S. HRG. 109–967

TAKING THE PULSE OF CHARITABLE CARE AND COMMUNITY BENEFITS AT NONPROFIT HOSPITALS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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TAKING THE PULSE OF CHARITABLE CARE AND COMMUNITY BENEFITS AT NONPROFIT HOSPITALS

WEDNESDAY, SEPTEMBER 13, 2006

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Present: Senators Snowe, Thomas, Santorum, Baucus, Rockefeller, and Schumer.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Thank you all for being patient. It seems like, from the long line outside, we must have a hearing that people are interested in.

We consider, today, the issue of nonprofit hospitals. Of course, these hospitals are a very vital part of our Nation's health care system. Federal, State, and local governments have provided nonprofit hospitals tens of billions of dollars each year in tax breaks through the tax code, because they are so essential.

It is our responsibility here in this committee of oversight, of how tax dollars are used, to examine these billions of dollars of tax breaks to understand what benefits they are providing to Americans. We recently did that, for instance, in regard to the R&D Tax Credit.

This is important, because I think the President's Panel on Tax Reform had the right idea, and that idea is that, when you look at a tax break, the question is, can it be justified by everyone else having to pay more taxes?

However, I think it is important that we recognize that this policy discussion is not just words and not just numbers, more than any other discussions that we have in this committee. This is about real people and about real people's lives.

I would like to recognize, in the audience, one of these people. I am not going to ask her to stand or anything, but she is here, one who is affected by today's hearing: Mrs. Diane Insco. She is seated in the audience here. I will be entering her statement into the record.

[The prepared statement of Mrs. Insco appears in the appendix.]

The CHAIRMAN. But it is a story we hear all too often in looking at these issues. In short, Mrs. Insco was making $14,000 a year when she was hospitalized due to problems related to her Type II diabetes. She was charged by a nonprofit hospital over $4,639, far more than if she had had insurance.

No one told her about financial assistance or charity care at this hospital. The tax-exempt hospital went after her for debt and ultimately put a lien on her house. Mrs. Insco almost lost her home.

Her story, fortunately, has a happy ending, when, after many lawyers and many phone calls, the hospital did the right thing and tore up the bill.

But I believe this committee needs to think about whether we are comfortable with a system that works only if you have every lawyer in the Yellow Pages getting into the act. I think we can do better, and, I believe, so do the vast majority of tax-exempt hospitals. So I thank Mrs. Insco for traveling to be with us here today and allowing me to share her story.

While there are many issues that I think are important in the area of nonprofit hospitals, I wanted, in my opening statement, to just focus on two of these: measurement and reporting of community benefit, and also discounted charges, or free care, to low-income, uninsured individuals.

I commend the Catholic Health Association and particularly Sr. Carol Keehan, here with us today to testify, who have provided real leadership in establishing best practices for measurements and best practices for reporting for community benefits.

The great frustration in looking at this area is that there is little common ground on how to measure and determine answers to very basic questions. It makes it extremely difficult to make policy judgments.

In our review of nonprofit hospitals, it was very rare to get the same answer or the same methodology to a question. That is not to say that the hospitals that responded gave wrong answers. It is just that this is very difficult to measure and compare. We found that it was not even comparing apples to oranges, but more like comparing apples to farm tractors.

I am pleased that the Catholic Health Association has given us guidance in common terms here, and I think it is something that we should be looking at across the board. Hundreds of hospitals have already agreed to comply with the Catholic Health Association standard.

Should we get everyone else on board? Well, I will be listening closely today to see to what extent Congressional action may be necessary and to what extent the IRS and the nonprofit hospitals can achieve much more meaningful uniform disclosure about hospital activities without additional legislation.

I would like to now look at charity care, particularly discounted care and free care for low-income uninsured. There actually seems to be some agreement that nonprofit hospitals should be providing such discounts and free care. The Catholic Health Association's and the American Hospital Association's testimony today will talk about basic policies in that area.

As always, there are details. But I think it is important for members and the press to recognize that the nonprofit hospital organi-

zations agree that there is a need for real charity care to be provided.

I think the question then comes about, how can we make this policy real for folks like Mrs. Insco, whom I have already referred to? I think that Sr. Carol has it exactly right in her testimony, and she will probably say this again, but let me quote: "It is one thing to have policies in place, and quite another to implement them." We need to think about how we can best make policies of discounted and free care to low-income uninsured a real benefit to those in need.

Nonprofit hospitals receive billions of dollars in tax breaks at the Federal, State, and local levels. The public has a right to expect significant, measurable benefits in return. I hope this hearing will help the Finance Committee decide how we can best ensure that nonprofit hospitals provide appropriate levels of benefit to the communities they serve. As we consider these questions, I think it is right to also bear in mind the particular issues facing critical access rural hospitals.

Let me end by saying that the Government Accountability Office and IRS Commissioner Everson have both commented that there is often little to no difference between for-profit hospitals and nonprofit hospitals when it comes to charity care and community benefits that are provided.

I am confident that many nonprofit hospitals are well-intended and do outstanding work on behalf of their communities and the poor. But I am concerned that the best practices of nonprofit hospitals are not common practices for all, and that needs to be changed.*

Senator Baucus?

Senator SCHUMER. Mr. Chairman?

The CHAIRMAN. Yes?

Senator SCHUMER. Mr. Chairman, I cannot stay. I would just ask unanimous consent that my statement be put in the record.

The CHAIRMAN. Sure.

Senator SCHUMER. It is a defense of nonprofit hospitals who do an incredible job in New York, and do much better, I think, than the for-profits in helping the poor. So, I thank you, Mr. Chairman.

The CHAIRMAN. I am glad to do that, Senator Schumer.

[The prepared statement of Senator Schumer appears in the appendix.]

The CHAIRMAN. Now, Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. Thank you, Senator, very much, for all the good work you are doing.

The book of Ezekiel admonishes that, "We operate through the hand of Providence when we bind up the injured and strengthen the weak." The Prophet makes this admonition to the community as a shared responsibility.

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*For additional information on this subject, *see also,* "Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals," Joint Committee on Taxation staff report, September 12, 2006 (JCX–40–06).

Many tax-exempt hospitals nobly carry out Ezekiel's instruction. They work to improve neighborhoods, they provide scholarships for students seeking health care careers, and, most importantly, they serve the health care needs of their communities.

In Montana, most nonprofit hospitals are critical access hospitals, that is, hospitals with 25 or fewer beds. They serve rural, often low-income, populations. Critical access hospitals play a key role in rural America's health care safety net.

I was proud to write the legislation that established that category in 1997. More than 4 out of 5 Montana hospitals are critical access facilities, and I dare say that in many rural parts of our country the primary hospital will be a critical access hospital.

Indeed, I think what often distinguishes nonprofit hospitals like those in my State is that they operate where for-profit hospitals do not. For one thing, they show up in small, rural areas. And they do more than just show up. Nonprofit hospitals are more likely than for-profit hospitals to offer services that are unprofitable.

For example, tax-exempt hospitals are more likely to offer psychiatric emergency services. Those services are typically money-losers. Tax-exempt hospitals are five times more likely than for-profits to continue offering services when doing so becomes unprofitable.

Those statistics should not come as a surprise. That is not necessarily a criticism of for-profit hospitals. After all, for-profit hospitals have shareholders, nonprofit hospitals do not. Tax-exempt hospitals can continue to offer unprofitable services on Main Street without regard to what they think on Wall Street.

Thus, many tax-exempt hospitals do good work. They do so in my State, clearly, and also in other parts of our country. But there are also significant examples where nonprofit hospitals have not provided the benefit to the public commensurate with the tax benefits that those hospitals receive.

Today we will hear about cases where nonprofit hospitals aggressively billed patients of limited means after they received vital care they could not afford. We will hear of aggressive hospital bill collectors that act like credit card companies. We will hear of hospitals taking legal action against patients with incomes near the poverty line.

This kind of behavior by tax-exempt hospitals is not in keeping with the spirit of our laws governing tax exemption. I say "spirit," because admittedly the standards that govern tax-exempt status are vague.

As a general matter, in order for a hospital to maintain its tax exemption, the hospital must provide "a community benefit." In the past, if a hospital simply had an open emergency room, had a board that was representative of the community, that accepted Medicare and Medicaid, then it qualified as providing a community benefit.

But recently the IRS and Federal courts have taken a more skeptical view toward the community benefit standard. The IRS now looks for a plus factor in addition to a policy of open admittance.

For example, the tax-exempt hospital must also have charity care, medical research, or a health education program. But the IRS

has not made clear just how much of this a hospital has to have; it is vague, it is unclear.

To some extent, this flexible standard makes sense. After all, the community needs in Manhattan, MT differ from those in Manhattan, NY. Unfortunately, some health providers take advantage of these loose standards.

For example, some providers classify their community benefit based only on their open admission policy, writing off bad debt as charitable care. Not surprisingly, some of today's witnesses will argue that the provision of free care should be the paramount consideration in granting tax-exempt status.

I am very interested in hearing what this standard might mean for rural providers like those in Montana, which often operate with thin or negative margins. The provision of charity care by tax-exempt hospitals is obviously important.

It has significant implications for both hospitals and the Federal treasury. But it is also important because it raises one of the most pressing problems facing our Nation, and that is the 46 million Americans who have no health insurance. Arguably, if all Americans had health insurance, we would not be having this discussion.

One in five Montanans is uninsured. That is one of the highest rates in the Nation. The uninsured are four times as likely not to seek a physician's care when they have a medical problem compared to those who do have insurance. Not surprisingly, the uninsured tend to get sicker and they tend to die earlier.

I realize that universal health care is not just around the corner. This Congress will not even cover the victims of Hurricane Katrina, one of this Nation's worst natural disasters. But until providers and insurers have an incentive to treat sick and uninsured patients, we are going to struggle with the problem of charity care.

I hope that this hearing will encourage more folks in Congress and the administration to think about how we can work together to solve the problem of the uninsured. It has been over a decade since Congress took a comprehensive look at how to tackle this problem, and we are long overdue.

Finally, on another note, Mr. Chairman, I am very proud to have here today Scott Duke, who will be one of our witnesses. Scott is the CEO of Glendive Medical Center in Glendive, MT. He is currently the chair of the Montana Hospital Association's Board of Trustees.

He was born in West Virginia, I am reminded. But he has wisely chosen, at his own discretion, to live in Montana. [Laughter.] Scott will be able to give us a perspective of rural hospitals from both West Virginia and Montana.

Thank you, Mr. Chairman.

[The prepared statement of Senator Baucus appears in the appendix.]

The CHAIRMAN. I am surprised that Senator Baucus referred to it as "rural hospitals," because I talk about rural hospitals and he talks about frontier hospitals. [Laughter.] Thank you.

I will introduce the rest of the group. It may be a very short introduction, but you are all leaders in your areas.

First of all, Phill Kline, Attorney General, State of Kansas. They will be appearing the way they are seated here. Next, we have Sr.

Carol Keehan, president and CEO of Catholic Health Association; Kevin Lofton, chairman of the American Hospital Association. Mr. Duke has been introduced. Then Dr. Nancy Kane, Harvard School of Public Health; and Ray Hartz, director of the Legal Aid Society of Eastern Virginia.

So would you proceed, Attorney General Kline?

STATEMENT OF HON. PHILL KLINE, ATTORNEY GENERAL, STATE OF KANSAS, TOPEKA, KS

Mr. KLINE. Thank you, Mr. Chairman, Senator Baucus, and members of the committee. I appreciate the honor to appear before you today to discuss the billing practices and procedures in treatment of the indigent by nonprofit health care delivery systems in Kansas.

My first day in office, I was greeted with a lawsuit initiated by an integrated, nonprofit health care system called Health Midwest that had been purchased by HCA. In that lawsuit there was the claim that my office did not have the authority to oversee that conversion from nonprofit hospital to for-profit status.

We ended up winning that lawsuit and, as a result, a $110 million foundation was established in Kansas to benefit the indigent in the area in which that hospital provided services.

Before I move on, I know this committee has had some interest in conversions, because the law is similar to the law as it relates to the Internal Revenue Code; however, it is very vague as it relates to the cy pres authority or how those conversions will be handled. I would like to touch on one issue that was raised within the litigation that had not been resolved.

One of our claims was that there was excessive payment in that conversion to the chief financial officer, who had negotiated a $7 million golden parachute as that nonprofit integrated system was converted to for-profit.

Unfortunately, the Kansas court that handled that litigation found that it did not have jurisdiction for review of that issue, and that is a sticking point as it relates to the eventual victory for the State of Kansas.

As the committee is aware, recent studies have revealed health care costs to be a major cause of personal bankruptcies and family indebtedness across the country.

As our population ages, the health care delivery system will play an even greater role in our economy. Kansas law affords the Attorney General cy pres authority and responsibility to ensure that charitable assets are utilized for their intended purposes.

For the aforementioned reasons, I established a task force dedicated to inquiring into the billing of charity care and collection practices of nonprofit hospitals in Kansas. The action was also taken due to various complaints received in my office regarding such practices.

I launched this task force with the goal of initiating a cooperative review of current practices and procedures, and as an effort to avoid media sensation or litigation threats.

I have found that, in almost all instances, those engaged in charitable health care have a strong dedication to the needs of those they serve and operate in a professional and appropriate manner.

There are exceptions. As in all human endeavors, institutions sometimes develop practices and procedures that do not reflect their initial mission or the heart of those involved.

That is especially true when responsibility for enacting a portion of that mission through collection practices is further removed from those who are directly engaged in the provision of care through contracts with outside collection agencies.

It was my hope that, in my approach, I would avoid tarnishing an industry, while identifying the obstacles and procedures to the fulfillment of the mission of nonprofit health care systems. This is what we are now very close to achieving.

Our discussions were initiated at one point in the process. It was necessary to selectively audit the largest nonprofit hospitals in the State. Eventually subpoenas were issued, and in response to those subpoenas discussions held, and a cooperative provision of documents was obtained. Those documents were analyzed and reviewed, and further discussion was held with CFOs of three of the nonprofits within our State.

As a result of those discussions and working with the Kansas Hospital Association, we are developing a best practices model that incorporates provisions relating to outside collection agency contracts, disclosure provisions, financial assistance to be provided to the indigent and under-insured, as well as everything involving hospital visitation rights and authority to initiate litigation.

We have had numerous subsequent individual meetings, and I appreciate the cooperation of the hospitals in Kansas. This eventual cooperative approach by the Kansas health care industry was not unforeseen. My office has generally received few complaints regarding nonprofit hospitals, when considering the nature of the services provided and the scope of this industry.

I suspected that this was true because such hospitals in Kansas operate with a high degree of integrity and dedication to their core mission. This is the case.

We have, together, however, identified some practices, policies, and procedures that should be utilized by all nonprofit health care delivery systems in Kansas, and those changes will be formulated and incorporated into the best practices model.

I am hopeful that this type of cooperative approach might be utilized by others without the necessity of litigation or sensational press, in order to grab the core mission and the heart of those serving the indigent and under-served in our Nation and provide a practice and procedure that is consistent with that core mission for which we have given them the nonprofit status to begin with.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Kline.

[The prepared statement of Mr. Kline appears in the appendix.]

The CHAIRMAN. Now, Sr. Keehan?

STATEMENT OF SR. CAROL KEEHAN, PRESIDENT AND CEO, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, WASHINGTON, DC

Sr. KEEHAN. Good morning, Chairman Grassley, Senator Baucus, and members of the committee. I am Sr. Carol Keehan, president and chief executive officer of the Catholic Health Association.

CHA has been actively involved in the issue of community benefit since the 1980s. For the past year, community benefit has been a major priority for our association, and I am pleased to be here today to discuss this issue with you.

By community benefit, I mean the programs and activities nonprofit hospitals provide to demonstrate they deserve the privilege of tax exemption. It includes free and discounted care to low-income, uninsured individuals, improving access to health care services for all, and making communities healthier places in which to live.

It is important for the committee to know, however, that we do not provide these community benefits in order to prove we deserve tax exemption. We do so because of who we are, organizations established to serve our communities and continuing to do just that.

Our board took seriously the issues raised by you about the need for nonprofit governing bodies to hold managers accountable and the need for sufficient public information about hospitals' charitable activities.

We concluded that to be more accountable we must, first, make sure leaders of our hospitals understand the legal basis for the community benefit standard, commit our organizations to reporting community benefit in a standardized way, using state-of-the-art accounting practices, and, finally, ensure that all Catholic hospitals publicly post the availability of their charity care and discounting policies.

Our first step was to publish, in May of this year, a revised Community Benefit Guidelines booklet reporting community benefit. It includes a detailed definition of the community benefit that is based on the IRS hospital revenue ruling and audit instructions and comprehensive guidelines for accounting for community benefit developed in consultation with national financial groups.

In the past, we have given this guide to our members as an aide. This year, we asked them to follow the guidelines consistently. We have also developed a packet of information to clearly explain the current IRS requirements about community benefit and tax exemption.

As of today, the informational video included in that packet has been viewed by more than 4,000 board members, senior managers, and sponsors of our Catholic health care.

In addition, CHA asked each governing board to pass a resolution committing their institution to using the guidelines consistently and to publicly post the availability of charity care and other financial assistance policies. The packet also included a pledge committing management to carry out the board resolution.

I am pleased to report that, as of today, that board resolution and management pledge have been received from 95 percent of CHA member health systems, and 90 percent of our member hospitals. Additional commitments come into my office every day as various governing boards meet.

Turning to the issue of charitable care, I want to assure you that all of our organizations have financial assistance policies. We have previously provided to Chairman Grassley a fairly comprehensive list of charity care and discount policies of many of our systems for

low-income, uninsured persons and those who experience catastrophic medical expenses.

These vary, as is appropriate, to meet the needs of populations in areas that have different costs of living and different median incomes.

Some of these generous financial policies include providing free care for patients earning up to 200 percent of the Federal poverty level, providing discounted care that does not exceed a certain percent of a patient's income, and offering sliding scale discounts to patients earning anywhere from 300 to 500 percent of poverty.

While our members have committed to publicly posting financial assistance policies, often patients do not tell us they are unable to afford their bills. For example, when patients come to us in emergency situations they may be in no condition to discuss it.

Other patients are reluctant to tell us they cannot afford to pay, or simply refuse or are unable, for a host of reasons, to fill out paperwork or to cooperate in doing it.

Our members have taken steps to address this problem and identify those eligible for charity care and discounting by appointing patient advocates to work with patients, informing patients about financial assistance by taking out newspaper ads, putting the information on all their patient bills, and writing to patients who have outstanding bills, and, lastly, instructing collection agencies to let hospitals know if they discover a patient is unable to pay their bill.

Mr. Chairman, we are pleased with the progress we have made. Our long-term commitment to the people in our communities is being demonstrated every day, and we believe that the community benefit tradition in Catholic and other nonprofit health care organizations has been reinforced by efforts to achieve greater consistency and standardization in reporting.

Over a decade ago, a former Chairman of this committee, Senator Daniel Moynihan, said, "A distinguishing feature of American society is the singular degree to which we maintain an independent sector, private institutions in the public service. This is no longer true in most of the democratic world; it was never so in the rest. It is a treasure, a distinguishing feature of American democracy."

It is important to us in Catholic health care that we continue that tradition of service and live up to the expectation that we are community benefit organizations. That is our mission and our commitment to you, as well as our commitment to the communities we serve.

Thank you. I will be happy to answer any questions.

The CHAIRMAN. Thank you for your statement. I have already expressed my appreciation for your leadership in this area.

Sr. KEEHAN. Thank you, Mr. Chairman.

[The prepared statement of Sr. Keehan appears in the appendix.]

The CHAIRMAN. Mr. Lofton?

STATEMENT OF KEVIN E. LOFTON, CHAIRMAN-ELECT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. LOFTON. Good morning, Mr. Chairman, Senator Baucus, and members of the committee. I am Kevin Lofton, chairman-elect of the American Hospital Association, and president and CEO of

Catholic Health Initiatives in Denver. We appreciate the opportunity to be here with you today.

All of us in the hospital family pride ourselves in how we take care of people. That is our job, our mission, and thousands of times a day, we meet this mission with skill and with compassion.

So when there are problems with a patient's hospital experience, we do not sit still. We take a hard look at how we do what we do. We fix problems that arise, and we work hard to make sure the problems do not happen again.

At the same time, Mr. Chairman, there is a lot of good news. For example, the 66,000 women and men of my health care system provided nearly $800 million worth of benefits to the communities in the 19 States that we serve through charity care, financial assistance, and many other programs.

One example occurred at Mercy Medical Center in Des Moines. The gentleman was a 64-year-old retired Maytag employee who had a heart attack just 2 months before becoming eligible for Medicare. His medical bills exceed $50,000, but his income was $9,000. Mercy Medical Center covered all of his expenses. He wrote to the staff, "Thank you to all who saved my life. It is great to be alive. I promise to sing and dance at your wedding."

There are thousands of examples like Ron, people who left the hospital feeling better about their health and feeling good about their experience, happy that their hospital is in their community, ready and able to take care of their needs.

The tip of the iceberg of these stories is represented by this brochure, *Care in Action,* which I would, if I may, submit for the record, which highlights many of the good things that hospitals do in their communities to fulfill their tax-exempt obligations.

