, this AMC formally changed its name to Tufts Medical Center in March 2008. We use the new name throughout this report.

² J.F. Ryan Associates, Springfield Financial Control Board Project Plan (2005).

³ We use the Family Economic Self-Sufficiency (FESS) measure as our self-sufficiency wage. The FESS was developed by the Crittendon Women's Union. This measure takes into account how much income is needed to pay for basic needs for families of certain sizes. We use the family with one adult, one preschooler, and one school-age child to better approximate the buying power of one income on a family. It is widely used as a benchmark by Workforce Investment boards, social service agencies and legislators. Lassen, Mary, *Family Cost Index is Widely Accepted*, Boston Globe, May 29, 2001, p. A18.

⁴ As reported by Senator Grassley at <http://grassley.senate.gov/releases/2007/07182007.pdf>

⁵ See The Massachusetts Institute for a New Commonwealth, "The Massachusetts Nonprofit Sector: An Economic Profile," (2006); Conference of Boston Teaching Hospitals, "Driving Greater Boston & New England: The Impact of Greater Boston's Teaching Hospitals," (Tripp Umbach 2007).

⁶ Community Labor United, *The Hourglass Challenge: Creating a More Equitable Economy for Greater Boston* (2006) at 27.

⁷ Boston Redevelopment Authority, "The Boston Economy 2007: Steady Growth."

⁸ Some also qualify as academic, scientific and educational exempt entities. For example, St. Elizabeth's can claim tax exemption based on its status as a religious institution. Charitable status is very important, but not controlling here.

⁹ PILOT means "payment in lieu of taxes." It is a voluntary agreement to pay money to a government in the absence of owing taxes. PILOT agreements are explained in more detail below.

¹⁰ It is important to note that despite the above discussion, the hospitals are not making profit every year. Some, particularly the smaller ones, have several years of loss. Even a few of the larger ones have had losses in one or two years over the five studied in the table below. The figures in the table above are not cumulative, but represent profit or loss in the year specified.

¹¹ Paige, Connie, *Engine 6 Funding Sought*, Boston Globe, June 26, 2005.

¹² Gabrielle Gurley, "Municipal Meltdown," *CommonWealth Magazine* (MassINC: Fall 2007), "The Massachusetts Nonprofit Sector: An Economic Profile," (2006); Massachusetts Budget and Policy Center, "Property Tax in Massachusetts: Trends and Options" (January 10, 2007); Boston Municipal Research Bureau, "Special Report: Boston's Property Taxes in Limbo," No. 07-4 (October 2, 2007); Boston Globe, "A Crisis in Cities and Towns," (Editorial: January 11, 2008).

¹³ Massachusetts Budget and Policy Center, "Property Tax in Massachusetts: Trends and Options" (January 10, 2007), at p.1.

¹⁴ This remains true despite the slight reduction in the property tax rate the City made for FY08.

¹⁵ This is 5.41% of the land by value.

¹⁶ Kocian, op cit. Lisa, *Officials Want Harvard to Pay Taxes Legislation Filed on Nonprofits*, Boston Globe, June 10, 2001, Globe West p. 1. Vennochi, Joan, Rich, *Old Harvard is Jeopardizing Watertown's Security*, Boston Globe, July 13, 2001, p. A23.

¹⁷ Greater Boston Cities that currently have at least one PILOT agreement include: Boston, Cambridge, Somerville, Medford and Newton.

¹⁸ Noonan, Erica, *Should Non-Profits Chip In?*, Boston Globe, October 18, 2007. The cities of Boston, Cambridge, Somerville, Medford and Newton currently have PILOT programs, and a growing number of other municipalities in Massachusetts are beginning to consider PILOT programs to deal with their fiscal shortfalls.

¹⁹ J.F. Ryan Associates, Springfield Financial Control Board Project Plan (2005).

²⁰ For example, in 2006, Mayor Menino got five colleges to make a \$10 million commitment to building campus partnerships between five colleges and 10 struggling public schools. Estes, Andrea, *City talks of donated medical care*, Boston Globe, April 12, 2006. *Untapped Assets*, op. cit. Grillo, Thomas, *Council Considers Fee for Off-Campus Students*, Boston Globe, March 19, 2000, p. B4. *What Harvard Owes Allston*, Editorial, Boston Globe, p. A26. *A college try for Boston*, Boston Globe Editorial, November 7, 2006.

²¹ City of Boston, Revenue Estimates and Analysis, FY08, p. 83

²² Zuckoff, Michael, *Communities Ask Colleges for Financial Contributions*, Boston Globe, May 6, 1990, West Weekly p. 1.

²³ Flint, Anthony, *Tug of War Over Resources Towns Reach for Gowns Pockets*, Boston Globe, September 24, 1990, Metro p. 1. Kong, Dolores, *Tug of War Over Resources Hospitals' Help Urged for City Needs*. Boston Globe, September 24, 1990, Metro p. 1. Marantz, Steve, op cit.

²⁴ Although the process is theoretically done on a parcel basis, data on PILOTs is not disseminated on a parcel basis, but on an institutional basis. The City's budget does disaggregate PILOTs lower than the institutional level. According to the Budget Management Office, parcel-level PILOT information is not collected. (Interview with OBM staff.)

²⁵ There are 45 tax exempt entities paying PILOTs to Boston in FY07. The average PILOT for 44 (excluding Massport) is \$280,491. Massport pays by far the largest PILOT at \$15,000,000. When Massport is included, the average PILOT shoots up to \$607,591. There are nine medical facilities paying a PILOT in FY07. The average PILOT for the medical facilities was \$457,264.