That is why we are here to discuss tax-exempt status for the Nation's not-for-profit hospitals, specifically how the community benefit standard allows not-for-profit hospitals to do the things that make their communities healthier, whether it is walking the streets to treat the homeless, establishing a clinic for vulnerable children, or countless other services hospitals provide every day.

In 2004 alone, hospitals delivered more than $27 billion of uncompensated care to patients, and uncounted billions more in value to their communities through services, programs, and other activities designed to promote and protect health and well-being.

We do this in a way that benefits not just the poor and marginalized, but the community as a whole, with services, programs, and activities tailored to the specific needs of the community.

At the same time, hospitals are available 24 hours a day, 7 days a week, 365 days a year, ready to assist their communities no matter what the emergency. Whether it is a man-made or a natural disaster, hospitals are there.

Diversity of hospital benefits is a direct result of the current community benefit standard. That standard is broad, which allows hospitals flexibility to tailor programs and services to meet the constantly changing needs of their unique communities, from Des Moines to Dallas, from Portland to Richmond.

In other words, Mr. Chairman, it works. That is why we fully support maintaining the community benefit standard as it exists.

Not-for-profit hospitals are part of, and responsive to, their communities.

Those communities should decide what programs and services are needed and hold hospitals accountable for meeting those needs. The community benefit standard helps this to happen.

I would add that, back in May, the AHA Board of Trustees voted unanimously to call on all hospitals to demonstrate their accountability to their communities. This includes making sure that there is charity care for the poor and uninsured, financial assistance for others in need, more careful collection procedures, and comprehensive reporting to the community on community benefits that not-for-profit hospitals provide.

Specifically, the board called for standardized public reporting of community benefit using the model developed by the Catholic Health Association, in cooperation with VHA.

The board determined that community benefit should be fully reported, thus including the direct and indirect costs of subsidized health care services, charity care, bad debt, and the unpaid costs of government-sponsored health care, including Medicaid, Medicare, and public and/or other indigent care programs.

In closing, Mr. Chairman, I would like to thank you for your recent remarks acknowledging the field's work on this issue and stating that you are not advocating legislation in this area. We agree with you that there are intellectually honest differences within the field regarding reporting that includes or excludes Medicare, underpayment, or bad debt.

But those differences should not, and are not, preventing not-for-profit hospitals from reporting the value of their community benefit. We look forward to continuing our work with you and the committee to ensure that such reporting is useful and complete. Thank you.

The CHAIRMAN. Thank you, Mr. Lofton. You asked for an insertion, and we will do that. I did not announce this, but if you have longer statements, they will be included in the record as well.

Maybe I did not make something quite clear, based on your statement about not having legislation. It is true that I do not anticipate legislation, but that is the purpose of this hearing.

Out of this hearing, or out of other staff work, or out of communication among members of this committee, there may be some legislation required. So I am not saying no to any legislation, I am just saying at this point I have not anticipated any legislation.

[The prepared statement of Mr. Lofton appears in the appendix.]

[The brochure, *Care in Action,* appears in the appendix on p. 231.]

The CHAIRMAN. Mr. Duke?

Senator BAUCUS. If I might, Mr. Chairman.

The CHAIRMAN. Go ahead.

Senator BAUCUS. Just one word about Mr. Duke. Mr. Duke is the administrator for a critical access facility in Dawson County, MT. Now, his hospital staff—let me put it this way. The people he serves are a number of people much, much lower than the total number of staff in Congress by a huge magnitude. I might also say that the area of Dawson County is larger than the State of Delaware.

Now, I have not calculated the per capita number of people in Dawson County, but it is very rural. In fact, I remember when Hillary Clinton, during her health care era, came to Montana. She got off the plane and looked around and said, "This is not rural, this is mega-rural, hyper-rural." [Laughter.] It is very rural.

The CHAIRMAN. Yes. And really what you meant to say, it is very frontier, is what you meant to say.

Senator BAUCUS. Yes.

The CHAIRMAN. Mr. Duke?

STATEMENT OF SCOTT A. DUKE, CEO, GLENDIVE MEDICAL CENTER, GLENDIVE, MT

Mr. DUKE. Chairman Grassley, Senator Baucus, and members of the committee, good morning.

My name is Scott Duke. I am the chief executive officer at the Glendive Medical Center located in Glendive, MT. That is eastern Montana, and about 10,000 people, a little over 9,800 or so, live in Dawson County. I am also the current chair of the Montana Hospital Association's Board of Trustees.

I appreciate the opportunity to testify today to bring you the unique perspective of the frontier in rural hospitals in America.

GMC is a not-for-profit community-based health care organization that provides a full spectrum of medical services. Among these services is a 25-bed critical access hospital, two skilled nursing facilities with a total of 155 beds, a 13-unit assisted living facility, a rural health clinic, a home care hospice agency, and we employ more than 450 people.

Since the late 1800s, our organization has provided medical services to the citizens of eastern Montana and western North Dakota. Today we are the only hospital for an area with approximately 15,000 people.

GMC's mission is very straightforward: we are committed to caring, health, and a healthier community. We attempt to fulfill this mission in a variety of ways. One way we do this is to provide medical treatment to anyone in need, regardless of their ability to pay.

Our facility has a clearly defined policy for providing financial assistance. Persons whose income is at or below 100 percent of the Federal poverty level are eligible to receive care at no charge.

Persons whose income is between 100 and 200 percent of the Federal poverty level are eligible to receive it based upon their income and assets. We also provide assistance for catastrophic events, and loans without interest if a patient fails to qualify for assistance using the other criteria.

We take a number of steps to make sure that patients know about, and understand, our policy. The Patient Notice of Financial Assistance is a patient-friendly notice that describes our program and is given to all patients upon admission. It is also posted in several areas throughout the facility.

Financial assistance for those who cannot afford care is just one way we serve our community. GMC has a long and proud history of making other investments in our community's health. They range from health screenings, telemedicine mental health consultations, scholarships, transportation, subsidized health services, outreach services, and economic development, to name just a few.

In 2005, GMC provided a total of $3,286,057 in community benefits. This included charity care, community services for which we were not paid, bad debt, and the shortfall in Medicare and Medicaid payments. The amount was calculated using actual costs, not charges.

Represented another way, GMC's community benefit is equal to 15 percent of its operating expense, and nearly four times the tax obligation we would pay if we were a taxable entity. Since 1999, GMC has voluntarily reported its community benefits following the model established by the VHA.

Nearly a third of Montana's hospitals use the VHA-CHA tool to compile all their community benefits. GMC is typical of the general acute care community-based not-for-profit hospital in Montana. These hospitals are the cornerstone of the Montana health care system.

No matter how big or how small, they are run by boards made up of community members. They tailor their services to meet the unique needs of the communities they serve.

Montana's hospitals have taken an additional step toward publicly demonstrating that they are fulfilling their charitable responsibilities. The MHA's Board of Trustees recently adopted policies regarding charity care, financial assistance, and community benefits reporting. The standards set by these policies mirror those adopted by GMC.

MHA's policies clearly outline expectations that members need to work closely with patients to ensure that they understand the cost of their care, the billing procedures and payment options, and collection practices. In addition, MHA members are expected to develop a community benefit plan and compile the report of community benefits at least annually using the definitions described in the CHA-VHA model.

The MHA policy differs slightly with the CHA-VHA model in that it asks members to report the unpaid costs of Medicare and bad debt. We believe these costs are legitimate benefits provided to the communities we serve. MHA policy also attempts to recognize that frontier and rural hospitals face obstacles not faced by hospitals in urban areas. Given the many struggles, the mere fact that these facilities exist could be argued as justifying their community benefits.

Mr. Chairman, Montana's hospitals believe a voluntary system such as the one I have outlined is far superior to a one-size-fits-all Federal mandate. The current IRS standards provide the flexibility to adapt our services to the specific needs of our rural communities.

I urge the committee not to take any action that would alter that standard. A standard designed for a larger urban hospital would be irrelevant in the community of Glendive, MT.

Montana's hospitals have built a legacy of providing charity care and other community benefits. Virtually all of them have a charity care policy, and most of these policies fit within the guidelines established by the MHA Board of Trustees.

In addition, each year Montana hospitals provide millions of dollars' worth of community services at no charge. We believe this is

evidence of and demonstrates our commitment to our communities, and fulfills the obligation we have as tax-exempt organizations.

Again, I thank you for the opportunity to testify.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Duke appears in the appendix.]

The CHAIRMAN. Now, Dr. Kane?

STATEMENT OF DR. NANCY KANE, PROFESSOR OF HEALTH MANAGEMENT, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Dr. KANE. Thank you, Mr. Chairman and members of the committee, for inviting me to talk about my views on the current state of hospital charitable activity, and to argue that there is a need for a higher standard for hospital tax exemption.

I feel a little bit like the Grinch who stole Christmas, but I train my students and work with community groups to try to help them understand hospital financial performance and charitable activity so that they can better argue for certain hospitals, in particular, to meet their community needs.

So, I have actually been exposed not necessarily to the hospitals represented at this panel, but to some of the ones that have made the competitive environment for those who are behaving according to the standard a little harder to deal with.

Over 10 years ago, I testified before a House committee on this subject, back when the Attorney General of Texas instituted proceedings against the board of a major hospital for failure to maintain its charitable status.

The particular case was so egregious that it actually inspired the Texas legislature to pass a higher standard for hospital tax exemption. Unfortunately, there is still no higher standard at the Federal level, and most States do follow the Federal standard for hospital tax exemption.

Meanwhile, the Federal standard has not kept up with either the pressing economic incentives facing hospitals today or the growing unfunded health needs of communities. The hospital sector is now around a $600 billion industry, with fewer, bigger, and more commercialized organizations than even 10 years ago.

Many communities have lost their local control over their hospitals, as their governing boards have merged into systems whose headquarters are often many miles out of the local community and are concerned about the health of hundreds of thousands of people in their areas.

As these systems become larger, they are also capable of taking on quite a bit more debt, which, by the way, does make them vulnerable to Wall Street pressures, even though they are not equity pressures.

It also gets them more involved with commercial enterprise, partly as a way to keep paying back that debt. Therefore, they have less incentive to serve financially disadvantaged needs in their populations.

At the same time, the charitable tax exemption has come to be worth billions of dollars per year, especially when you put together all sources of tax exemption at the Federal, State, and local level.

When you couple that with the billions of dollars in disproportionate share payments that have been authorized to go towards, basically, uncompensated care, we have created not an unfunded mandate, but a funded non-mandate, for charity care.

Many hospitals enjoy the funds without obeying the non-mandate by taking the money and not providing much charity care, or responding to the needs of their local communities, the most vulnerable communities.

Worse yet, it is impossible to identify the hospitals that are doing the good work and providing the right amount of charity care from those who are doing nothing because there is no national data set.

Neither the IRS Form 990, nor the Medicare cost report, requires that hospitals publicly report charity care in a consistent, standardized way. CMS tried to do this in 2004, but the instructions were a little ambiguous.

Two years later, the instructions have not been revised and we still do not know who is providing uncompensated care across the Nation. Therefore, I have a little consulting business to help States figure out how to measure uncompensated care in ways that they can meaningfully act on. But that is ridiculous. There should be a national data set for reporting uncompensated care in a standard way.

The other problem with the Federal standard is there is almost no oversight of charitable organizations. It has been under-staffed and under-funded at both the Federal and State levels.

I will say that the IRS, State Attorneys General, and legislators are stepping up their efforts recently in the wake of revelations, that largely emerged from the private sector, of harmful hospital pricing, billing, and collection practices, along with very high executive compensation packages and minimal charity care.

But even with more attention and resources, both the State and Federal authorities are finding that the existing standard does not clearly prohibit behavior that society is finding, nonetheless, pretty unacceptable.

So I believe we should have a higher standard and that the Federal standard should be legislated to have a higher expectation for tax exemption. I do not support the notion that tax exemption should be simply revoked. Many hospitals are indeed behaving charitably in their communities that benefit enormously from them.

It would be far better to level the playing field for those that truly earn their tax exemption in ways that communities most value, by requiring that all hospitals seeking to maintain their tax-exempt status play by the same rules.

The key components of those rules, I think, should include tying patient eligibility for discounts to the patient's income, to the affordability for the patient. That, unfortunately, is going to start including insured patients because, frankly, a lot of them have deductibles that they can no longer afford to meet.

Also, requiring transparency in reporting to the IRS, and in communicating to the community about hospital charity care policy. Requiring the IRS to regularly certify the basic reasonableness of hospital charity care levels and relate it, if necessary, to the value of their tax exemptions. Requiring that hospitals partner with com-

munity groups to improve population health, especially for vulnerable populations, with that kind of activity contributing towards their reasonableness test with the IRS. Requiring that community benefit planning, implementation, and reporting are consistent with the Catholic Health Care Association guidelines, which I read through and am very supportive of, and think that they are exactly what we could use for a standard for our higher standard of tax exemption.

I also would like to see the community benefit report in a standardized fashion attached to the IRS Form 990 so that we do have a national data set.

Finally, I would expect or require hospital boards to have a permanent tax-exempt compliance committee that is responsible for planning, review, monitoring, and reporting on charity care policies and other community benefits.

Thank you for your attention. I will be happy to answer any questions.

The CHAIRMAN. Thank you, Dr. Kane.

[The prepared statement of Dr. Kane appears in the appendix.]

The CHAIRMAN. Now, Mr. Hartz?

STATEMENT OF RAY HARTZ, EXECUTIVE DIRECTOR, LEGAL AID SOCIETY OF EASTERN VIRGINIA, INC., NORFOLK, VA

Mr. HARTZ. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to talk here on this vitally important issue.

My name is Ray Hartz. I am the executive director of the Legal Aid Society of Eastern Virginia, which provides free legal assistance in civil matters to the poverty population of the greater Hampton Roads area. We have five offices, comprising both very rural and very urban areas, in Williamburg, Hampton, Norfolk, Virginia Beach, and on the Eastern Shore of Virginia.

We serve over 200,000 people who live below 125 percent of the poverty level, which is approximately one-quarter of all such poor persons in Virginia. I have worked for legal aid organizations virtually my entire career in Virginia, but also in Florida, and also in Arizona.

From my experience of working with the low-income communities in Hampton Roads and elsewhere, I can positively attest to this committee that the people of low income, especially the working poor, are experiencing a health care crisis.

I am not referring to the quality of the health care, I am talking today about the crisis of trying to survive under the mountain of medical debt to a hospital and a hospital that has an aggressive and effective collections department.

Everywhere I have practiced, hospitals have been very efficient in getting judgments against those who owe them money, and then in collecting on those judgments through wage and bank account garnishments.

For example, last Thursday—I just looked up on the Internet last night—in the city of Norfolk, just the city of Norfolk, which is the third-largest city in my area, there were over 100 actions to collect hospital debts brought by one of the nonprofit hospitals. Last

Thursday was not an unusual day. This level of suits brought happens on a weekly basis.

Every private hospital in Hampton Roads is nonprofit. Each has a charity care program, either free of charge care and/or discounted care, for the un- or under-insured patient. Unfortunately, the reality is that very few low-income uninsured patients are ever told about the existence of these programs.

Attached to my written testimony are statements to this committee from several clients from eastern Virginia detailing the problems that they have had in accessing charity care. One statement, if I can just briefly refer to it, is from a Ms. Bragg who lives on the Eastern Shore of Virginia, which is a very rural area.

She is 47 years old. She is employed, but she cannot get health insurance through work. Two years ago, she had some medical treatment done at a nonprofit hospital and the bill was just under $3,000. She makes slightly more than $1,000 a month. When she could not pay, the bill collectors starting calling.

She was told by the bill collectors that the interest on her past due account was 24.12 percent. Ms. Bragg realized that, at her income, even with a payment plan, she could never even be able to pay off the accumulating interest, let alone the underlying hospital bill.

Ms. Bragg wrote in her statement about the great distress this bill and the hospital's collection efforts—repeated collection efforts—caused her. She rarely has money left after paying rent, food, and her medicines as it is.

But it occurred to me that maybe she should consider herself lucky, because at least as of now, the hospital has not garnished. Even at just $1,000 a month, she is subject to having money garnished from her paycheck. Right now, luckily, that has not happened yet.

The first time that Ms. Bragg was ever informed about the hospital's charity care plan was when we called her last week to ask if it had been offered to her. That is the norm, not the exception.

Over the past week or so, our staff has spoken with more than 20 clients burdened by unpaid hospital debt. Not one of them reported being informed of a charity care program at any time during their hospital stay. Only one of those clients was ever told about the program, and this was during the collection process. A bill collector informed her about it.

Several of these clients did learn about the program, the charity care programs, through other service providers or through friends. But when they approached the hospital to find out more, they only met with difficulty and inconsistent responses. One client was told by the hospital's billing department point-blank that her poverty did not matter, she had to pay the full amount owed.

Another statement I will refer to just briefly is from Joyce Butler, a 52-year-old woman in Virginia Beach. She was homeless for 2 years. She has accumulated more than $10,000 in debts. She receives repeated harassing telephone calls, sometimes two or three a week, demanding immediate payment.

If I could refer the committee to the last line of her statement, she said, "I wish I had known there was such a thing as charity care. It would have eased my mind so much over the years. Unfor-

tunately, I was not made aware of this program. I wish I had known." She only learned about it when she called us for a bankruptcy and we asked her about it.

I will be brief, because I see I am out of time. But one important thing. The denial of access to charity care has a devastating effect on the lives of low-income clients, especially working poor and their families. As I noted before, hospitals are extremely efficient in collecting.

They have lawyers on staff, they file the bills, they garnish. It is a local situation. Once a judgment has been entered, a hospital can—and does, usually—garnish the client's wages up to 25 percent. The bank account can be completely wiped out. We are talking about garnishing the wages of people who are already hovering on the edge of financial oblivion.

The result of this is the client may lose their car and the ability to get to work. Their children may go hungry. The family may become homeless. But it does not need to be this way. Many of these people—if not most of these people—would have been eligible for the charity care program that the local hospital, the local nonprofit hospital where they received their care, runs, but were never informed about it.

Mr. Chairman, very briefly, I would just say I have spoken recently with members of legal aids around the country, and also from my past experience. This is not a Virginia problem of people not being told, this is a problem in the other two States I have been in, and virtually every State. I talk to directors of legal aids or legal aid-type programs, and the charity care programs exist but the clients never find out about them.

Mr. Chairman, I appreciate the opportunity to talk about this important situation, and I would be happy to answer any questions the committee may have.

[The prepared statement of Mr. Hartz appears in the appendix.]

The CHAIRMAN. Yes. Well, we have had good testimony. Now we will take a 5-minute round of questioning for those people who are still here. If others come back, this may be changed. But right now it is: Grassley, Baucus, and Thomas, in that order.

I am going to start with Dr. Kane, but anyone else could supplement or add to her answer, or disagree with it if you want to.

I appreciate the comments that we received about the best practices from different hospitals. But as we have heard, there is often a gap between what are policies, meaning what is on paper, regarding charity care and community benefit, and what actually happens.

Also, we have the Government Accountability Office noting in a report last year that a great deal of charity care and community benefit provided by nonprofit hospitals is actually concentrated in the work of a small number of charity hospitals.

There is an old saying that we often repeat around here that would be applicable to this situation. Senator Phil Gramm used to say, "Some are pulling the wagon and some are sitting in the wagon."

So my question is, why should we not take the good standards that the Catholic Health Association has put forward and already

adopted by hundreds of hospitals and make them the baseline for all nonprofit hospitals as a requirement for tax-exempt status?

Before you answer, let me say this, additionally. We can certainly build in some flexibility to modify requirements for different situations, like rural areas. But right now we have no real measurable requirement in the law in exchange for providing these billions of dollars of tax breaks at Federal, State, and local levels. So, rhetorically, does this make sense? Should every nonprofit hospital not be required to help pull the wagon?

Dr. Kane?

Dr. KANE. Well, you have made it easy for me. I can say yes. But I will elaborate a little bit. Perhaps you have all become aware that we are down about 20 percent in terms of the number of hospitals in the last quarter-century.

Most of the hospitals that are no longer with us, a far larger number of hospitals that are gone, were public hospitals. In other words, the hospitals that were really the primary safety net and have lost out in the competitive battle, were those that were pulling the wagon.

I think, therefore, it is imperative to level that playing field, to adopt the Catholic Health Association community benefit reporting guidelines. I have to say, frankly, as an aside, that as a member of MEDPAC, although I cannot speak for MEDPAC, we believe that Medicare payments should be adequate for efficient hospitals and would hate to see the costs above payment be considered charity, when others might consider it being inefficient. So, I just want to put my little 2 cents' worth in on that.

But, yes. I do think that the standard that the Catholic Health Association is presenting is very much a workable standard that should be applied so that people get out of the wagon and all start pulling together. Thank you.

The CHAIRMAN. Before I go to my second question, does anybody want to say anything one way or the other? [No response.]

Then for Mr. Hartz, and followed by anyone who might want to add views, you work directly with low-income uninsured who have tried to navigate the often extremely confusing mazes. You have talked about those in your testimony, revealing how difficult this can be for, not only your clients, but also for attorneys working on their behalf.

In your opinion, what could hospitals do to make their charity care policies more accessible to those who need it more? And more importantly, what steps do you think Congress should take to ensure that the gaps you spoke of will no longer exist?

Mr. HARTZ. Mr. Chairman, what occurred me, and I am certainly no expert in hospital administration, just from the perspective of the clients, I think four very simple things could be done which would benefit the clients immensely.

One would be for each hospital to apply their existing charity care programs uniformly and fairly. Two, to provide notice of the existence of the charity care program to all patients at registration and at discharge. Three, to have some notice of the existence of the charity care program in every communication made by the hospital, or a bill collector on their behalf, to the patient which is an effort to collect a hospital debt. I think it could be as simple as, "We have

a hospital charity care program. For more information, call this number." And, four, to provide patients who are denied charity care an opportunity to present additional information with the representation of counsel or some assistance to have that decision reviewed. How that would work, I am not sure. But the problem I found, as I emphasized in my testimony, is people just do not know. I think if everybody got it when they came in and got it when they left, that would settle it.

One other thing from talking to people, the first question they are asked when they check in is, "What insurance do you have?" Everyone I have talked to, that is the first question the hospital asks them. If they do not have insurance, it seems obvious they should be examined.

Now, obviously, not all people would be eligible for charity care, but that is the group of people, at the very least, you ought to focus in on, and maybe the hospitals provide some greater detail of information regarding the charity care program to them.

The CHAIRMAN. Sr. Keehan?

Sr. KEEHAN. Thank you, Mr. Chairman. Mr. Hartz makes some very, very good points. But as someone who ran a hospital here in DC for 15 years, it is not as simple. That is not an excuse. It means we have to keep learning from each other, from his experience and our experience. First of all, we make a huge effort when people are coming in, particularly for emergency care, to focus on what the emergency is, what the problem is.

We have really pushed very hard for staff not to make the first and foremost question when people come in, particularly for emergencies, what kind of insurance do you have, and if you do not have the right insurance, let us sit down and talk about it before we treat you. We have made great progress in that and we do not want to go backwards.

Second, we do, as part of our guidelines and as part of our board resolution, ask hospitals to post the availability in the admitting office, in the emergency room, on the website. Many, many of our facilities put it on every bill they send out.

Quite frankly, there are many, many reasons that it is difficult to get the applications. Sometimes people are too proud to say they are poor, and we understand that. That is a lifelong problem. People really mind having to say they cannot afford to pay.

Other times, people have great difficulty in getting the paperwork that they need to document it. Other times people have an immigration status. We have some people—many people—particularly in our urban areas, who are mentally ill. They are frightened by the questions that we have to ask.

I would not want to face this committee saying we have given charity care, which drives up health care costs, to people who could afford to pay but did not because we were sloppy in our charity care policies.

It is a horrible challenge. We listen to those same stories. We deal with those people over and over again when they come in, and our hearts ache for them. That is part of the reason we spend so much time talking about getting good quality coverage.

We need to learn from each other every way we can learn, working together with organizations in the community, whether it is the

Health Department, Legal Aid, Catholic Charities, any one of the organizations that tries to reach out to find better and better ways.

But I can tell you, people work very, very hard to do this, but there are many challenges. It is not as simple as putting the availability of charity care on the bill or posting it at the admitting office, but those are all good suggestions.

The CHAIRMAN. Mr. Kline, did you want to jump in on this?

Mr. KLINE. Yes. Thank you, Mr. Chairman. An observation. Building on both the comments, I am sure that you have met with frustration at times when you have negotiated language to legislation, and then later viewed its implementation by an agency far removed from the discussions that occurred within this room——

The CHAIRMAN. Every day.

Mr. KLINE. Every day. [Laughter.] Much of what we deal with and what we have discovered in our discussions with the nonprofits in Kansas is that, as the responsibility for collection is further removed from the hospital itself, it is further removed from the mission.

Oftentimes outside contracts provide collection agencies with means and methods that the hospitals themselves would not agree with. Sometimes those collection contractors prohibit further contact between the patient and the hospital.

Sometimes those collection agencies do not in any way engage or encourage a retroactive review of the charitable services available because, as many of them are on a contingency basis, it reduces the possibility of further collections and fees that they may generate.

Sometimes those collection contracts, in fact, have temporal deadlines where they are incentivized to collect certain outstanding fees by a set deadline and thereby, by the luck of the draw—or unfortunate luck of the draw—somebody who can ill afford care is meeting up against that deadline.

If the agency collects from them a relatively minor fee, which has a significant impact on that patient's life, they receive a bonus and, therefore, the collection agency's efforts are heightened. So there are some procedural steps that can be taken in best practices that will prevent some of what I believe is just an institutional evolvement.

As you move away from the core mission of a nonprofit hospital and you get into the financial realm and you move further down the stream, their goal is to collect money, not to engage in the overall mission of a nonprofit hospital.

We have provided the committee with a draft of our best practices that we have negotiated with the Kansas Hospital Association that has some procedural steps that will help integrate that mission into all of the collection efforts of a nonprofit, such as requiring the CFO to give approval before they initiate litigation, prohibiting temporal guidelines in outside collection agency contracts, and as well, disclosure and retroactive review of potential financial assistance to pay a bill.

Those things are legitimate. They strike at the very heart of the mission that the good people before you have, and there are procedures that can be implemented that are consistent with the operation of a hospital, as well as the nonprofit and charitable mission that they are concerned with.

The CHAIRMAN. Before you speak, Mr. Lofton, let me assure Senator Baucus that I am going to go to him next. I am not going to ask another question.

Go ahead.

Mr. LOFTON. Mr. Chairman, the examples that Mr. Hartz gave are unfortunate. A lot of what we are talking about is how we can better communicate the policies, not that they do not exist, not that hospitals are not willing to provide the care.

I am sure that we could go to some of those same hospitals and we would be able to get examples of hundreds of people who were provided the information, received the information, and also provided the information we need to be able to certify them.

When you spoke earlier about whether or not there should be legislation supporting the CHA-VHA guidelines, the AHA board passed a resolution in May and we fully believe that uniform reporting is the order of the day.

The AHA resolution supports the CHA-VHA guidelines in all aspects. I think the most important aspect is in the relationship to cost, that we are actually recording cost of care, not charges.

The one area of exception relates to whether or not the under-funding of Medicare or bad debt should be included in community benefit or whether it should be reported separately.

When you look at our organization, which is a member of the Catholic Health Association, we report the community benefit excluding Medicare under-payments, but we still report that in annual reports and the like.

At the end of the day, we fully support everything that the CHA-VHA guidelines entail, but it is a simple matter of an intellectual difference about what is included in community benefit.

At the end of the day, someone is going to pay the bill, someone is going to pick up the tab. So the AHA position is that uniform reporting is where we need to go, and at the same time there needs to be full reporting that also includes the under-funding of Medicare.

Dr. Kane talked about the Texas legislation. One of the reasons that the AHA passed the resolution the way it did is because many States have passed similar laws. Texas, in the example she gave, is one of the States that includes the under-funding of Medicare and bad debt. So we are following guidelines that at least a dozen States have approved, and each of those States requires that the under-funding of Medicare be included in what they call community benefit.

The CHAIRMAN. Mr. Duke?

Mr. DUKE. Mr. Chairman, from the rural perspective in Montana, I would echo Sr. Keehan's comments. We actually have found, in trying very, very hard to get the information out, the word "charity," puts a bit of a stigma out there, not just in our fine State, but probably in many areas of the country. So we have sort of changed the name to "uncompensated care."

Now, you hear that term used back and forth in different contexts, but there is a reason for that in the effort of trying to get the word out and to try to be successful, because I would echo the comments that we know we fall short on that. We do not have the data to be able to be sure, but if I could speak to it in terms of

Mr. Lofton's comments, what we are trying to do in putting out the information in a complete way is to inform and educate the folks who are coming to us about the costs of care, the high cost of care and what goes into that. One might argue that, if you have a person who would qualify under charity care, but they do not apply for that and end up being into bad debt, that is a community benefit.

So what we need to do, in learning from each other and in growing in this effort in terms of trying to get the word out and get everyone qualified, that applies in the rural area, it applies in the urban area, and we really are in favor of that, speaking from a rural State.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

I would like to start off by asking, first, I assume that nobody here advocates repealing the tax-exempt status for nonprofits. Am I accurate? All right.

Second, I assume that most of you believe that we would not be sitting here if this country had universal health insurance. Do I see all heads nodding? Does anybody disagree with that? [No response.] So everybody agrees. I see heads nodding by all six panelists. They all agree. All right.

Mr. KLINE. Mr. Chairman?

Senator BAUCUS. Yes. You do not agree?

Mr. KLINE. I am sorry, Senator Baucus. I am not here to address that particular issue.

Senator BAUCUS. No, no. I am just asking generally.

Mr. KLINE. I just did not want to go on the record that I——

Senator BAUCUS. No, no. I understand. But just generally. Generally we probably would not be here if everyone had health insurance.

Mr. KLINE. You can call me back for another hearing, Senator, as it relates to universal health care.

Senator BAUCUS. But you are a private citizen. You must have a view. You are a public official, but you are also a person. You are, after all, Phill Kline. You must think about these things.

Mr. KLINE. I think about a lot of things, Senator. [Laughter.]

Senator BAUCUS. Including this. So you probably agree. [Laughter.]

Mr. KLINE. I was not aware that it was the prerogative of the Senate to make a statement like that.

Senator BAUCUS. I am just guessing.

Mr. KLINE. I am here at your invite. [Laughter.]

Senator BAUCUS. That is just my opinion. All right. That is for another day. Hopefully an earlier day than some might think.

Why can we all not just adopt standards that are similar to the Catholic Health Association's standards? Maybe not exactly, but why is that not a significant part of the solution here? I compliment you, Sister, very, very much on all you have done. We have spoken in the past, Sister, and I am just very impressed with all that you are doing for your community.

But I would like anybody to comment on that. I know there is the question of, is Medicaid considered charity care or not. I am not clear about bad debt, whether that should be included or not. I

know the Catholic Health Association says, no, you should not include Medicaid because that is a government program.

But I would like each of you to address the degree to which we should adopt standards similar to those adopted by the Catholic Health Association.

Mr. LOFTON. Senator Baucus, as I mentioned, the AHA board adopted a resolution in May. If you go through all of the elements of the AHA-VHA guidelines, we are in complete support of all of the guidelines in terms of what charity care is included.

The difference comes on whether or not the under-funding of Medicare as a specific component is included in the community benefit or whether you include that as an under-funding of payment separate and apart from community benefit.

Senator BAUCUS. I understand that. But how do we skin that cat? How do we reach agreement on that?

Mr. LOFTON. Again, part of the dilemma that we face is, if we were to pass a resolution that would stipulate that that is included, as I mentioned, there are about a dozen States where the current law has hospitals report Medicare under-funding.

It is all a matter of a definition. It is a fine intellectual line between the two. But I think that we can get to uniform reporting, we are very close. We are very supportive of the CHA position.

Again, using my own system, Catholic Health Initiatives, as an example—we are a member of the Catholic Health Association—we report community benefit under the exact guideline the way that the CHA promulgates, but we also report, because everyone needs to know, the amount of Medicare under-funding because that cost is borne somewhere in the system.

So if Congress is looking at whether or not you will be able to actually compare apples and apples, you would have all of the information in front of you.

Senator BAUCUS. Right. Sister, you have thought about this, the degree to which your association's guidelines can be virtually universally adopted.

Sr. KEEHAN. Senator Baucus, the really good news on this is that it is possible now for the not-for-profit hospitals. You have VHA, AHA, and CHA agreeing on what we should measure—with the exception of two things—and how we should measure it. Before, we had charges, we had costs, we had charges without write-offs, we had what services should be included.

We have now come down, with this booklet, on exactly what you can measure, what you cannot measure, on what things you are doing, health fairs for the community, what things you are doing that are pure marketing that are all right to do, but do not call them community benefit. We agree, virtually, on everything.

CHA agrees that the unpaid cost of Medicare is not all due to inefficiency. We are a little different from MEDPAC. We agree there is an unpaid cost of Medicare that gets passed on, because anything that adds to the cost of health care gets passed on. We agree that bad debt, just like department store shoplifting raises your price, gets passed on.

We agree that communities deserve to know what those costs are. They deserve to know other things as well. If you are in California, you deserve to know what the cost of the seismic retrofit is

for the earthquake stuff. But we do not believe you should report those costs to your community in the category of community benefit.

Tell your community about that. Tell them about other things like the malpractice costs, other kinds of costs that are particularly true in a community. A community with a lot of black lung that is uncompensated would want to do that.

So the good news is, even if you follow exactly the way AHA wants you to report, it is very, very easy, because the lines are so clear. You can extract out from the AHA reporting absolute comparable comparisons to the CHA reporting.

Where you cannot compare is in the for-profit hospitals who continue to report their charity care and those kinds of things at charges. So in the not-for-profit world, this is a huge step forward.

Senator BAUCUS. Right. Let me ask Mr. Duke, your response. Would the hospital in Dawson live with that?

Mr. DUKE. It can, and has, actually, as the Sister described, since 1999, and has brought that forward with that one intellectual difference. The reality is, the Montana Hospital Association, as I said in my testimony, recently adopted that as an expectation.

In fact, as we are working on this, it is a work in progress, we are receiving daily the commitments from all of the members, which is virtually all the hospitals in the State, that they are agreeing with that and they can meet those standards. Now, we do not have 100 percent yet, but we are well over 90. So in our State, that is happening and we can live with it.

Senator BAUCUS. Dr. Kane, why is this not just a large part of the solution, just all the nonprofits adopting this?

Dr. KANE. You are talking about a reporting system, and I think that is part of the solution. A standardized reporting system is part of the solution. I guess the second part to that question is, what are you going to use it for?

I think that is where people start disagreeing about what should be in it as a community benefit and what should be there for anybody to know about. I mean, they are not going to post the profits they make on their private insurer contracts, so let us get real here.

We do not want to know all about the financing of the hospital. We want to know, what are they doing that makes it worth giving them a tax exemption?

I agree with Sr. Keehan, that, for a variety of reasons, the Medicare shortfall, when it does happen, is not necessarily a charitable act, given freely by the hospital.

I do think what you need to think about in these reports is how they are going to be used, and for what purpose.

Senator BAUCUS. Well, how should it?

Dr. KANE. That is the only reason it is controversial.

Senator BAUCUS. And so how should it?

Dr. KANE. I suggest in my testimony that the IRS should be reviewing these community benefit reports, have them attached to the IRS Form 990, and review them in light of the value of hospital tax exemption, to say, is it merited, and have hospitals have to really justify their tax exemption on the basis of what they do for

truly charitable giving purposes and not things that are sort of forced upon them by the government.

Senator BAUCUS. Sister, what is wrong with that?

Sr. KEEHAN. Senator Baucus, it is absolutely perfect.

Senator BAUCUS. Good. We can stop there. [Laughter.]

Sr. KEEHAN. As you know, the 990s, for the first time, are going to be required to be filed electronically. CHA has worked carefully with our members and with some other experts to develop a template which will allow our members to report community benefit electronically with their 990. We are encouraging them to do that because we believe there is an accountability responsibility.

We are trying to make it not only uniform, but we are trying to make it as easy to move from the reports they develop using the guide, to putting those reports on electronically, just the same way they take their basic financial statements and move them to the electronic.

Senator BAUCUS. All right.

Mr. Duke, can you live with Dr. Kane's solution?

Mr. DUKE. Yes.

Senator BAUCUS. You can?

Mr. DUKE. Yes.

Senator BAUCUS. Good. Well, why can all nonprofits not live with that? I know you cannot speak for all nonprofits. But maybe I would ask Mr. Lofton.

Mr. LOFTON. I do not think that we are saying that we cannot live with that. As she said, it is a simple matter of, what do you want to use the information for. The AHA position is that the community, as well as the IRS, everyone needs to understand, these are the costs to provide care, these are the aspects of pure charity care. No one disagrees with those.

But there are other community benefit aspects that contribute to the overall community that should go into consideration of why we deserve the tax-exempt status.

The fine line describing bad debt was in several of the testimonies here. It is a simple matter sometimes, a patient could come in today, and if they do not have all of the proper information, then they are a bad debt today.

If they come in tomorrow with the information, they are then provided charity care or sliding fee discounts. So, it is a very fine line. We feel that the difference, in terms of the costs and what we receive, should be included in the community benefit standard.

Senator BAUCUS. What about other criteria in determining the tax-exempt status? What about executive salaries, for example? Some of them are pretty high for a nonprofit, or at least what most people think of as nonprofits. Does anybody have any reaction to that? Dr. Kane?

Dr. KANE. That is actually already prohibited, if you take the inurement part of the nonprofit standard down to the level of practice. So I think that is one of the few things that attorneys general have been able to act on, if they can find a way to get them reported to them meaningfully.

I mean, one of the issues around executive compensation is that because hospitals report on 990s, they can break up the CEO's sal-

ary into 10 different entities or put it in a private, for-profit management company and you will never see it.

So that is another area where the reporting would be better done standardized, but it is already part of the nonprofit standard that an individual cannot inure benefit, and excess compensation would be considered that.

Senator BAUCUS. Is it proper for the IRS then to take these standards that we are developing here as the criteria that they use in determining nonprofit status? Is that a proper function for them to do? I mean, the statute is pretty broad. Should there be any more guidance from the Congress as to the degree to which these privately developed standards are utilized? Anybody?

Sr. KEEHAN. I think that we have worked closely in developing these standards with the IRS. The IRS freely admits, health care has moved, and moved, and moved. From the first time in the late 1980s when we did these standards to 2006, health care has grown fairly significantly in technology, expense, et cetera. So I think this is a good basis. We built this basis off the IRS information.

We built it in consultation with them, in consultation with the CPA Association and health care financial management. So I think right now we are all on as much of the same page as we can get. Again, it goes back to, how do you want them to use it?

Senator BAUCUS. That is my question.

Sr. KEEHAN. Is there a bright line? You made the point better than anybody. If you look at a hospital in downtown Manhattan and a hospital in Manhattan, MT, you cannot look for the same thing, but you can very easily look for community benefit.

I would venture, although I do not know the hospital well in Manhattan, MT, that just being there, being available, keeping about 40 to 60 people employed and being available for that wide an area in that very rural area, is a huge benefit. Whereas, you would look for different things in Manhattan, NY.

Senator BAUCUS. Well, I have a confession in this: there is no hospital in Manhattan, MT. [Laughter.]

Sr. KEEHAN. It was your example. I was trying to help you. [Laughter.]

Senator BAUCUS. I appreciate it very much.

So who is the enforcer here, IRS?

Mr. LOFTON. Ultimately it has to be the IRS. When we are talking about the issue of executive compensation, this is broader than just health care. We have to look at universities, we have to look at foundations. So the IRS inquiry that Sr. Carol referred to, we are in full support that that is where guidance would come from.

The AHA board passed the resolution in May to do what Dr. Kane mentioned; to make sure that CEOs are signing off on the 990s, to make sure that they are fully accountable for what is being turned in to the IRS.

Senator BAUCUS. All right. My time has expired here. But, just generally, does anybody disagree with having the IRS being the enforcer? Most people do not like the IRS.

Mr. LOFTON. I would be in favor of them enforcing the regulations, but I do not see the IRS's role in terms of deciding what is appropriate compensation. Those are two different things.

So if we are talking about reporting of information, making sure that we are living up to all of the guidelines, then that is the role of the IRS. The IRS's role is not to get into determining what is an appropriate level of compensation.

Senator BAUCUS. Are you talking about executive compensation?

Mr. LOFTON. For executive compensation. Right.

Senator BAUCUS. Even if it is $50 million, that is not an issue?

Mr. LOFTON. Well, I do not think that is the case anywhere in not-for-profit health care, the numbers that you are giving.

Senator BAUCUS. I do not want to dwell on that, anyway.

Thank you, Mr. Chairman. My time has expired.

The CHAIRMAN. Thank you, Senator Baucus.

Professor Kane, you mentioned in your testimony an estimate of $20 billion a year in tax breaks for these hospitals. I would like to know if that $20 billion includes the estimate of the value of tax-exempt bonds issued to finance the activities of nonprofit hospitals.

Dr. KANE. My written testimony is a very rough estimate. And, no, it would not include the value of tax-exempt bonds. I have actually published an article about how to estimate the value of tax exemptions. In doing so, you cannot always quantify everything on both sides, benefit and tax-exempt value.

But the reason I have trouble with tax-exempt debt and calculating a value for it is that, while individuals do not have to pay taxes on the interest that they earn from tax-exempt debt and therefore that is a tax expenditure by Congress, also for-profit companies get to borrow and deduct interest, so the exact calculation is hard, quantitatively.

However, from a non-quantifiable perspective, the access to tax-exempt debt is incredibly valuable to nonprofit hospitals. It is more of a broader gestalt than it is a specific number.

I do not know if you have become aware that there have been some studies done that suggest that at this point—and this is just something that people need to think about in thinking about tax-exempt debt and who gets it—it looks like these very large systems with lots of cash are the ones who are able to raise the debt, and the very small critical access hospitals in Montana or wherever are less able to get access to that debt because they do not have the cash and they are small.