²⁷ *Untapped Assets*, Editorial, Boston Globe, September 9, 1993. Marantz, Steve, *Boston Rethinking Exemption Nonprofits' Funds Sought*. Boston Globe, February 4, 1991, Metro p. 13.

²⁸ Kocian, op cit. Kocian, Lisa, *Looking for a Deal on Taxes Harvard, Town in Talks Over Arsenal Complex*, Boston Globe, August 16, 2001, Globe West p. 1.

²⁹ Some versions of this counted only out-of-state students; others counted only students living off-campus. Slack, Donovan, *Council Mulls Budget Measures*, Boston Globe, January 30, 2003, p. B8. Dade, Corey, *Council Rivals Outline Goals*, Boston Globe, September 19, 2003, p. B8. *Councilor wants new fee for colleges*, Boston Globe, February 11, 2004, New England in Brief.

³⁰ Greenberger, Scott S., *Hub Would Tax the Tax-Exempt*, Boston Globe, May 17, 2003, p. A1. *Tax-Exempt Fairness*, Boston Globe Editorial, June 7, 2003, p. A12.

³¹ Drake, John C. *What price history?*, Boston Globe, April 17, 2008.

³² It is also important to note that there is a personal property tax in Boston and the value of exempting such property (such as medical devices, office equipment, etc.) is significant. However, the personal property valuation information is, unlike real property valuation, private and not available to us for analysis

³³ This is based on the Massachusetts Family Economic Self-Sufficiency Standard (MASSFESS), developed by what is now Crittendon Women's Union. In the 10 years since its introduction, the MASSFESS has become a widely used benchmark. Note that in the employment section of this study we use a self-sufficiency wage for a family of three, not four. The reason we use a family of four in the passage above is to keep the data consistent with the median family income data. The reason we use a family of three in the employment section is to compare the purchasing power of a single income.

³⁴ US Bureau of the Census, 2002 Economic Census.

³⁵ Research conducted by SEIU L1199.

³⁶ Massachusetts Job Vacancy Surveys, Department of Workforce Development, 4th Quarter 2004 and 4th Quarter 2005.

³⁷ Cardiovascular Technologists and Technicians, Licensed Practical and Vocational Nurses, Medical and Clinical Technologists and Technicians, Medical Records and Health Information Technicians, Nuclear Medicine Technologists, Nursing Aides, Orderlies, and Attendants, Physical Therapist Aides and Assistants, Radiologic Technologists and Technicians, Registered Nurses, Respiratory Therapy Technicians, and Surgical Technologists.

³⁸ MA Division of Career Centers and Division of Unemployment Occupational Employment and Wage Statistics May 2005

³⁹ Massachusetts Division of Unemployment Insurance, "Commonwealth of Massachusetts Employment Projections 2000—2010."

⁴⁰ Center for Labor Market Studies, "Assessment of Postsecondary Education Needs and Participation by Working Adults in the Greater Boston RCC," (Northeastern University: February 2004).

⁴¹ Bureau of Labor Statistics Wages by Area and Occupation, Metropolitan Area Wage Data, Boston-Cambridge-Quincy MA NECTA Division, May 2006.

⁴² Hourglass Challenge at pp. 30-31.

⁴³ H.B. Boyle et al, "Investing in Massachusetts Working Families: A Framework for Economic Prosperity," (Boston, MA: The Women's Union, The Massachusetts Family Economic Self-Sufficiency (MassFESS) Project, April 2004), page 39.

⁴⁴ Health Access and SEIU 250, "Your Money or Your Health: Discriminatory Pricing and Aggressive Debt Collection Practices by Sutter Health in San Francisco," (May 2004). See also, David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness And Injury As Contributors To Bankruptcy," *Health Affairs* 24 (2005).

⁴⁵ Leslie Bennett, "It's All in the Numbers: A Beginner's Guide to Charity Care Analysis" (Consumers Union of U.S., Inc. undated) at 1-2.

⁴⁶ Other ways that hospitals have argued they are providing their charitable services: through community service programs, in community benefits agreements with individual community groups (such as community development corporations), and pay payments such as Linkage and PILOTs. There is nothing wrong with any of these programs, but they are insufficient indicators of the community benefits hospitals should provide as large employers engaged in medical business and paying no taxes. Reasons for this are:

- ▶ Community Service programs—same concerns as stated in the text concerning community benefit programs.
- ▶ CBAs with CDCs—these are private agreements with organizations that are not legally representative of the community, they are not easily available to the public for review, they do not compensate for lost revenue to the city.
- ▶ Linkage—this is a requirement that all developers must pay if their developments meet certain criteria; it is neither voluntary nor a medical business community benefit.
- ▶ PILOT—these payments are not for community benefit but for compensation for essential services of the city.

⁴⁷ <http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf>

⁴⁸ Beginning in Fiscal year 2004, the Uncompensated Care Pool began using a prospective payment system that based current year payments on prior years' experience (plus several adjustments). Because of this change, it was possible for some hospitals to receive payments greater than their experience in that year. Additionally, certain hospitals (including BMC and CHB) receive guaranteed rates or amounts of payments to reflect their particular mission of serving large numbers of uninsured patients.

BUILDING A BETTER FUTURE TOGETHER



CLU | COMMUNITY
LABOR
UNITED

8 Beacon Street, Second Floor
Boston, Massachusetts 02108

www.massclu.org

© 2006 Community Labor United. All rights reserved. June 2008