So the tax-exempt debt is currently favoring large hospitals with lots of cash, and not necessarily creating better access to capital for some of our smaller hospitals.

So in a way, not necessarily in the sense of tax-exempt regulation, but more maybe in the sense of how tax-exempt debt gets accessed and distributed, it is not providing access to hospitals that have a lot of trouble getting their hands on cash. It is actually accelerating hospitals that already have cash getting their access to capital.

The CHAIRMAN. On another question, Mr. Kline, the first thing you mentioned in your testimony interests us, and also the Joint Committee on Taxation has proposed policy changes in that area about those conversions.

Also, I heard something unrelated to this hearing, that that same thing happened at credit unions going to be banks. So, I have written to Commissioner Everson on that.

But give me your views in this area, whether or not this area of hospital conversion continues to be an area of concern to you and other AGs, and whether Congress ought to act.

Mr. KLINE. Thank you, Mr. Chairman. The HCA purchase of Health Midwest was the largest nonprofit conversion in United States history at that time. There was no guidance under statute or law as it relates to how to ensure that the charitable assets to be received through that purchase would be dedicated to the original mission. That was extraordinarily problematic.

I believe that the legislative body has a legitimate interest in that function because it was the legislative body that granted the tax-exempt status in the first place.

If you review conversions as they have occurred in various States throughout the Nation, you will see that often Attorneys General, relying on what is really common law authority emanating from the 13th century, have exercised their authority and responsibility to oversee those conversions in established charitable foundations, which generally are operated under the control of the Attorneys General subsequently after the conversion.

I believe that that was an inappropriate approach, as the grant of authority initially was from the legislative body and these funds and benefits were granted by the legislative and executive branch.

However, there is really no statutory authority, even to an Attorney General, as to how those boards would operate, whether they would have to be entirely consistent with their original mission, and much of this is handled through negotiation, quite frankly.

I have mentioned to the Hospital Association in Kansas, and I believe that they are interested—we just have not had sufficient time—that a model piece of legislation needs to be developed to understand what steps need to be taken before that is approved.

The uncertainty is hard for investors, it is hard for the purchaser, it is hard for the nonprofits, it is hard for the consumer, and so I believe action is appropriate and needed in that area.

The CHAIRMAN. Maybe then my last question would be to you, Mr. Kline, and to Mr. Lofton and to Sr. Carol. In our investigation of several hospitals, we found that top hospital executives were receiving perks that are above what is allowable for private sector executives.

These were supported by the Government Accountability Office report that was released last year. Some examples. We found executives staying in some of the nicest hotels in the world, dinners at exclusive restaurants, theater tickets, and the list goes on and on.

Lavish spending was not limited to out-of-town excursions. Some hospitals surveyed by the GAO found leases being paid on expensive automobiles—Jaguars, BMWs, Mercedes—and there are hospitals paying annual country club dues.

So the question is, how is this serving the communities in which these hospitals are located? Do you agree that those types of perks seem to detract from the hospital's overall mission of providing community benefits and quality care? I would like to have the three of you answer.

Mr. KLINE. Mr. Chairman, in our review of the conversion of Health Midwest we found that there was a golden parachute nego-

tiated by the chief executive officer of the nonprofit to the tune of $7 million to benefit him personally at the moment of conversion.

I found that extraordinarily excessive and contrary to the inherent mission of that nonprofit. Unfortunately, the court in Kansas did not have the jurisdictional reach, in its opinion, to be able to address that issue.

I will say also that hospitals are engaged in a multi-billion dollar industry. Even with their nonprofit status, they are negotiating with for-profit companies that extend services and extend equipment, necessary materials, drugs, and so forth so that they can perform their mission.

Business sometimes includes those things. It is very easy to be sensational and to be able to identify something that might seem excessive to the individual that is, in a comprehensive fashion, essential to their negotiation with other businesses and industry to deliver their services. It is a tough issue.

The CHAIRMAN. I think you are saying that competition might dictate considering those things, right?

Mr. KLINE. Well, I believe that in the operation of business sometimes things can be taken out of context and be made to look more onerous than what they are. A holistic approach to the nonprofit industry will demonstrate that they are full of people who are committed to a compassionate cause.

We do have exceptions. How do we identify the standards that allow them to perform their crucial mission with the flexibility necessary to meet the local needs of the population, while at the same time identifying those that are excessive? It is a terrible, terrible chore that you have undertaken. It is a difficult one.

But I would say that it is very easy to pick apart any business in industry and find extraordinary examples of a few people who have been excessive in what they have done.

The CHAIRMAN. Sr. Keehan?

Sr. KEEHAN. Part of our effort with the education of boards and the sponsors of health care has been to sensitize people to what can often be perception. Certainly we are not advocating excessive perks. We do recognize that we have executives whom we compete for within a market, and that many of the skill sets for our executives are the same skill sets in a for-profit world.

On the other hand, I think the Attorney General is right, that you can pick apart some things. I think that lavishly paying for excessive perks, in general, is not appropriate. However, at times when folks say someone has a membership at a country club, it implies that this is their sort of leisure world funded by the hospital.

Sometimes people take a membership on the behalf of an association in a place where you can have board committee meetings, a place that is more convenient than the facility, a place where you can have board meetings, where you can have seminars, things like that, a place where you can meet.

Would you rather pay for a membership at a club and have a person meet there in a reasonably business-like setting or have different meetings at every restaurant in town? I think sometimes it just does not sound good.

So we would encourage people to be sensitive to the way it sounds, but also, though, encourage understanding that some of the

things are not as excessive as some people may make them out to be. But in general, we certainly would agree with you. If you find something egregious, the board needs to be taking responsibility for it.

The CHAIRMAN. And Mr. Lofton?

Mr. LOFTON. Mr. Chairman, I would be happy to respond. Also, when I finish that, if I could comment back on your question about the taxes and financing.

The CHAIRMAN. Sure. Go ahead. Then Senator Baucus, if he has got another question, and then that will be it.

Mr. LOFTON. All right. Again, the AHA board passed a resolution to improve the board's responsiveness in terms of looking at both executive compensation and perks. Again, if there are examples where those perks are being exceeded, then there would be no reason to try to defend that.

But as Sr. Carol indicated, a country club membership, in and of itself, a name-brand hotel, in and of itself, there are summer rates, there are times where the hospital, in smaller rural communities in particular, may be the largest employer in town.

It is part of the executive's responsibility to interact with the business community, to provide leadership in the community. So, sometimes just conducting the affairs of the office will take you to situations where those perks may be appropriate.

As it relates to tax-exempt financing, the comment was made that it really is a zero-sum game, six of one, half dozen of the other, in terms of whether you look at the tax-exempt side versus the reductions that the for-profits are able to take off of the interest that they pay. So, that kind of balances itself out.

The point was also made about the disadvantages of rural hospitals. I would just add for the record that that situation is not the case where you have hospitals that are part of affiliations or part of other, larger systems. Catholic Health Initiatives is a very large system in the aggregate, but in our system two-thirds of our markets are in rural communities. We have 18 critical access hospitals.

So, those small, critical access hospitals have the same access to not-for-profit, tax-exempt financing as our larger facilities. That is part of, again, the reason why we need to be able to generate bottom lines, is to be able to reinvest capital back into the communities that we serve, so it is another way that not-for-profit hospitals are giving back to the community. So, tax-exempt financing is very important to us.

The CHAIRMAN. Thank you.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

As you know, there are some efforts around here that start, usually at the other end of Pennsylvania Avenue, to cut Medicaid reimbursement. I would like you to respond to the effects of cutting Medicaid reimbursement, Sister.

Sr. KEEHAN. Senator Baucus, thank you. We already have a continually growing number of uninsured. We have huge numbers of uninsured American children. We have made some dent in that with the SCHIP program and with the Medicaid program, but we also have an increasing number—and Mr. Hartz spoke to it—of

working poor who are being driven out of their insurance programs.

If we are saying that the economy is improving, why are we going after the people, the Americans, who are least able to afford health care? If the economy is improving, we should be putting that economy to the service of Americans who, at this point, do not have the opportunity to be part of that growing economy and are being squeezed more and more every day.

Senator BAUCUS. Very good point.

Mr. Duke, the effects of Medicaid reimbursement?

Mr. DUKE. Yes. And if I could, Senator, can I go back to one of the original questions you had? Just something for the record.

Senator BAUCUS. Sure.

Mr. DUKE. One of the things about the landscape in Montana, with our rural hospitals, our frontier hospitals, the VHA-CHA model is a complicated model, I should have recognized for you in answering that. It is difficult for some of those very small—the really small ones—to meet those compliance issues.

I am not saying they are bad or they are wrong, but I should have pointed that out. Quite frankly, as we look at that we need to think about it. I do not have all the answers, certainly, but I should have added that in.

Senator BAUCUS. Sure. That is all right.

Mr. DUKE. That is a real issue for some of our really small ones.

Senator BAUCUS. That was the Sister's very generous Manhattan to Manhattan point.

Mr. DUKE. Yes. Thank you.

Sr. KEEHAN. Except there is no Manhattan.

Mr. DUKE. I would echo the Sister's comments, and also add this. We are fortunate in Glendive. As we track our numbers, we are about 51 percent Medicare and right about 5 percent Medicaid, and we know we are lower, generally speaking, than a rural area might be.

But the real concern which you brought forward earlier is the issue around the growing number of under-insured and uninsured, and that certainly is something that we are tracking.

For us, with the nursing homes and the way that we look at that side of the population, the only thing I can tell you is that it would be devastating to us because we already have little or no margin within the system, and when we talk about having cuts to the very valuable Medicaid side of things, especially on our nursing home side—I am quite concerned about the talk now about reducing the bed tax issue down from 6 percent to 3 percent.

In Montana, that is about $20 a day, which is borne on the back of the providers to help make up for that deficit. If we talk about cutting it further, it would be extremely devastating.

Senator BAUCUS. Should Form 990 be expanded or modified? I guess IRS is reviewing it right now. But I will just give you a chance, all of you, to say to IRS, to us, what should Form 990 contain? Maybe executive compensation issues. It is there anyway. People can make their own judgments whether it is good or not good, but without taking direct action one way or another. But what about the 990? Dr. Kane?

Dr. KANE. Actually, before I joined MEDPAC I did a fairly substantial report on the 990 and its shortcomings. That is in a June 2004 MEDPAC report, which I think is cited in my written testimony.

Senator BAUCUS. All right.

Dr. KANE. But it is very difficult to reform the 990 for any one type of charity because it serves, I do not know, 60,000 types of charities. Hospitals are the largest and most complex, so it is very hard to get the 990 to be standardized across so many diverse types. If you think a hospital among the two Manhattans is different, try the difference between a small charity and a teaching hospital complex.

Senator BAUCUS. Yes. Different.

Dr. KANE. So I think you cannot expect too much from the 990 because of that range, but I think in the instance of hospitals, we do need to ask for standardized supplemental reporting that meets the needs, I think, of the community benefit issues.

Frankly, even the financial statements and the executive compensation kind of reporting in the 990 is not up to what you need in a complex organization. So, I do not know that the IRS wants to do this, but if they want to have 990–H, it might be good for the hospitals only.

Senator BAUCUS. Right. What I am trying to get at is, who is the enforcer here of these standards? For example, there are organizations that self-regulate, the American Bar Association, for example. The National Association of Securities Dealers is another one. I see eyeballs rolling here—I do not know quite what that means—by one of the witnesses. But who helps make sure all this happens, what we are striving for, to get proper community care and so forth? Who does this?

Mr. LOFTON. It is very clear that, at the end of the day, we all want full transparency and full accountability of the information.

Senator BAUCUS. What about these bad actors that we hear about?

Mr. LOFTON. What bad actors?

Senator BAUCUS. Some bad actors that we have been hearing about that have been cited here that are ripping poor people off. There are always a few rotten apples.

Mr. LOFTON. Well, the 990s need to be structured to look at total compensation. At the end of the day, we have to make sure that the people that we are trying to attract to run our Nation's health care organizations are the best and the brightest.

Senator BAUCUS. I know. But is this just voluntary? Is it, all right, we will adopt these standards if we want to, and if we do not, we will not? We will modify what we want to. Should we leave it that way?

Mr. LOFTON. No, no. I am not suggesting that it is voluntary.

Senator BAUCUS. So who is the enforcer here?

Mr. LOFTON. I think, again, the IRS has a responsibility for all tax-exempt nonprofit organizations.

Senator BAUCUS. Is that sufficient?

Mr. LOFTON. Sufficient with what they have today?

Senator BAUCUS. Yes. Are the IRS actions sufficient?

Mr. LOFTON. I would not say that there would need to be a legislative solution. That is just a simple matter of making the requirements known, and then hospitals, in this case, responding and making sure that all of the information is appropriately submitted.

Senator BAUCUS. Dr. Kane?

Dr. KANE. Well, I think you have to go with what you can do, and I think the IRS is the right place to start. But I think, certainly, the States have Attorneys General who really try hard as well, although they do not have the resources. Texas had a nice effort, but they really had no way to fund the enforcement of even what they got reported to them.

So I think there is a funding issue and there is an oversight issue and a lack of resources that needs to be considered, but really the IRS is a great starting point. They have developed the standards and are trying to go out and develop a team to do the kind of work that we are talking about. So that is a great place to start.

I think the States could use some help as well. I think, in fact, hospitals are supposed to be local businesses. Ideally, you would like to get the accountability function pushed down to more local levels, but again, you have 50 States with 50 different statutes.

Senator BAUCUS. Right. I do not want to spend too much time on this point. But we have the SEC, which regulates publicly held companies. We also have the National Association of Securities Dealers, which is self-regulating, self-policing.

I am wondering, should the American Hospital Association form an NASD role and kind of be self-policing and boot people out who are on their own and not meeting the standards?

My guess is that most of these hospitals are looking for a good credit rating. They do not want to upset investors, and so forth. I am just wondering if there was something else, so we do not have to keep coming back to this hearing, short of passing universal health insurance?

Sr. KEEHAN. I think it is very complex. The most important thing you want to be sure that hospitals meet the standard on is quality, so we have organizations that are independent of the member organizations, like the Joint Commission, that does that. We have CMS that has a role because it is a huge payor and it has a role in looking at quality and looking at cost.

Senator BAUCUS. Right.

Sr. KEEHAN. And then you have IRS, because of the tax. I think that the IRS has been very, very interested, in tune, and has been a very willing partner to talk about and explain to us the complexity and where we can get to the main issues as we revise the 990. I do not know that the American public would allow one of the trade associations to regulate things like its tax-exempt status.

Senator BAUCUS. Oh, no, no. Not that. Just to have a little more self-policing with, say, the American Hospital Association, or Catholic Health Association.

Sr. KEEHAN. The better we all do at this, the easier it will be for the bad apples to stand out, Senator.

Senator BAUCUS. Yes. We need the IRS here. Mr. Chairman, did we invite the IRS?

The CHAIRMAN. No.

Senator BAUCUS. Oh. We did not invite the IRS? Anyway, I am sorry.

Mr. LOFTON. What the AHA has done is to endorse recommendations that would standardize the information to improve accountability. But to think that the AHA would be a monitor for 990s, I do not think that that would be the proper role.

Clearly, we would endorse having volunteer monitoring, and we really look for that to be, again, a local phenomenon based on the local governing boards.

Senator BAUCUS. All right. I am finished, unless somebody wants to say something that has not been said that should have been said. Did anybody say something so outrageous that it deserves a response or it needs to be said? [No response.]

The CHAIRMAN. All right. All I wanted to do is, Senator Baucus and I have been working together on this. I have a suggestion I wanted to throw out here. First of all, I owe all of you a thank-you for your time.

As background to what I am going to suggest, I just would say that I think this has been a very useful hearing with a wide range of views. Some issues are just common sense that we should seek to deal with when possible, and some of those have been pointed out.

But it seems to me that one judge of what ought to be allowed in the area of perks is, the tax code does not allow publicly traded corporations to deduct certain expenses, and it seems questionable to me that tax-exempt organizations ought to be allowed to provide the same perks.

But there are other matters that need to be given serious consideration. The question is, what can be accomplished through voluntary agreement by hospitals? We also have the roles of States that have been spoken of several times here.

We have what Senator Baucus just brought up about the IRS, and we have been in communication with them, but they have certain things that they can do. Whether they will do them or not, I do not know, but those would not require statutory changes.

Also, we have to consider all this with a realistic eye of what can be accomplished, whether it is by government agency, or whether it is by the States, or whether it is voluntarily by the hospitals, because those are different forms with different pressures.

So for those reasons, not having answers to those questions, the Finance Committee staff will develop a staff discussion paper that will provide our committee members proposals to consider in addressing these issues that we have heard addressed today, and I think particularly the proposals of the Catholic Health Association.

Proposals that have already been agreed to by hundreds of hospitals can serve as a starting point, as well as common-sense suggestions by you, Professor Kane. I want this draft developed in consultation with Senator Baucus. In addition, the committee will benefit from hearing from knowledgeable parties in considering a draft proposal.

The approach is similar to a model that we used with charity reform, which I believe was successful ultimately in getting wide bipartisan consensus, both in our committee as well as in the charity

community, and may have proved beneficial in this process as well. So, we will look at that as something to duplicate.

Of course, this document would be available for public comment, and that is the purpose of it, to lay everything out on the table, because I think it is important that we continue making progress, as evidenced by some of the thinking that has been presented here and some of the good-faith effort put forth, without Congress taking any action.

Do you have anything to add to that?

Senator BAUCUS. No.

The CHAIRMAN. All right. Thank you all very much.

The hearing is adjourned.

[Whereupon, at 12:01 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Committee On Finance

Max Baucus, Ranking Member

Opening Statement of U.S. Senator Max Baucus (D-Mont.)
Taking the Pulse of Charitable Care and Community Benefits
at Nonprofit Hospitals

The Book of Ezekiel admonishes that we operate through the hand of Providence when we "bind up the injured" and "strengthen the weak."

The prophet makes this admonition to the community — as a shared responsibility.

Many tax-exempt hospitals nobly carry out Ezekiel's instruction. They work to improve neighborhoods. They provide scholarships for students seeking health-career careers. And most importantly, they serve the health-care needs of their communities.

In Montana, most non-profit hospitals are "Critical Access Hospitals." They serve rural, often low-income, populations. Critical Access Hospitals play a key role in rural America's health-care safety net. And I was proud to write the legislation that established the category in 1997. More than four out of five Montana hospitals are Critical Access facilities. They are located in some of this country's most isolated communities.

Indeed, one thing that often distinguishes non-profit hospitals — like those in Montana — is that they operate where for-profit hospitals do not. For one thing, they show up in small, rural areas.

And they do more than just show up. Non-profit hospitals are more likely than for-profit hospitals to offer services that are unprofitable.

For example, tax-exempt hospitals are more likely to offer psychiatric emergency services. Those services are typically money-losers for hospitals. And tax-exempt hospitals are five times more likely than for-profit hospitals to continue offering services when doing so becomes unprofitable.

--2 more--

Those statistics should not come as a huge surprise. And that's not necessarily a criticism of for-profit hospitals. After all, for-profit hospitals have shareholders, and non-profit hospitals don't. Tax-exempt hospitals can continue to offer unprofitable services on Main Street, without regard to what they think on Wall Street.

Thus many tax-exempt hospitals do good work, in Montana and across the country. But there are also significant examples where non-profit hospitals have not provided a benefit to the public commensurate with the tax benefits that those hospitals receive.

Today we will hear about cases where non-profit hospitals aggressively billed patients of limited means after they received vital care that they could not afford.

We will hear of aggressive hospital bill collectors that act like credit card companies. We will hear of hospitals taking legal action against patients with incomes near the poverty line.

This kind of behavior by tax-exempt hospitals is not in keeping with the spirit of our laws governing tax exemption. I say spirit, because admittedly, the standards that govern tax-exempt status are vague.

As a general matter, in order for a hospital to maintain its tax exemption, the hospital must provide "a community benefit." In the past, if a hospital simply had an open emergency room, had a board that was representative of the community, and accepted Medicare and Medicaid, then it qualified as providing a community benefit.

But recently, the IRS and federal courts have taken a more skeptical view toward the community benefit standard.

The IRS now looks for a "plus factor" in addition to a policy of open admittance. For example, a tax-exempt hospital must also have a charity care, medical research, or health education program. But the IRS has not made clear how much of this a hospital has to do.

To some extent, this flexible standard makes sense. The community needs in Manhattan, Montana, differ from those in Manhattan, New York.

Unfortunately, some health providers take advantage of these loose standards. For example, some providers classify their community benefit based only on their open admission policy, while writing off bad debt as charitable care.

Not surprisingly, some of today's witnesses will argue that the provision of free care should be the paramount consideration in granting tax-exempt status.

--1 more—

I am interested in hearing what this standard might mean for rural providers, like those in Montana which often operate with thin — or negative — margins.

The provision of charity care by tax-exempt hospitals is an important subject. It has significant implications for both hospitals and the federal treasury.

But it is also important because it raises one of the most pressing problems facing our nation — that 46 million Americans have no health insurance. Arguably, if all Americans had health insurance, we would not be having this discussion.

Nearly one in five Montanans is uninsured. That's one of the highest rates in the nation. And the uninsured are four times as likely not to seek a physician's care when they have a medical problem, compared to those who have insurance. Not surprisingly, the uninsured tend to get sicker. And they tend to die sooner.

I realize that universal health care is not just around the corner. This Congress would not even cover the victims of Hurricane Katrina, one of this nation's worst natural disasters.

But until providers and insurers have an incentive to treat sick and uninsured patients, we're going to struggle with the problem of charity care. I hope that this hearing will encourage more folks in Congress and the administration to think about how we can work together to solve the problem of the uninsured.

It has been over a decade since Congress took a comprehensive look at how to tackle this problem. We are long overdue.

Finally, I am proud that Scott Duke is one of our witnesses today. Scott is the CEO of Glendive Medical Center in Glendive, Montana. He is currently the Chair of the Montana Hospital Association's Board of Trustees. And Scott will be able to give us the perspective of rural hospitals.

I look forward to the witnesses' testimony. I look forward to hearing where hospitals succeed — and where they fail — to serve the community. And I look forward to learning how we all might better "bind up the injured" and "strengthen the weak."

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Testimony of

Scott A. Duke, CEO
Glendive Medical Center
Glendive, Montana
Before the U.S. Senate Committee on Finance
September 13, 2006

Good morning. My name is Scott A. Duke, Chief Executive Officer for the Glendive Medical Center (GMC) located in Glendive, Montana. I am also the current chair of the Montana Hospital Association's board of trustees. I appreciate the opportunity to testify today.

GMC is a not-for-profit, community-based health care organization that provides a full spectrum of medical services. Specifically, GMC is comprised of a 25-bed critical access hospital (CAH), 75-bed skilled nursing facility, 13-unit assisted living facility and a home care and hospice agency that serves four counties. GMC also operates the Eastern Montana Veteran's Nursing Home, an 80-bed skilled nursing facility. In addition, 22 physicians and mid-level providers practice at our facility and provide outpatient services at the Gabert Clinic, which is a federally designated rural health clinic (RHC). GMC employs more than 450 people.

Since the late 1800's, GMC has provided medical services to the citizens of Eastern Montana and Western North Dakota. Today, we serve an area with approximately 15,000 people. Three other CAH's are located within a 50-mile radius of Glendive.

The nearest large, tertiary care hospitals are a three-hour drive to the west in Billings, Montana and to the east in Bismarck, North Dakota. GMC is fortunate to have a local volunteer ground ambulance service and access to fixed wing air medical transport to transfer patients to these facilities.

GMC's mission statement is very straightforward: "We are committed to caring, healing and a healthier community."

We attempt to fulfill this mission in a variety of ways. As in all of Montana's not-for-profit hospitals, one way we do this is to provide medical treatment to anyone in need – regardless of their ability to pay.

Our facility has a clearly-spelled out policy for providing financial assistance to patients. Under this policy, persons whose income is at or below 100 percent of the federal poverty level are eligible to receive care at no charge.

Persons whose income is between 100 and 200 percent of the federal poverty level are eligible to receive financial assistance based on their income and assets. Our policy also includes assistance for catastrophic events and loans without interest if persons fail to qualify for assistance using the other criteria. I have attached a copy of these policies to my testimony.

We also take steps to ensure that patients know about and understand our policy. The "Patient Notice of Financial Aid" is given to every patient at admission, along with a patient-friendly description of the facility's financial assistance program.

Using these policies, in 2005, GMC provided nearly $457,000 in charity care and almost $1.5 million in uncompensated care.

GMC has a long and proud history of making investments in our community's health and well-being. In 2005, our facility provided more than $1.3 million of community services at no charge. These services ranged from health screenings, telemedicine mental health consultations, scholarships, transportation, subsidized health services and economic development – to name just a few.

Overall, in 2005, GMC provided a total of $3,286,057 in community benefits to the Glendive area, including charity care, community services for which we weren't paid, bad debt and the shortfall in Medicare and Medicaid payments. All of these figures are based on cost – not charges.

The total community benefit provided by GMC represents 15 percent of its operating expense and nearly four times GMC's tax obligation if it were a taxable entity.

Since 1999, GMC has voluntarily reported its community benefits, following the model established by the VHA. A summary of the 2006 report is included in my testimony.

GMC is typical of the general, acute-care community hospitals in Montana. These hospitals are the cornerstone of Montana's health care system. All of Montana's not-for-profit hospitals – no matter how big or small – are run by boards made up of community members. They tailor their services to meet the unique needs of the communities they serve.

Twelve of Montana's 57 hospitals are VHA members; another five are CHA facilities – all of whom use the VHA/CHA model as the starting point for reporting their community benefits.

Montana's hospitals have taken an additional step toward publicly demonstrating that we are fulfilling our charitable responsibilities.

The Montana Hospital Association (MHA) Board of Trustees recently adopted several policies regarding charity care, financial assistance and community benefit reporting. The board made clear that members are expected to meet these standards. These policies are attached to my testimony.

One of these policies relates to serving uninsured patients with limited means. Members are expected to provide care at no charge to uninsured patients whose income is less than 100 percent of the federal poverty level.

For uninsured patients whose income is between 100 and 200 percent of the federal poverty level, members are expected to provide financial assistance. This assistance can be on a sliding scale based on income, assets and other considerations. The MHA policy also makes clear that members are expected to work with patients to ensure that they understand the cost of their treatment, their payment options and billing and collection practices.

Another policy relates to identifying and reporting community benefits. Under this policy, members are expected to conduct a periodic community needs assessment, assign a staff person responsible for developing a community benefit plan, and identify and compile their community benefits. At a minimum, this compilation should be distributed to the full community annually.

The MHA approved policy strives to achieve consistency in reporting community benefits and, with two exceptions, follows the definitions of community benefits incorporated in the CHA and VHA model.

We differ with CHA and VHA in that we expect members to report the unpaid costs of Medicare and bad debt. We believe these costs are legitimate benefits provided to the communities we serve.

The MHA policy establishes three methods that facilities can use to compile and report community benefit information. In doing so, MHA recognized that frontier and rural hospitals in Montana – as in other states – face obstacles not faced by hospitals in urban areas. Given their many struggles, the mere fact that these facilities exist could be argued as justifying their community benefit.

Each facility is expected to select one of the three methods to identify their community benefits. Specifically facilities can:

- Using the list of community benefits as defined by CHA/VHA, list the activities in which they are engage and provide their bad debt and unpaid Medicare costs.
- Using the list of community benefits as defined by CHA/VHA, list their activities and the direct cost of engaging in those activities and provide their bad debt and unpaid Medicare costs.
- Complete the CHA/VHA Community Benefit Reporting document. In addition, members are expected to provide their bad debt and unpaid Medicare costs.

We developed this three-tiered system in recognition of the obstacles many CAHs would face if they were forced to complete the entire CHA/VHA Community Benefit Reporting document. Many CAHs staff their business office with only one or two people. It's all they can do to keep up with the routine business requirements.

Even though we don't require these facilities to complete the CHA/VHA document, we do expect them to, at a minimum, list the community services they provide, and where possible, their costs.

Montana's hospitals believe a voluntary system such as the one I've outlined is far superior to a one-size-fits-all federal mandate.

We recognize the need to demonstrate that we are fulfilling our obligation to serving community needs, and we underscore the importance of enabling communities to demonstrate their accountability in a way that fits their local circumstances.

The current Internal Revenue Service standard provides the flexibility we need to adapt our services to the specific needs of our communities. I urge the committee not to take any actions that would alter that standard and impose obligations on us that don't fit with the needs of our community. A standard designed for Manhattan in the heart of New York City, will be irrelevant to the community of Manhattan, Montana.

Montana's hospitals have a strong overall record of providing charity care and community benefits. According to an MHA survey conducted earlier this summer, virtually all of our state's hospitals have a charity care policy. Most of these policies fit within the guidelines established by the MHA Board of Trustees.

Last year, Montana's hospitals provided about $100 million in uncompensated care, according to the MHA/AHA Annual Survey of Hospitals.

In addition, each year, Montana's hospitals also provide millions of dollars worth of community services at no charge.

We believe this evidence demonstrates our commitment to our communities and to the obligation we face as tax-exempt organizations.

Thank you for this opportunity to testify.

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

MHA Billing, Collection, Financial Assistance & Charity Care Policy

(Applies to all MHA member hospitals.)

- Financial Assistance for the Uninsured of Limited Means
  - MHA members are expected to provide financial assistance and counseling for uninsured people of limited means, without regard to race, ethnicity, gender, religion or national origin.

  - Financial assistance provided by organizations to uninsured people of limited means should in no way substitute for state efforts to provide or expand coverage to the uninsured.

    State Medicaid programs should be required, at a minimum, to sustain a "maintenance of effort," keeping programs' eligibility at least at their current levels.

    Further, state Medicaid programs also should be required to expand coverage to all individuals at or below the poverty level.

    Until that time, **facilities should have policies to provide services to uninsured patients below 100 percent of the federal poverty level at no charge.**

    Existing clinical and geographical criteria used by facilities to determine eligibility for certain services would apply. (E.g. certain typical eligibility criteria for admission to services -- like the three-day stay for SNF, homebound status for home health, a terminal diagnosis for hospice -- wouldn't change.)

  - MHA members are expected to provide **financial assistance to all uninsured patients between 100 and 200 percent of the federal poverty level.**

    - For these patients, facilities may provide discounts on a sliding scale that takes into consideration the patient's income, other liquid assets and other special.
    - The discounts should be similar to those extended to public and private insurers.

    Facilities may choose to provide greater assistance such as extended payment schedules, limiting charges to a percentage of the patient's annual income or otherwise limit the patient's charges.

1720 Ninth Avenue P.O. Box 5119
Helena, Montana 59604-5119
tel: 406-442-1911 fax: 443-3894
www.mtha.org

- MHA members may offer financial assistance to uninsured patients with incomes **in excess of 200 percent of the federal poverty level at their discretion.**

- Financial assistance is contingent on the cooperation of a patient in providing the information necessary for a facility to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from facilities shall have a responsibility to pay according to the terms of that policy.

- Cosmetic surgery and other non-medically necessary services are exempt.

- MHA members will make information about a facility's financial assistance policy easily available to the public.

- Facilities that have financial assistance policies that meet or exceed those above shall have immunity from related class action lawsuits.

- **Ensuring Fair Debt Collection Policies (Applies to all Members)**
  - If using outside debt collection organizations, MHA member organizations will obtain written assurances that the organization complies with the Fair Debt Collection Practices Act and the ACA International's Code of Ethics and Professional Responsibility.

  - MHA member organizations will have written policies as to when and under whose authority a patient account is advanced for collection. If a patient has completed a facility's application for financial assistance, that account should not be advanced for collection pending determination of eligibility.

  - MHA member organizations will have written policies as to when and under whose authority a lien can be placed on a patient's primary residence.

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

MHA Reporting Community Benefit (Applies to MHA-member non-government, not-for-profit organizations)

- MHA member organizations are expected to conduct a periodic community needs assessment, with a frequency to be determined by the organization. (This can be done collaboratively with other community organizations.)

- MHA member organizations are expected to assign responsibility for a community benefit plan to an organization employee.

- MHA member hospitals are expected to identify and compile the benefits they provide their communities using one of three methods:

    - List the community benefit activities the organization engages in (Appendix A includes a list of the activities compiled by CHA that could count as community benefit activities), plus the amount of bad debt and charity care (at cost) and unpaid costs of government-sponsored health care programs (including Medicaid, Medicare and public and/or indigent care programs.)

    - List the community benefit activities the organization engages in, including the direct costs for as many of these programs as possible, plus the amount of bad debt and charity care (at cost) and unpaid costs of government-sponsored health care programs (including Medicaid, Medicare and public and/or indigent care programs.)

    - Complete the Community Benefit Guidelines outlined in CHA/VHA's Community Benefit Reporting document, including, in addition, the organization's direct and indirect costs of subsidized health care services, charity care, bad debt and the unpaid costs of government-sponsored health care (including Medicaid, Medicare and public and/or indigent care programs.)

- MHA member extended care organizations are expected to identify and compile the benefits they provide their communities. CHA has developed a list of eligible activities for aging services providers – very similar to the list for hospitals – that should form the basis for developing a community benefit report.

- MHA member organizations are expected to report their community benefits to their community at least once a year. They also may attach their report to their Form 990.

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Appendix A

Community Benefit Activity Planning Form (CHA)

Community Health Services

- Community health education
- Community-based clinical services
- Health care support services
- Other

Health Professions Education

- Physicians/medical students
- Scholarships/funding for professional education
- Nurses/nursing students
- Technicians
- Other health professional education
- Other

Subsidized Heath Services

- Emergency and trauma services
- Neonatal intensive care
- Hospital outpatient services
- Burn unit
- Women's and children's services
- Renal dialysis services
- Hospice/home care/adult day care
- Behavioral health services
- Other

Research

- Clinical research
- Community health research
- Other

Financial Contributions

- Cash donations
- Grants
- In-kind donations
- Cost of fundraising for community benefit programs
- Other

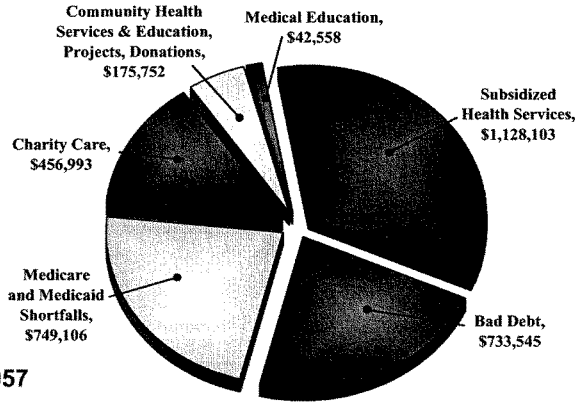
Glendive Medical Center

Community Benefit Report 2006

Glendive Medical Center (GMC) is pleased to share our 2006 Community Benefit Report. In the past year, GMC is proud to have provided more than $3.2 million in total community benefits. This report illustrates our ongoing investment in the communities we serve and our commitment to provide quality medical care, regardless of a person's financial means. This commitment is an important element in fulfilling our mission of ***"Caring, Healing, and a Healthier Community".*** The information also demonstrates our dedication and history of providing a variety of community benefits. Some of these include: health screenings, telemedicine mental health consulting, scholarships, transportation, subsidized health services, and economic development.

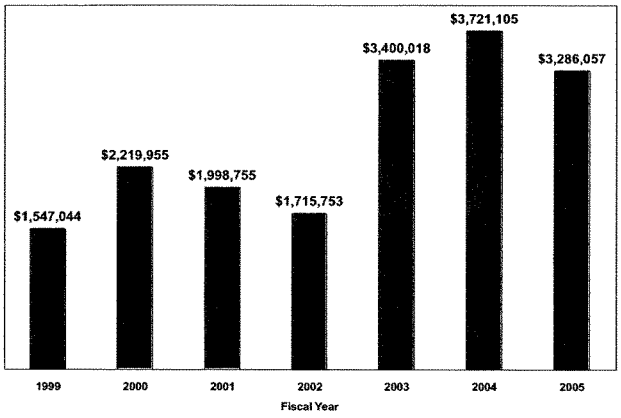
Total Community Benefit

The graph to the right illustrates GMC's total community benefit, by category, based on actual cost.



Total Benefit: $3,286,057

Community Benefit History 1999 - 2005

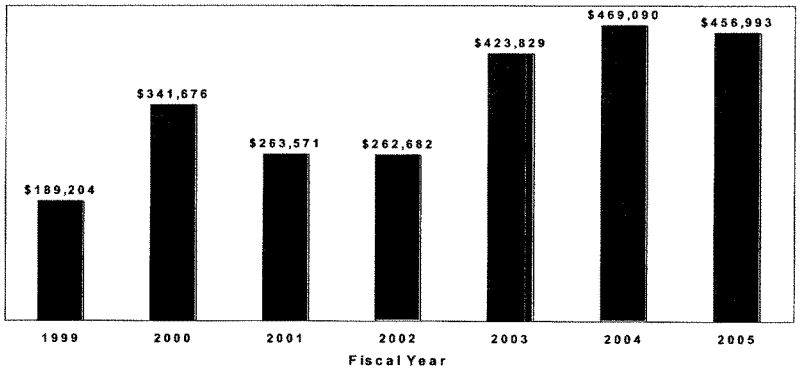


Glendive Medical Center

Community Benefit Report 2006 (Cont.)

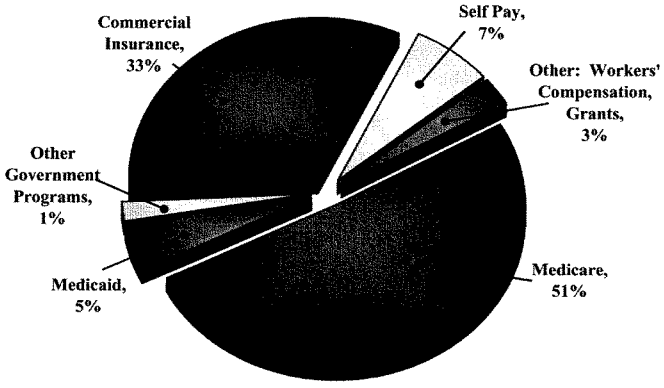
Charity Care

In the past year, GMC provided more than $450 thousand in charity care and nearly $2.5 million in the past seven years. As a not-for-profit community hospital, GMC has an obligation to provide care for all who come to us in need. This obligation includes providing financial assistance, if needed. In recognizing that the costs of healthcare services can create a significant financial burden, GMC created a program to provide financial assistance that applies equitable and consistent standards for all patients. As a part of this program, GMC prepares this report annually. The graph below trends the history of GMC's charity care for the past seven years.



Payer Mix

The graph to the right depicts GMC's Critical Access Hospital payer mix for fiscal year 2006 based on gross revenue.



Policies and Procedures for
Glendive Medical Center **Finance Department**

SUBJECT: Financial Assistance

Written/Revised by: Barbara Markham CFO **Original Date: _____**

Policies & Procedures Review Date: **Previous Revision Date:**

Approved by:_____ **Effective Date: _____**
Scott A Duke CEO

Purpose: Glendive Medical Center(GMC) is a not-for-profit medical center that provides inpatient, outpatient and emergency services, committed to caring, healing and a healthier community. GMC provides quality rural health care to all patients who seek services, including those individuals who lack the ability to pay for such services. This policy sets forth the policy, process and guidelines by which such patients can access Financial Assistance including Uncompensated Care.

Policy: To fulfill its mission of providing compassionate and high quality rural healthcare to patients it serves, it must also achieve cost efficiency of those services through effective management of its resources. Therefore, it is the policy of GMC to maintain a process for proper identification of patients eligible for Financial Assistance.

This policy covers medically necessary health care services provided by GMC for inpatient and outpatient hospital care. It does NOT include extended care, respite care, swing bed, transportation costs, elective procedures and any services provided by outside vendors, including, but not limited to non hospital based providers.

It is the policy of GMC to differentiate between the patients who are unable to pay from those who are unwilling to pay for all or part of their care. GMC will provide Financial Assistance including Uncompensated Care to those patients who are unable to pay based upon the eligibility criteria set forth herein in Appendix A-C. In order to conserve scarce healthcare resources, GMC will seek payment from all patients who do not qualify for Financial Assistance. While qualifications for Uncompensated Care is ideally determined at the time of service, GMC will continue to review all determinations as potential insurers or other financial resources are discovered during the billing and collection process.

GMC will furnish financial assistance information to every patient or responsible party of a minor patient and assist them to apply for financial assistance including Uncompensated Care. All patients and other responsible parties will be treated fairly, with dignity, compassion, respect and cultural sensitivity throughout this process.

Definitions:

1. Uncompensated Care Financial Assistance. Uncompensated Care is free care provided to patients who are not covered by any medical or other insurance or other entity in whole or in part (co-payment, co-insurance, deductible, spend down, etc.), who are ineligible for any governmental coverage (Medicare, Medicaid,etc.), who are liable for payment and meet the established hospital guidelines for Uncompensated Care.

2. Self-Pay Patient: Those patients who are liable for all or a portion of their care but are not eligible for Uncompensated Care. Self pay patients may be eligible for financial assistance through installment payments and other programs.

3. Catastrophic Financial Assistance:: Patient is not eligible for any other assistance and unable to pay the self responsible portion of the account in 24 months or less based on set criteria as shown in Appendix C.

Procedures:.

A. The following will take place to insure all eligible patients/responsible parties are aware of the uncompensated care program:

1. Appropriate signs explaining the program will be posted in the Admission areas of Glendive Medical Center.

2. Each patient(or their guarantor)of Glendive Medical Center except for ones receiving Nursing Home, Respite Care and Swing Bed services will be provided information for Uncompensated Care, Installment Plans Assistance and Catastrophic Financial Assistance.

3. Any person may request and receive an Uncompensated Care application.

B. The following requirements must be met by any patient to qualify for uncompensated care consideration:

1 .An application must be requested from the collection department in order to determine eligibility.

2. A completed application and required documentation must be received by the collection department before final determination can be made:

a. Signed and Dated Application.
b. Most recent Federal Income Tax return including signed signature page.
c. Income information for the prior thirteen weeks prior to the application. (Example – application made 07/01/06, income information for January through June, 2006 must be furnished.)
d. All documentation requested on the documentation checklist.

C. Upon receipt of application, the date received will be stamped on the application and will be processed within 30 days.

D. If a Medicaid Eligibility/Denial Determination is delayed, a Conditional Eligibility may be given if the applicant qualifies and that date should be shown on the application. When Conditional Eligibility is given, no further statements should be sent and no further collection proceedings should take place. A letter should be sent informing the applicant that they are eligible contingent upon Medicaid denial. Review and signature by CFO or their designee is required prior to sending the letter.

E. Final Determination will be made at the time all information has been received. If the applicant is Medicaid eligible, the account will be turned to the appropriate insurance biller for filing purposes. If the applicant qualifies, a letter will be sent to the applicant stating at what level based on the current Federal mandated poverty levels per the current facility criteria in Category A and Category B.

If the applicant does not qualify, a letter should be sent stating the denial and the reason for that denial.

Review and signature by CFO or their designee is required prior to sending the final determination or the denial except when approval has been given for Conditional Determination.

F If the patient is Medicare and the uncompensated care is allowable for reimbursement under the Medicare program, the account will be classified as a Medicare Bad Debt. All other balances will be classified as Uncompensated Care.

G. An adjustment will be made to the accounts receivable accounts upon Final Determination. The accounts will be logged on either the Medicare Bad Debt Log or Uncompensated Care Log in the appropriate month.

H. Conditional or Final Determination will be given as follows:

1. Requests(meaning completed application with all requested items attached except for Medicaid eligibility/Denial) received prior to Inpatient Discharge or outpatient services, will be processed within two working days. "Working Days are the five working days each week that the collection department is open"

2. Requests completed after Inpatient Discharge or Outpatient Services, will be processed no later than the end of the first "full" billing cycle following the request (again a completed application with all items attached except Medicaid Eligibility/ Denial.) (Example: Request received 5/15/06, determination will be made by 6/30/06.)

Files will be held in the Collection Departments files until compliance audits have been completed. Each fiscal year's files should be reconciled to the logs (Medicare and Uncompensated Care). and kept separate from other years. These files should contain the bills, copies of insurance vouchers, completed applications with all required items attached. If a balance is due from the patient, a copy of that account should be placed in the active file with the appropriate information.

Appendix A
Uncompensated Care Financial Assistance Guidelines

1. Notice of the availability of the Financial Assistance Program will be posted at patient registration sites, admissions/Business Office and emergency department within each facility and presented to patients upon request.

2. Each person requesting Financial Assistance needs to complete a Financial Assistance application.

3. A preliminary application stating household size and household income will be accepted and a determination of probable eligibility will be made within ten business days of receipt.

4. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior year tax return;
   (b) Current pay stubs;
   (c) Letter from employer; and
   (d) A credit bureau report obtained by the GMC's Patient Financial Services Department.

5. An individual will be eligible for Financial Assistance if the maximum household income level does not exceed 200% the Federal poverty guidelines, they do not own liquid assets exceeding $2,500 which should be available to satisfy their bills or their other assets values excluding their principal home and one vehicle do not exceed $2,500.

6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.

7 Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the Hospital.

8. Final eligibility for Financial Assistance will be determined within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The CFO or designated responsible party will approve the final eligibility determination.

9. Documentation of the final eligibility determination will be made on all (open-balance) patient's accounts. A determination notice will be sent to the patient.

10. A determination of eligibility for Financial Assistance will remain valid for a period of three (3) months for all necessary services provided based on the initial date of the determination letter. For recurring outpatient therapeutic services (such as chemotherapy or radiation therapy), patients may qualify for Financial Assistance for up to six (6) months on the basis of a single application.

11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of GMC.

Appendix B
Installment Payment Plan Financial Assistance Guidelines

General Conditions for Installment Payment Plan

1. Each person needs to complete Financial Assistance application
2. Patient is not eligible for any of the following:
   a. Medical Assistance
   b. GMC Uncompensated Care
3. Patient does not have the ability to pay the self-responsible portion of the account in full.

Factors for Consideration:

The following factors will be considered in evaluation Installment Payment Plan assistance:

1. Current Medical Debt
2. Liquid Assets (leaving a residual of $2,500)
3. Other Assets excluding Principal home and one(1) vehicle
4. Annual Income
5. Other Exepnses including health insurance premiums

Evaluation Method and Process:

1. The Collection Clerk with review the Installment Plan Application and collateral documentation submitted by the patient/responsible party.
2. The Collection Clerk will then complete an installment plan worksheet to determine payment plan based on completed application.
3. Installment plan agreement will be presented to patient/responsible party stating amount and number of payments .
4. No interest payments will accrue during the repayment of this installment plan loan.
5. GMC may adjust payment terms if necessary to assist person/responsible party to meet their obligations.

Appendix C
Catastrophic Financial Assistance Guidelines

Purpose:

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance for Uncompensated Care, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a GMC Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the medical bill is greater than the patient/guarantor's ability to repay with current income, liquid assets, and other assets over $2,500 excluding primary home and one vehicle in 24 months or less.

General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
    - Medical Assistance
    - The GMC Financial Assistance Program for Uncompensated Care
3. The patient cannot repay the self-responsible portion of the account in 24 months or less.
4. GMC has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the non-charitable amount is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a GMC Catastrophic Assistance Application and non-duplicated supporting documentation.

Factors for Consideration:

The following factors will be considered in evaluating a Catastrophic Assistance Application:

1. Current Medical Debt
2. Liquid Assets (leaving a residual of $2,500)
3. Other Assets excluding Principal home and one(1) vehicle
4. Living Expenses
5. Projected Medical Expenses
6. Annual Income
7. Spell of Illness
8. Supporting Documentation

Exceptions

1. GMC has the right to refuse financial assistance for elective procedures, which may result in catastrophic medical debt.

2. Administration may make exceptions, as circumstances deem necessary.

Evaluation Method and Process

1. The Collection Clerk will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.

2. The Collection Clerk will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

Definitions:

Current Medical Debt

> Self-responsible portion of current inpatient and outpatient affiliate account(s).Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are also considered.

Liquid Assets

> Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.

Other Assets

> Homes, Vehicles, Other Property

Living Expenses

> Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.

Projected Medical Expenses

> Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)

Take Home Pay

> Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.

Spell of Illness

Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.

Supporting Documentation

Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.

Glendive Medical Center
provides hospital care to anyone, regardless of ability to pay.

Uncompensated Care: Help for low income families with hospital expenses!

What is Uncompensated Care? Uncompensated Care is a way to help low income people and families pay for hospital medical services. Uncompensated Care is either free care or reduced-price care, depending on your income.

Who is eligible for Uncompensated Care? People and families with incomes within our income guidelines are eligible for Uncompensated Care if they:

(1) do *not* have the financial resources to pay for care.

(2) are *not* insured, that is covered by a group or individual medical plan, worker's compensation, Medicare, Medicaid, or any other state, federal, or military program;.

(3) are *not* involved in a situation where someone else has a legal responsibility to pay for the costs of medical services -- for example, an auto accident.

Important Note: *Glendive Medical Center does not discriminate based on age, race, color, national origin, religion, sex, handicap or disability.*

What does Uncompensated Care cover? Uncompensated Care covers necessary or emergency hospital care. It covers inpatient and outpatient hospital care.

It does NOT cover extended care, respite care, swing bed, transportation costs or elective procedures, and usually does not cover doctors' services.

How do I apply? To find out what is needed to prove you are eligible and what services will be covered, please contact:

MarySue
Patient Financial Services
345-3354

Glendive Medical Center (GMC)
Notice of
Financial Assistance

GMC is proud of its commitment of providing quality health services to all patients.

If you do not have health insurance or are concerned that you may not be able to pay for all or part of your care, we may be able to help. GMC has a program that provides financial assistance to patients based on their income, assets and financial needs.

Federal and state laws require all hospitals to seek payment for care provided. As such, GMC has established policies which consistently apply billing and collection practices. This notice is provided to all patients at admission, when accessing medical services, and if there are billing questions or payment delays. GMC's pledge to our patients is to assist you with any question or issues you may have. It is important that you let us know as soon as possible if you have any concerns related to paying your bill so we can assist you.

For more information, please contact MarySue in our patient financial services office at 406-345-3354. All inquiries will be promptly addressed with courtesy and kept strictly confidential.

Responses to Questions for the Record From Scott A. Duke
November 1, 2006

Questions from Senator Santorum

1. *I have talked with many of the hospitals in PA and a number have charity care policies in place that provide free care to our most needy (under 200% of the federal poverty line), reduced care for those who have some ability to pay (above 200% but less than 400% of the poverty line), and even work with patients to qualify them for programs that will cover their medical expenses retroactively. However, to remain fiscally viable – even as a nonprofit – a medical facility has to make ends meet. The question then is how to balance the charitable mission of an organization with the need to remain financially stable to continue to serve your communities. How has your organization struck that balance? Is there a difference in how you reach that balance based on whether the nonprofit is a faith-based organization or a secular one? What is done with "margins"?*

Our mission at the Glendive Medical Center (GMC) is to serve the health needs of our community and its residents, regardless of their income level and their ability to pay. As a not-for-profit hospital, any margin we receive for serving our community is reinvested in our community's health care – either to pay for care provided to those who can't afford medical treatment or in strengthening the community's health infrastructure. I believe this is true regardless of whether a hospital is faith-based or secular.

The balance between margin and mission is obviously delicate; without some margin, we cannot fulfill our mission. Earlier this year, the Montana Hospital Association adopted policies designed to ensure all patients are assured medical treatment, regardless of their ability to pay for that care.

These policies, similar to those adopted this year by the American Hospital Association; specify that hospitals should provide services to uninsured patients below 100 percent of the federal poverty level at no charge. Financial assistance should be provided to patients whose income falls between 100 and 200 percent of the FPL.

The MHA and AHA policies also provide guidance about how to collect debts fairly, report community benefits and provide financial information to patients. In addition, we have endorsed AHA's 2003 policy statement governing hospital billing and collection practices.

Taken as a whole, I believe these policies provide a framework for balancing our mission with the need to achieve a margin.

2. *We have heard some contend that while a nonprofit hospital's charity care policy may be sound, that patients are not aware of this policy and thus it is ineffective. At least in my state, the policies are required to be posted in key public areas, and generally a copy is given to the patient and conversations can be initiated by the patient or the hospital to determine if a patient is eligible any time in the payment or collections process. In addition, the Hospital Association of Pennsylvania put out guidelines on charity care and financial aid in July 2004 that includes a section on implementation such as communicating the availability of the policy, training staff on the policy and administering the policy fairly, respectfully and consistently. Without requiring every patient to be pre-screened for eligibility, what other specific points do you think should be added*

This is a very valid concern, especially in small communities like Glendive, Montana where, too often, patients believe there is a stigma attached to charity care and financial assistance.

To address this concern, we post a notice about the policy in various locations throughout the facility. We also include an informational letter with the patient's statement. In addition, we provide education and updates for our Board of Directors, Medical Staff and all employees related to this topic and they in turn serve as community ambassadors sharing the information with family and friends.

The Montana Hospital Association also has addressed this concern by urging its members to adopt the actions recommended in AHA's Principles and Guidelines. In general, these include providing financial counseling to patients about their hospital bills and making available to the public information about charity-care policies and other forms of financial assistance.

3. *How do you balance the desire to get patients enrolled in plans or qualified for the charity care policies without forcing patients to provide personal and financial information that they may not want to provide?*

GMC's policy is similar to the Montana Hospital Association and American Hospital Association policy which makes it clear that in order to receive financial assistance a patient needs to do their part in providing the information necessary to determine that they are eligible for assistance.

4. *In the Commonwealth there is a requirement that nonprofit hospitals certify annually to the Department of Public Welfare that they have a charity care program, their efforts to seek collection of all claims and attempts to obtain health coverage for patients. If we continue to provide charity care above a certain level – such as 400% of the poverty level – does that not discourage the purchase and maintenance of health insurance?*

Again, this is a question of balance. GMC's policy is much lower than 400%. We use 100% of FPL for free care and a sliding scale up to 200% of FPL. This is in

accordance with the Montana Hospital Association and the American Hospital Association policy recommendation for financial assistance for patients whose income falls below 200 percent of the federal poverty I believe that is a reasonable approach.

In some Montana communities, providing assistance for hospital care for those patients whose income falls below 400 percent of the federal poverty level would entitle everyone to financial assistance.

Facilities can, at their discretion, provide financial assistance at a level above 200 percent of the FPL, but that must be a local decision that reflects the needs and interests of the community.

5. *Community benefit is a concept that will vary greatly from hospital to hospital and area to area. I understand that some have argued that all community benefit should be limited to charity care or specific standardized items. In my experience the community benefit of the Children's Hospital of Pennsylvania offering training for parents on how to properly use child safety seats in cars and the low-income health clinics by our research hospitals both serve their community. How do we continue to ensure that there is community benefit but take into consideration the difference between types of hospitals, charitable missions, size and location?*

As I stated in my testimony on September 13, the current community benefit standard should not be changed. The current standard allows hospitals to tailor their services and programs to the unique circumstances of its community and recognizes that the needs of Glendive, Montana are vastly different than those in Philadelphia or Pittsburgh.

A one-size-fits-all standard wouldn't accommodate this kind of flexibility.

Questions from Senator Rockefeller

Question 1: Topic: Uninsured

I think the real issue facing all hospitals, but primarily nonprofit hospitals, is the problem of the uninsured. The Census Bureau just reported last month that, in 2005, the number of uninsured adults rose to 46.6 million. And, the number of uninsured children rose for the first time since 1998 to 8.3 million.

As I understand it, nonprofit hospitals have a hard time trying to shoulder the uncompensated health care burden caused by lack of health insurance. In West Virginia, nonprofit hospitals had $442 million in uncompensated health care in 2005. By comparison, the uncompensated health care burden of WV's for-profit hospitals was only $64 million.

With the added costs of Medicare and Medicaid cuts as well as cuts to health professions training programs, many nonprofit hospitals struggle to keep their doors open. And, their tax exempt status is the only thing that allows them to stay afloat.

Sister Keehan, Mr. Duke and Mr. Lofton, can you talk a little bit about the challenges faced by your hospitals because of the lack of health insurance? You can't just move costs around can you?

The growing number of uninsured in America is an enormous problem for not-for-profit health care providers as well as our entire society. It is an especially serious problem in Montana where nearly 20 percent of our state's population is uninsured.

Our state's uninsured population contributes significantly to the uncompensated care provided by Montana's hospitals, which in 2005, topped $160 million (charges).

Cuts in payments for services provided by Medicare and Medicaid exacerbate the problem. In rural communities like Glendive, Medicare and Medicaid often account for two-thirds or more of our hospital's revenue. The failure of these programs to pay the full cost of treating their beneficiaries has forced us over time to increase charges to recover these unpaid costs. This, in turn, contributes to higher health insurance costs and makes health insurance even less affordable.

Montana's hospitals have consistently supported legislation and other programs that would expand health care coverage. Until we achieve that goal, Montana's hospitals will continue to serve anyone who seeks treatment, regardless of their ability to pay.

Question 2: Topic: IRS Determination of Tax-Exempt Status

It has been suggested by some that the 1969 IRS Community Benefit standard for determining tax exempt status is too broad and was wrongly decided. However, it is true that nonprofit hospitals contribute to their communities in a variety of ways. Some nonprofit hospitals focus almost exclusively on providing charity care.

Others, such as teaching hospitals, focus more on scientific research that will lead to treatments and cures for diseases. Other nonprofit hospitals provide invaluable education services to their communities.

We have a Children's Health Van at Marshall University in West Virginia, which I helped create, that provides vital health education services to children and their families. Most of these families would have no contact with the health care system otherwise. I think that is a huge community benefit.

Don't you agree that nonprofit hospitals benefit communities in a variety of ways – from charity care to scientific research to capital investment and infrastructure development?

Who else is going to make the investment in health care that we are going to need as our population ages.

I completely agree that not-for-profit hospitals benefit communities in a variety of ways and that without their presence, these services may not be available. This is especially true in rural and frontier America.

In Glendive, my hospital provides health screenings, telemedicine mental health consultations, scholarships, transportation, subsidized health services, outreach services, and economic development to name just a few.

Many of these services would not be available if GMC did not provide them. Overall, as reported in the VHA community benefit survey, GMC's total community benefit represented 15 percent of its operating expenses in 2005.

Question 3: Topic: Nonprofit Hospital Tax Exemption Recommendation

In your testimony this morning you made a number of recommendations for a higher standard for a federal tax exemption. Your first suggestion is that nonprofit hospitals be required to provide charity or discounted care equal to the value of their tax exemption. I am concerned about what such a strict standard would mean for other public benefits that hospitals currently provide. Le me list just a sample of the other community benefits that members of West Virginia's Hospital Association provide:

i. *free health screenings;*
ii. *cancer education programs;*
iii. *wellness classes and support groups;*
iv. *scientific research;*
v. *in-kind donations of equipment, pharmaceuticals and medical supplies;*
vi. *workforce development.*

It seems to me that a "community benefit" standard that considers only charity care disregards many of the other extremely valuable functions that nonprofit hospitals provide our communities. Why shouldn't those other contributions be considered in determining tax exempt status? And how accurately can we possibly quantity the value of those services to the community?

Mr. Duke and Mr. Lofton, what are your thoughts on this?

I agree completely. A community benefit standard that only takes into account charity care would ignore all the other services that hospitals provide at no charge to their community and would, most likely, reduce not-for-profit hospitals' ability to provide these services.

Questions from Senator Bingaman

1. *Over the past several years, attention on the issue of how hospitals handle charitable care and community benefits has clearly had a positive impact, as hospitals across the country have revised their policies and made those very policies more transparent to the public.*

   This hearing was rightly focused largely on issues around "charitable care" and "community benefits" and the "tax-exempt status" of certain hospitals in the country.

   I would like to bring to the table another issue that is of importance to my state and those of the Chairman and Ranking Member and that has to do with the Medicaid and Medicare disproportionate share hospital (DSH) programs. These programs are also under the jurisdiction of the Senate Finance Committee, and I think that we should also think carefully about the billions of dollars spent on those programs and the impact they have on charitable care and community benefit.

   First, due to historical nature of the DSH program, there are profound differences in the amount of federal Medicaid DSH dollars that go to provide assistance to hospitals that care for a disproportionate share of low-income Medicaid and uninsured patients based on state boundaries. States such as New Mexico, Iowa, Montana, Arkansas, Oregon, North Dakota, Idaho, Utah and Wyoming receive less than an estimated $82 per uninsured individual in DSH funding compared to over $650 per uninsured individual in New Hampshire, Louisiana, Rhode Island, Main and Missouri. In other words, federal Medicaid DSH dollars are flowing to certain states to help hospitals deal with the uninsured at more than eight times the level than nine states represented on the Senate Finance Committee.

   For the information of Mr. Hartz, Virginia also receives less than $100 per uninsured individual from the federal Medicaid DSH program.

   What should the Senate Finance Committee do to improve the fairness within the Medicaid DSH program and the equity in funding that goes to help hospitals address uncompensated care in their communities and states?

Should DSH funds follow the uninsured patient so that hospitals are not, what some might call "double-dipping," by both collecting DSH funding and then billing the uninsured patient separately?

Disproportionate share payments have helped to strengthen Medicaid as the safety net for this nation's uninsured and low-income. However, despite the large number of uninsured in Montana, as you noted in your question, our state has not benefited as much as other states from the DSH program.

I was pleased that the Medicare Modernization Act included provisions that improved DSH distributions for Montana and other states. However, much remains to be done in this area, and I encourage the Finance Committee to continue to strive for greater equality in DSH payments.

In communities like Glendive, Montana, these payments can help offset our increasing costs for serving the uninsured.

2. *On a related matter, the Medicare DSH program has a formula that has the paradoxical effect of, while intended to target money to safety net and charitable hospitals, of actually reducing funding to hospitals as they provide more and more uncompensated care. The formula is flawed in that uncompensated care is not reflected in the numerator but only in the denominator. Thus, for every increase in uncompensated care at a hospital, the formula has the perverse effect of actually reducing DSH dollars to that hospital.*

   "The DSH formula rewards hospitals that treat poor patients who have health insurance but penalizes hospitals for treating patients who do not have health insurance," says Sean Nicholson at AEI in a report entitled Medicare Hospital Subsidies. "Ironically, the structure of the DSH payment formula may...reduce the supply of hospital care to the (low-income) uninsured, the group that arguably faces the greatest barriers to medical care." Mr. Samuelson estimated that, in addition to losing revenue through uncompensated care on uninsured patients, hospitals lose an additional $171 per uninsured admission, on average, due to reductions in Medicare DSH payments.

   In recognition of this problem, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations in the past regarding revising the Medicare DSH formula, including:

   - *The low-income share measure should reflect the cost of services provided to low-income patients in both inpatient and outpatient settings. This, of course, would help rural hospitals greatly, as they provide a larger volume of the care in such settings.*
   - *In addition to Medicare SSI and Medicaid patients, the low-income share measure should include uninsured and underinsured patients represented by uncompensated care and also other patients sponsored by other state*

and local indigent care programs. This would help eliminate disparities in Medicare DSH payments caused by differences in Medicaid eligibility rules across states.

- *Medicare DSH should be concentrated among hospitals with the highest share of low income patients. A minimum threshold should be established below which a hospital receives no DSH payment but there should be no "notch" that would provide substantially different payments to hospitals just above and below the minimum threshold.*

Mr. Nicholson argued that the MedPAC proposals "correct most of the problems with the structure of the DSH program. The more inclusive measure of care provided to the poor would direct more DSH funds to hospitals that provide a substantial amount of uncompensated care but have a relatively low volume of Medicaid and Medicare/SSI patients...The proposed index would also eliminate the perverse incentive that currently exists of penalizing hospitals that increase the number of uninsured patients they treat. Under the recommended formula, admitting more uninsured patients would increase rather than decrease DSH payments."

As such when the federal government is investigating the issue of charitable care and community benefit provided by hospitals, should the federal government also reassess a funding formula in the Medicare program that actually has the perverse incentive of penalizing hospitals for caring for uninsured and underinsured patients?

In addition, what do the witnesses think about the recommendations made by MedPAC in 1998, 1999 and 2001 and summarized in the bullets above to revise the Medicare DSH formula and do they agree with Mr. Nicholson that they would improve the Medicare DSH formula?

And finally, to what extent should DSH funds be targeted on core safety net providers that are financially vulnerable?

It's important to attempt to improve the effectiveness of the DSH program, and Montana's hospitals look forward to working with the committee and other stakeholders in such an effort. Unfortunately, in the absence of a more detailed analysis of the MedPAC proposals, I'm not able to determine whether they would have a significant impact in rural areas like Glendive, Montana.

**Testimony of Diane Insco, Cincinnati resident,
before the U.S. Senate Finance Committee
September 13, 2006**

Good morning. My name is Diane Insco. I was born and raised in Cincinnati, Ohio. I never thought I'd be testifying at a hearing like this. But something is terribly wrong when hospitals can demand such high prices from people like me who don't have health insurance. So I'm here to speak out about it, in the hopes that it will keep other families from having to go through what my family went through.

I am 54 years old, and I have Type II diabetes. My husband Frank worked as a roofer until he was disabled in a job-related accident nine years ago. I worked at different jobs whenever I could. We were never rich, but over the years we managed to raise two sons and purchase a small home. My husband and I and our 34-year-old son Taft, who has a mental disability and can't support himself, have lived in that house for 13 years.

Then, one day in May of 2003, something happened to me that nearly cost us our home.

I was driving down the road when I started feeling dizzy. I pulled over, and suddenly blacked out. My blood sugar was way up and my blood pressure had bottomed out. I don't remember much, except that I was taken by ambulance to Mercy Fairfield hospital. I spent two nights there.

I do remember receiving a bill. It was for $4,639. Because I was uninsured and unemployed, I had no way to pay it. Even though I got a job at Kroger's a few months later, my total income that year was only about $14,000.

I have since learned that I was charged the full sticker price for that hospital visit. If I had been insured, I probably would have been charged less than half that amount.

I still can't believe it. Why would a hospital charge the highest prices to people who don't have insurance? It makes no sense to me.

No one ever told me that financial assistance might be available. I never received any kind of notice or application. I just assumed that the hospital didn't really expect me to come up with that kind of money.

It wasn't until much later that I found out I was wrong.

Last year, my health got worse and I had to stop working. We were living on a fixed income and barely making ends meet. But the interest rate on our mortgage was going up, and the monthly payment was going to be more than our income. Frank and I had to refinance if we wanted to keep our home.

That was when we learned that the hospital had gone to court and placed a lien on our home. It had happened the year before, and we didn't even know it. We couldn't refinance our mortgage as long as that lien was there.

We were sure we were going to lose our house and be homeless. That's a devastating thing to think about. I couldn't imagine where we would go with our three pets and our handicapped son.

Fortunately, we got help from SEIU. The union's lawyer helped us apply for financial assistance from the hospital. Eventually, the hospital forgave our debt and we got the lien removed.

It was just in time. We were two months away from a big increase in our mortgage that we couldn't afford. We were able to refinance after all, and for the time being at least, we can keep our home.

Still, I can't help but wonder --- if we qualified for charity care, why didn't the hospital tell us that in the first place? What would have happened if SEIU hadn't come along? Would we have lost our house, just so the hospital could collect its money?

I've met other people who have had a similar experience. When they hear my story, they have some hope for a good outcome for themselves. I want to do my part to make sure they have a good outcome. That's why I'm here today --- to ask you to help those who can't help themselves.

I hope that you can do something to make sure hospitals treat people who don't have insurance a lot better than they treated me.

Thank you for allowing me to share my story with you.

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PREPARED STATEMENTS OF RAYMOND A. HARTZ
EXECUTIVE DIRECTOR
LEGAL AID SOCIETY OF EASTERN VIRGINIA, INC.
TO THE U.S. SENATE FINANCE COMMITTEE

September 13, 2006

My name is Ray Hartz. I am the Executive Director of the Legal Aid Society of Eastern Virginia, which provides free legal assistance in civil matters to the poverty population of Greater Hampton Roads. We have five offices, in Williamsburg, Hampton, Norfolk, Virginia Beach and on the Eastern Shore, serving more than 200,000 people living below 125% of the federal poverty level -- approximately one fourth of the poverty population of Virginia. I have worked for legal aid organizations virtually my entire career and in three different states: Virginia, Florida and Arizona.

From my experience of working with the low income community in Hampton Roads and elsewhere, I can positively attest to this Committee that people of low income, especially the working poor, are experiencing a health care crisis. I am not referring to the quality of the health care, I am talking today about the crisis of trying to survive under the mountain of medical debt to a hospital that has an aggressive and effective collections department. Everywhere I've practiced, hospitals are very efficient in

getting judgments against those who owe them money, and then in collecting on those judgments through wage and bank account garnishments. For example, last Thursday, September 7, one of our non-profit hospitals had more than 100 separate actions to collect hospital debts in the Norfolk General District Court. And I can assure this Committee, that number is not unusual.

I think some numbers we are all aware of: according to the US Census Bureau, last year 46.6 million Americans lacked health insurance. That's 15.9% of all Americans; 13.9% of all Virginians. Lacking insurance, my clients often put off seeing a doctor until the problem is unbearable, and that's when they go to the hospital emergency room.

Every private hospital in Hampton Roads is non-profit. Each has a charity care program, either for free-of-charge care and/or for discounted care for the un- or under-insured patient. Unfortunately, the reality is that very few low income, uninsured patients are ever informed of the existence of these programs. Attached to my written testimony are statements to this Committee from several clients from eastern Virginia detailing the problems they had in accessing charity care.

One statement is from Ms. Bragg who lives on the eastern shore of Virginia. She is 47 years old, employed, but she cannot get health insurance through her work. Two years ago she had some medical treatment done at a non-profit hospital, the bill was just under $3,000. She makes slightly more than $1,000 per month. When she couldn't pay,

the bill collectors started calling. She was told that the interest on her past due account was 24.12%. Ms. Bragg realized that, even with a payment plan, she would never be able to pay off even the accumulating interest. Ms. Bragg wrote in her statement about the great distress this bill, and the hospital's collection efforts, caused her - she rarely has money left after paying the rent, food and her medicines as it is. But maybe she should consider herself lucky. If the hospital were to obtain a judgment against her, it could garnish a portion of her paycheck, and throw her even deeper into the despair of poverty.

The first time Ms. Bragg was ever informed about the Hospital's charity care plan was when we called her last week to ask if it had been offered to her. That is the norm, not the exception. Over the past week, our staff has spoken with more than twenty clients burdened by unpaid hospital debt. Not one of them reported being informed of a charity care program at any time during their hospital stay. Only one of these clients was ever told about the program and this was during the collection process. Several of these clients learned of the program through other service providers or friends. Approaching the hospital for further information about charity care, however, only met with difficulty. One client was told by the hospital's billing department point blank that her poverty did not matter. She must pay the full amount billed.

The denial of access to charity care has a devastating effect on the lives of low income clients, especially the working poor and their families. As I noted before, hospitals are

extremely efficient when it comes to pursuing debts, and they often obtain court judgments against our clients. Once a judgment has been entered the hospital can, and does, garnish the client's bank account and or wages. Up to 25% of a client's income is vulnerable to garnishment. To be clear, we are talking about garnishing the wages of people already hovering on the edge of financial oblivion. We are talking about a family's life savings instantly vanishing by a garnishment on their bank account. A client may lose her car and ability to get to work. Her children may go hungry. The family may become homeless. It does not need to be this way, for many of these people would have been eligible for charity care if they had only been informed that it existed.

Last October, when the new federal bankruptcy law went into effect, the only protection these clients had was lost. In the first nine months of 2005, the Legal Aid Society of Eastern Virginia provided more than 150 bankruptcies for our clients. As a result of the new bankruptcy law, we are effectively precluded from providing even that relief. We had provided bankruptcies for our clients through the assistance of the private bar, through our Private Attorney Involvement program. When the new law took effect, all of the private attorneys who had assisted us with bankruptcies informed us they would no longer be willing to do so. As a result, the low income working poor who come to us suffering under wage garnishment too often must be told that there is nothing that can be done. For many, there is simply no way to tighten their budget enough to make up for the 25% loss in wages.

In practice, it seems few of the hospital employees in the admission, discharge or collection units of these hospitals appear to be aware of the existence of charity care. This past spring, a team of legal aid attorneys conducted a survey of twenty hospitals located throughout Virginia regarding charity care. They had great difficulty obtaining even basic information from many of the hospitals regarding their charity care programs. Two Virginia hospitals simply refused to respond to repeated requests to complete the survey. Over this past summer, my office made similar requests of our local hospitals and encountered the same challenges. In almost every instance, it took repeated phone calls to contact anyone who could offer us any information. Lawyers on our staff found the experience very frustrating. Imagine what they might be feeling if they had a devastating debt motivating this search.

This week I have spoken with Legal Aid programs around the country, and the problems I have described are not unique to Virginia. In almost all the states I spoke with, the same problems are present – charity care programs exist at the hospitals, but many eligible patients never learn of their existence.

Therefore I would recommend that non-profit hospitals be required to take several very simple steps:

1. Apply their existing charity care programs uniformly and fairly.
2. Provide notice of the existence of the charity care program to all patients at registration/intake and discharge.
3. Have some notice of the existence of the charity care program in all communications to patients which are in an effort to collect a hospital debt.
4. Provide patients who are denied charity care an opportunity to present additional information, with the representation of counsel, to have that decision reviewed.

I appreciate the opportunity to present these remarks to the Committee and I hope my testimony has been helpful in the Committee's examination of this vitally important issue.

STATEMENT OF DENISE BRAGG

To Chairman Grassley and the Honorable Members of the Senate Finance Committee:

My name is Denise Bragg and I would like to express my interest in the investigation by this Committee into non-profit hospitals over-charging uninsured and underinsured patients with limited or no income, and the failure of these hospitals to inform patients about the availability of uncompensated or discounted care programs.

I am a 47 year old woman. I live in Section 8 Housing in Painter, Virginia. I am currently employed by Head Start. I make about $1047 per month. I currently have no medical insurance.

I required medical assistance from Shore Memorial Hospital in August 2004. When I registered, I informed the hospital personnel that I was employed but that I had no insurance. At no time do I recall, either at registration, during my stay, or at discharge, receiving any information about the availability of uncompensated or discounted care from this non-profit hospital. I do not recall any posted information or any employee who spoke to me about the availability of uncompensated or discounted care. When I received my bill for $2995, there was nothing on it indicating that I could apply for financial assistance, or that I might be able to receive my care for free. I was shocked to see that I was charged $2015 for a nuclear medical diagnosis.

This distressed me greatly. I only receive $1047 per month when I am working. My rent, food and medicine eat up most of this income every month. I have very little extra money at all. I also have had to ask for financial assistance from my son.

Since I could not pay, and the hospital would not assist me, I began to be harassed by their bill collector. I could not pay the bill in installments because, at the time, I was unemployed and collecting unemployment. I was barely making ends meet. I received a letter telling me to pay the entire amount to protect my credit. In addition, I was charge 24.12% interest on the balance of the account. Even if I had been able to make payments, the payment would not have even covered the interest charged for the month. I tried to file bankruptcy but was unable to do so because I didn't have enough money to pay for the filing fees or the attorney.

I am not a person who likes to ask others for help. I try very hard to make it on my own. I am trying to make payments every month, as I am able, but it is not much and not often. At this rate, I will be paying on this bill for years to come.

If my statement today about my experiences of being unaware of the availability of charity care and of being hounded for the payment of my huge hospital bill will help convince the members of this Committee to change the way hospitals are required to assist people like me, I will feel like my difficulties and suffering were worthwhile.

Dated as of September 12, 2006

Denise Bragg (SEAL)
Denise Bragg

STATE OF Virginia
COUNTY OF Accomack, to-wit:

Subscribed and sworn to before me, a Notary Public in and for the City and State aforesaid by Denise Bragg, this 12th day of September, 2006.

NOTARY PUBLIC

My Commission expires: 2/31/2008

Statement of Joyce Butler

My name is Joyce Butler and I reside in Virginia Beach, VA. I am a 52-year-old divorced woman. Due to my chronic health problems, I am unable to work. The last few years of my marriage, my husband was incarcerated and unable to support me. From 2001 – 2003, I was homeless. I was eventually able to stay with my son and later, my daughter. I cared for my son's child, and am now caring for my daughter's 4-month-old son Elijah.

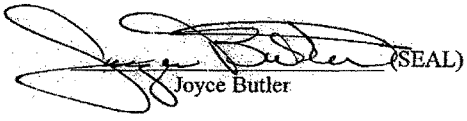
In recent years I have had to go to the hospital, usually Sentara Bayside Hospital, for various reasons. I have never had health insurance, not even when I was married. I try to stay away from doctors due to the cost, until I absolutely have to go, but that means that I usually end up at the hospital.

I have had judgments entered against me by Sentara Bayside Hospital over the past several years for $3,756.89, $5,232.21, and $1,831.80. I have never been able to pay these bills. I have never been informed, at any of my numerous hospital visits, about the availability of any type of charity or discounted care. Each time I registered, I was asked if I had insurance. I would reply that I did not, and I was required to sign papers agreeing to pay the bill for the services. I have never seen a discounted bill from the hospital. I didn't even know there was such a thing as charity care until I spoke with my lawyers at Legal Aid who were trying to assist me with filing for bankruptcy.

In the last few years, I have been contacted by phone and letter numerous times by collection agencies seeking to collect on the hospital bills. Sometimes I would be called two or three times in a single day. I always told the collectors that I was unemployed and that I had no means of support but they always insisted that I had to pay my bills. I asked if I could arrange a payment plan and that I might be able to pay $5-10/month, but they always told me that this was unacceptable. When I tried to explain that I had no more to give them, they continued to harass me.

Thank you very much for allowing me to tell you how difficult this issue of paying my hospital bills has been for me. I wish I had known that there was such a thing as charity care. It would have eased my mind so much over the years, to know that even though I required health care, the health care system was set up to protect people like me. Unfortunately, I wasn't made aware of this protection. I wish I had known.

Dated as of September 12, 2006



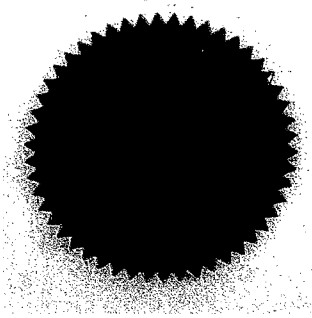
(SEAL)
Joyce Butler

STATE OF VA
COUNTY OF VIRGINIA BEACH, to-wit:

Subscribed and sworn to before me, a Notary Public in and for the City and State aforesaid by Joyce Butler, this 12 day of September, 2006.

Denyse Benedict
NOTARY PUBLIC

My Commission expires: My Commission Expires January 31, 2008



Written Statement of Georgette Young

My name is Georgette Young and I reside in Norfolk, Virginia. I have two daughters. I also have a chronic health condition. The condition requires that I receive regular medical attention from private doctors and, on occasion, from a hospital. I was laid off from my temporary service job about two years ago. Although I was working regularly, my employer did not offer health insurance benefits. I continue to actively seek work which will provide health benefits for my daughters and me.

In April, 2006, I needed to go to Virginia Beach General Hospital for treatment my doctors prescribed. My doctors told me I would need to ask the hospital to provide their service under their Charity Care Program, where low income uninsured patients receive medical service at no charge. I made sure to bring my pay stubs, tax return and other financial records with me to demonstrate my qualifications under the program.

When I registered at the Hospital, I asked about their Charity Care Program. After some delay I was given the forms to fill out to apply. I later made sure that the Hospital had copies of all my financial documents. I was told it would take between six and eight weeks for a decision on my eligibility, and I did receive the treatment my doctors prescribed.

In June, 2006, I received a letter from the Hospital's Collection Department informing me that my account was past due and I needed to pay $5,005.07. The collection letter did not mention my application for Charity Care, but did say that "This is an urgent matter that needs your response."

I spoke with the Hospital's Collection Department again as recently as last week. Again I asked about my Charity Care application, but the collection agent I spoke with had no information on the status of my application. Instead, I was told that I should stop thinking about Charity Care and that my "concern now must be getting this bill paid." The Hospital's collection agent told me that the least they would accept would be $125.00 per month to pay off the bill.

I cannot pay $125.00 per month and continue to stay in my apartment. I cannot provide the things my two teenage daughters need if I were to make these payments.

I thank this Committee for giving me the opportunity to tell my story and to let the Committee know about the problems I have had obtaining Charity Care.

Dated as of September 12, 2006

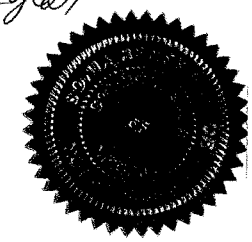
Georgette Young (SEAL)
Georgette Young

STATE OF Virginia
COUNTY OF Norfolk, to-wit:

Subscribed and sworn to before me, a Notary Public in and for the City and State aforesaid by Georgette Young, this 12 day of September, 2006.

Sonia R. Taylor
NOTARY PUBLIC

My Commission Expires: 9/30/10



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RAYMOND HARTZ, ESQUIRE
EXECUTIVE DIRECTOR

CARL J. STEVENS, ESQUIRE
DEPUTY DIRECTOR

SHERRY D. HARRISON
ADMINISTRATOR

WRITTEN RESPONSES OF RAYMOND A. HARTZ
EXECUTIVE DIRECTOR
LEGAL AID SOCIETY OF EASTERN VIRGINIA, INC.
TO WRITTEN QUESTIONS OF THE U.S. SENATE FINANCE COMMITTEE

July 31, 2007

From Senator Santorum

1. We have heard some contend that while a nonprofit hospital's charity care policy may be sound, that patients are not aware of this policy and thus it is ineffective. At least in my state, the policies are required to be posted in key public areas, and generally a copy is given to the patient and conversations can be initiated by the patient or the hospital to determine if a patient is eligible any time in the payment or collections process. In addition the Hospital Association of Pennsylvania put out guidelines on charity care and financial aid in July 2004 that includes a section on implementation such as communicating the availability of the policy, training staff on the policy, and administering the policy fairly, respectfully and consistently. Without requiring every patient to be pre-screened for eligibility, what other specific points do you think should be added?

   ANSWER:
   Non-profit hospitals in my section of Virginia have made very similar efforts to inform their patients of the hospital's charity care program. In practice however, it does not work. The problem is that many, and perhaps most, hospital patients who are eligible for a hospital's charity care program never learn of the program's existence.

   Posting a notice on a hospital wall is not a realistic way to identify and inform eligible patients. A hospital would never rely on such a means to communicate something it really wanted the patients to know, such as how to pay their bill.

It would be extremely easy for hospitals to screen patients for eligibility for their charity care program.

Screening for charity care would be simple for the hospitals to implement. All hospitals ask each patient what insurance the patient has, if any. When a patient informs the hospital they are not insured, the hospital could ask the patient a few quick questions to screen for charity care eligibility. The screening would take no more than two minutes. All the hospitals in my area base their charity care programs on the federal poverty guidelines, as does my program. We screened more than 10,000 people last year, and not a single person objected to being asked the financial eligibility questions. If a person does object, then the hospital would not proceed with the eligibility screening.

Low-income uninsured patients will not be informed of non-profit hospitals' charity care programs until the hospitals are required to inform them in a meaningful way. An effective and simple way to do this would be to prohibit non-profit hospitals from instituting collection activities on a hospital debt without having some documented evidence of either the patient's ineligibility or non-cooperation with the hospital's charity care program.

2. How do you balance the desire to et patients enrolled in plans or qualified for the charity care policies without forcing patients to provide personal and financial information that they may not want to provide?

ANSWER:
As mentioned above, Legal Aid Society of Eastern Virginia screened over 10,000 people last year for financial eligibility for our services. Not one refused to provide the information when requested by our intake workers. But should a patient choose to not apply for the charity care program, then the hospital would not have to screen that patient for eligibility in its charity care program. If hospitals really want to identify the patients who are eligible for their charity care programs, they should at a minimum ask the patients.

3. In the Commonwealth there is a requirement that nonprofit hospitals certify annually to the Department of Public Welfare that they have a charity care program, their efforts to seek collection of all claims and attempts to obtain health coverage for patients. If we continue to provide charity care above a certain level – such as 400% of the poverty level – does that not discourage the purchase and maintenance of health insurance?

ANSWER:
I am not aware of any hospital in the nation with a charity care program with eligibility up to 400% of the federal poverty level. For a family of four, that

would be an annual income of over $80,000. All the non-profit hospitals in my area use 200% of the federal poverty level.

4. Community benefit is a concept that will vary greatly from hospital to hospital and area to area. I understand that some have argued that all community benefit should be limited to charity care or specific standardized items. In my experience the community benefit of the Children's Hospital of Pennsylvania offering training for parents on how to properly use child safety seats in cars and the low-income health clinics by our research hospitals both serve the community. How do we have continue to ensure there is community benefit but take into consideration the differences between types of hospitals, charitable missions, size and location:

ANSWER:
I am certainly personally aware of the great services provided by many non-profit hospitals. My testimony to the Committee is in no way meant to cast any over-all judgment of the value of the community benefit provided by non-profit hospitals. What I have tried to convey to the Committee is how the hospitals' charity care programs operate in practice, as well as to inform the Committee about the dire effects the hospitals' failure to identify eligible patients has on low income people.

From Senator Rockefeller

It has been suggested by some that the 1969 IRS Community Benefit standard for determining tax exempt status is too broad and wrongly decided. However, it is true that nonprofit hospitals contribute to their communities in a variety of ways. Some nonprofit hospitals focus almost exclusively on providing charity care. Other, such as teaching hospitals, focus more on scientific research that will lead to treatments and cures for diseases. Other nonprofit hospitals provide invaluable education services to their communities.

We have a Children's Health Van at Marshall University in West Virginia, which I helped create, that provides vital education services to children and their families. Most of these families would have no contact with the health care system otherwise. I think that is a huge community benefit.

Don't you agree that nonprofit hospitals benefit communities in a variety of ways – from charity care to scientific research to capital investment and infrastructure development?
Who else is going to make the investment in health care that we are going to need as our population ages?

ANSWER:
As I mentioned above in my responses to Senator Santorum's questions, I am not making any suggestion that hospitals do not benefit the community. In my experience as a long time Legal Aid attorney however, I have seen the effects hospital bills have on low income families, especially working families. As I mentioned in my testimony before the Committee, hospitals are generally very effective in using the legal process to collect debts. As a result, low income persons routinely have their paychecks and bank accounts garnished, to often catastrophic effect for their family. Without warning, a low income family can have their entire bank account taken in garnishment. Families struggling to provide a decent home for their children can lose one quarter of their income to a wage garnishment.

I am confident that hospitals provide great benefits to the communities through many programs and services I am not even aware of. But as a Legal Aid attorney, I am very aware of the real harm which befalls low income persons who were not informed of the existence of a charity care program.

From Senator Bingaman

What should the Senate Finance Committee do to improve the fairness within the Medicaid DSH program and the equity in funding that goes to help hospitals address uncompensated care in their communities and states?

Should DSH funds follow the uninsured patient so that hospitals are not, what some might call "double-dipping," by both collecting DSH funding and then billing the uninsured patient separately?

ANSWER:
Unfortunately, I feel unqualified to comment on the Disproportionate Share Hospital programs as I am unfamiliar with them.

DANIEL K. INOUYE
HAWAII

APPROPRIATIONS
Subcommittee on Defense—Ranking Member

COMMERCE, SCIENCE, AND TRANSPORTATION
Subcommittee on Surface Transportation and Merchant Marine

COMMITTEE ON INDIAN AFFAIRS—Vice Chairman

DEMOCRATIC STEERING AND COORDINATION COMMITTEE

COMMITTEE ON RULES AND ADMINISTRATION

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FAX (808) 961–5163

September 13, 2006

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In conjunction with your Committee's hearing on charitable care and community benefits at nonprofit hospitals, I wish to submit the attached statement on my proposal to assist teaching hospitals support organizations.

As always, I appreciate the Committee's continued support for my proposal.

Aloha,

DANIEL K. INOUYE
United States Senator

DKI:mcb
Enclosure

DANIEL K. INOUYE
HAWAII

APPROPRIATIONS
Subcommittee on Defense—Ranking Member

COMMERCE, SCIENCE, AND TRANSPORTATION
Subcommittee on Surface Transportation and Merchant Marine

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STATEMENT BY SENATOR DANIEL K. INOUYE
Hearings on Charitable Care and Community Benefits at Nonprofit Hospitals
Senate Committee on Finance
September 13, 2006

The Catholic Health Association guidelines on charity and community benefits, which the Committee uses as a model for rating health care organizations, categorizes a number of benefits provided by the nation's non-profit hospitals. In addition to the free and discounted health services for patients unable to pay, non-profit hospitals also provide a number of significant community benefits.

Non-profit hospitals render major community benefit by providing health services that by their nature entail significant financial loss. Among them are emergency and trauma services as well as behavioral treatment. If non-profit hospitals do not offer these services, the government would have to devise some way of meeting the need.

Another major category of service subsidized by non-profit hospitals is community health improvement. This includes health education, community-based clinical services, screening, support programs, outreach and counseling, as well as social services.

The Catholic Health Association guidelines further state that "helping to prepare future health care professionals is a distinguishing characteristic of non-for-profit health care and constitutes a significant community benefit." Non-profit teaching hospitals train health professionals in a clinical setting. Through subsidized residencies, internships, and other in-service programs, non-profit hospitals provide nearly all the postgraduate medication education in the country. This education prepares future doctors, nurses, and other health professionals such as social workers, pharmacists, physical therapists, technicians, and dietitians.

The role of non-profit teaching hospitals in the community is evident in the work of The Queen's Health System and Medical Center in my State. It is the oldest and largest private, non-profit hospital in Hawaii. It serves as the primary clinical teaching facility for the University of Hawaii's medical residency programs in medicine, general surgery, orthopedic surgery, obstetrics-gynecology, pathology,

and psychiatry. It also conducts educational and training programs for nurses and allied health personnel. It operates the only trauma unit as well as the chief behavioral health program in the State. It also maintains clinics throughout Hawaii, health programs for Native Hawaiians, and a small hospital on a rural, economically depressed island. Its medical reference library is the largest in the State.

To help pay for these community benefits, The Queen's Health Systems, as do many other non-profit hospitals, relies on income from its endowment. The New York Times has reported that the growing need for charitable health services has placed greater pressure on non-profit hospitals to improve their facilities and programs. You and your Committee have supported my effort to extend to teaching hospitals a measure of access to capital which the tax code already grants to pension funds, schools, and universities.

The Senate adopted my proposal in its version of H.R. 1836 the Economic Growth and Tax Relief Act of 2001. The House conferees, however, objected that the measure was unrelated to the bill's focus on individual tax relief and the conference deleted the provision from the final legislation. Subsequently, the Finance Committee included the provision in H.R. 7, the CARE Act of 2002 and in S. 476, the CARE Act of 2003. In the current Congress, section 340 of S. 6, the Marriage, Opportunity, Relief, and Empowerment Act of 2005 re-introduced the proposal.

The provision would allow teaching hospital support organizations limited access to debt financing. The access would be far more restricted than schools, universities, and pension trusts now have. Under safeguards developed by the Joint Committee on Taxation staff, a support organization for a teaching hospital could not buy and develop land on a commercial basis. The provision only allows the organization to build or re-build on property in its endowment. The staff's revenue estimates show that the provision with its general application will help a number a teaching hospitals.

Through the enactment of this provision, the Committee can assist and strengthen the nation's teaching hospitals in their charitable, educational services. As the Committee's hearings show, substantial health needs would go unmet if not for our charitable hospitals.

Statement to the United States Senate Committee on Finance
"Taking the Pulse of Charitable Care and Community Benefit at Nonprofit Hospitals."
September 13, 2006

Nancy M. Kane, DBA
Professor of Management
Department of Health Policy and Management
Harvard School of Public Health

Mr. Chairman, Members of the Committee:

Thank you for inviting me to comment on the charitable activities of nonprofit hospitals and to suggest policies that would strengthen the current tax-exempt standard. I have testified before other Committees about both the impact of hospital pricing policies on the uninsured and the need for a higher standard for hospital tax exemption, so I will briefly summarize that testimony here and then elaborate on why Congress should act to set a higher standard, and what policy goals should be reflected in that standard.

Summary of Past Testimony:

With respect to hospital pricing, charges for patient services have been distorted over many years, reflecting hospital tactics to maximize third party revenue rather than actual costs or affordability to the patient. Only a small proportion of patients or insurers paid full charges, and the uninsured generally paid only pennies on the dollar. However, as the number of uninsured and even insured patients with substantial deductibles has grown, the sticker shock of a hospital bill, not to mention the collection efforts used by some hospitals or their agents to collect more of the bill, has kept people from seeking appropriate medical care while forcing a growing number of citizens into bankruptcy. Poor credit ratings in turn put already vulnerable people at long term economic disadvantage such as being unable to obtain a home mortgage or even a job.[1]

The standard for hospital tax-exemption, as modified by the IRS in 1969 to omit a specific charity care requirement, has not kept up with the substantial unfunded health needs of communities. The terms and conditions under which charity care is provided are entirely up to the discretion of the hospital board in most states, and boards often delegate the development of charity care policy to management. Several studies have shown that the majority of tax-exempt hospitals do not provide charity care commensurate with the value of their tax exemptions.[2] Only when the definition of charity care is expanded to include a variety of other activities deemed by hospitals to be of community benefit does their tax-exemption appear to be earned.

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[1] For extensive documentation on the impact of medical debt, see the following link: http://www.accessproject.org/medical.html#md_housing

[2] See, for instance, Kane N and Wubbenhorst, WH. "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption." The Milbank Quarterly, Vol 78, No. 2, 2000.; General Accounting Office, 1990. "Nonprofit Hospitals: Better Standards Needed for Tax Exemption." GAO/HRD 90-84. Washington, DC.; "An Analysis of the Tax Exemptions Granted to Cook County Non-Profit Hospitals and the Charity Care Provided in Return", May, 2006. Heather O'Donnell and Ralph Martire, Center for Tax and Budget Accountability, 70 E. Lake Street • Suite 1700 • Chicago, Illinois 60601 • www.ctbaonline.org

However reasonable parties differ as to whether all these other activities justify tax-exempt status. In addition, the activities may or may not be reflective of the priorities and needs of local communities.

Why Do We Need A Higher Federal Standard for Hospital Tax-Exemption?

- *Charity Care Competes with Growing Economic Incentives in a Competitive Hospital Market*

The need for a better standard for tax-exemption grows with increasing consolidation and competitiveness of the hospital sector in the United States. The hospital sector has grown from $28 billion in 1970 to $571 billion in 2004, while the number of hospitals are down by about 20% from the mid-1970s.[3] Consolidation of hospitals into large competing health systems serving bigger geographic areas has helped to distance hospital governance from local community influence. At the same time, larger systems are able to take on more debt and a more complex array of businesses. The changes in governance structures coupled with consolidation and increased borrowing strengthens the influence of economic interests at the expense of charitable mission.

The United States is unique among industrialized nations in its reliance upon private nonprofit charitable hospitals competing for resources in a market-oriented, fragmented payment environment. Other countries have independent nonprofit hospitals but these institutions generally must be accountable to a public authority, one that also controls the funds, such as a provincial or national health authority whose primary responsibility is the health of a geographic area. Also most wealthy industrialized nations do not have millions of uninsured people. In the US, no public entity is responsible for the health of a geographic area; instead, geographic areas are viewed as "markets" within which hospitals compete for paying patients and try to keep the nonpaying patients from putting them at a serious competitive disadvantage. The private nonprofit hospital in the US is also unique in its heavy dependence upon private markets for capital financing, which further raises the pressure on hospitals to be driven by economic concerns.

- *Large, Funded Non-Mandates for the Provision of Charity Care*

While government is often criticized for imposing "unfunded mandates" on the private sector, in the hospital business, the magnitude of "funded non-mandates" for charity care is impressive. If the value of tax-exemption is roughly 5% of hospital expenditures (using the guideline used in Texas' community benefit law), then the value of tax exemption from all sources (federal, state, and local) approaches $20 billion/year for private nonprofit hospitals[4]. Add to that roughly $22

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[3] Table 2, National Health Expenditure by Type of Expenditure , at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf; ; number of hospitals is from the National Center for Health Statistics, American Hospital Association

[4] Private nonprofit hospitals are roughly 70% of hospital beds; assume then that they represent 70% of total hospital expenditures, which were $571 billion in 2004. 5% of (571 billion * 70%) = $20 billion (rounded)

billion in Disproportionate Share payments (Medicare and Medicaid)[5], which goes to both public and private nonprofit hospitals, to make a total of over $40 billion annually in tax breaks and payments for charity care that is not required to be spent on charity care. While the number is only approximate, the conclusion is clear: Government has authorized significant resources to address a social need that many hospital recipients of those resources are not addressing.

- *No National Public Reporting System for Charitable Activity*

Neither the IRS Form 990 nor the Medicare Cost Report, the only two national sources of mandatory public reporting by nonprofit hospitals, has a standard definition of charity care or a fixed place to report it in their forms. Unfortunately, a recent attempt by CMS to require uncompensated care information (the new Schedule 10) suffers from ambiguous reporting instructions, rendering the 2004 reported results unusable. CMS has not revised the schedule yet so the public remains in the dark as to the net amount of charity care provided.

With respect to the IRS Form 990, the Panel on the Nonprofit Sectors' June 2005 Report to Congress recommended that "information about the organization's charitable purpose and key program achievements should be included on the first pages of the form." [6] This reflects the fact that many organizations, including hospitals, do not report on how they are meeting their charitable mission in a meaningful or consistent way.

- *Understaffed and Underfunded Public Oversight*

Egregious malfeasance by a nonprofit hospital may be challenged by the state attorney general, but this is a rare event because most state attorneys general have many competing interests as well as very limited resources with which to monitor nonprofit hospital behavior. In recent years, several attorneys general as well as local taxing authorites and state legislators have stepped up their efforts to challenge hospitals on their charitable activities (or lack thereof). From New Hampshire to Utah, state legislators and attorneys general have been actively questioning the appropriateness of billing and collection practices, while challenging tax-exemption requests for hospital-acquired property and businesses that were previously tax-paying. In New Hampshire, a legislative committee was set up to study hospital property tax exemptions; among its conclusions was that historically, charity was "the reason that led the legislature to grant these hospitals tax exemption."[7] In Ohio, the Ohio Tax Commissioner denied local tax exemption for Cleveland Clinic's newly acquired clinic in a wealthy suburb because it provided minimal charity care.[8] In Illinois, the state passed legislation requiring community benefit reporting in 2003; in 2006, the state attorney general proposed legislation (HB 5000)

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[5] Medicare Disproportionate Share payments are allocated on the basis of a hospital's share of Medicaid to total patient days, and the proportion of Medicare patients who are eligible for Supplemental Social Security Income. However the formula does not consider the amount of charity care provided by the hospital, and does not consider the provision of care to uninsured patients in the allocation formula. Medicaid DSS payment allocations are supposed to reflect the amount of care provided to uninsured patients, among other factors, and are subject to state discretion; state reporting regarding the actual distribution of net Medicaid DSH funds is not reliable or consistent across the country

[6] Panel on the Nonprofit Sector. "Strenthening Transparency, Governance, and Accountability of Chariable Organizations.' Final Report to Congress, June 2005. Convened by The Independent Sector

[7] Talbot, Roger. "State eyes hospitals' tax-exempt status." The Union Leader, Dec 18, 2005. News Section, P. A12.

[8] Treffiner, Sarah. "Ruling presents new challenge to hospitals' tax-exempt status." Cleveland Plain Dealer, November 27, 2005. Metro Section, p. B6.

requiring minimum charity expenditures by nonprofit hospitals[9], and continues to investigate dozens of Illinois hospitals' practices with respect to pricing, billing, collection, and the provision of charity care. In North Carolina, a bill was proposed that would limit the types of property that can be exempt, and would require provision of a minimum level of charity care expenditure.[10] In Kansas, the attorney general opened an investigation of hospital billing and collection practices[11], and in Utah, Intermountain Health agreed to less aggressive debt collection practices under pressure from the Legislature.[12] In Minnesota, the Attorney General investigated aggressive debt collection and inadequate provision of charity care, forcing four hospital systems to agree to discount charges to the uninsured by 40 – 60%.[13]

Oversight at the federal level is strengthening but has historically been weak as well. The IRS receives Form 990 filings from hospitals every year, but historically it has lacked the resources to even review the forms, much less determine whether or not the content is valid or the reported activities appropriate. From 1996 through 2001, staffing for the tax-exempt division of the IRS fell by 15%, while the number of Form 900s filed by charities increased by 25%. The Form 990 examination rate for all charities was less than 1% over that period.[14]

Even with more resources and reviews, the information in the Form 990 does not allow the IRS to determine whether or not a hospital is fulfilling its charitable mission. While the IRS is now stepping up its efforts to review and investigate nonprofit hospitals and other tax-exempt entities with respect to whether or not their charitable status is merited, it still lacks a clear standard by which to make that judgment.

What Should Go Into a Federal Standard for Hospital Tax-Exemption?

The range of federal policy options goes from simply revoking tax-exempt status to setting a higher and more articulated standard for tax-exemption.

The option of simply revoking tax-exempt status for hospitals has a number of critical drawbacks. One is that it punishes a whole industry, including the many hospitals that have responsibly balanced their charitable mission with their financial requirements and have maintained a high degree of transparency and accountability to their communities. Another drawback is that the value lost to hospitals would greatly exceed the gain in federal tax revenues, as federal tax-exempt status is required for hospitals to receive most grants and donations, and qualifies hospitals for state and local exemptions and tax-exempt debt. Perhaps most important, charitable nonprofit status is still associated with community trust, an intangible asset with enormous value in many markets.

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[9] "Charity Standard," in the St Louis Post-Dispatch, Feb 11. 2006, third Edition. Editorial Section, p. A 49.
[10] Horton, Hamilton C. "Re-Examine Tax-Exempt Status for Hospitals." June 11, 2005. Winston-Salem Journal, Metro Edition, Section A, p. 11, "My View."
[11] Pear. Robert, "Nonprofit Hospitals Face Scrutiny over Practices," New York Times, Mary 19, 2006, Section 1, Column 5, national Desk, P. 18.
[12] "Baskin, Brain, "Fixing Charity Issues Seems Somebody Else's Problem," Arlamsas De,pcrat Gazette, July 3, 2005. Front Section.
[13] ibid
[14] GAO. 2002. Report to the Chairman and Ranking Minority Member, Committee on Finance, US Senate. "Tax Exempt Organizations: Improvements Possible in Public, IRS, and State Oversight of Charities." GAO-020-526.

Far better would be for Congress to define a higher standard for federal tax exemption, one which articulates meaningful behavioral expectations of tax-exempt hospitals. These could include:

- Requiring that eligibility for charity or discounted care be tied to the magnitude of the self-pay portion of the bill relative to the patient's financial resources, regardless of patient insurance status. The IRS would regularly review this policy for reasonableness, and require that it be provided on a standardized disclosure form attached to the IRS Form 990 and on the hospital's web site. A basic "reasonableness" test would be that the cost of charity care directly provided by or supported through the hospital and its related entities approximate the value of the hospital and its related entities' tax exemptions from all sources.
- Require that hospitals and related health service-providing entities insure that patients are aware of the availability of charity and discounted care. Part of the requirement would be that hospitals regularly monitor the level of awareness in the community of the hospital's charity care and discounted care policies, particularly among the most vulnerable populations.
- Require that hospitals and related entities (and their agents) justify to the IRS their debt collection practices in terms of methods used and collection rates (amounts collected relative to amounts owed) over a rolling five year period. The IRS would regularly review these reports to insure that hospitals and their agents are not using aggressive debt collection practices primarily to discourage access to health services (for example, very low collection rates associated with highly aggressive collection tactics).
- Require that hospitals partner with community groups and agencies to improve access to care for vulnerable populations in their service area, with regular reports to both the IRS and the hospital or system board. The hospital entities' subsidies of programs that evolve from working with community groups to expand access to vulnerable populations could count toward meeting the reasonableness test.
- Require that hospitals produce a community benefit report as an attachment to the IRS Form 990 and on the hospital web site that is compliant with the voluntary reporting guidelines established by the Catholic Healthcare Association and its collaborators. Any deviance from the guidelines should be highlighted and the impact noted (eg inclusion of bad debt or Medicare shortfalls should be separately identified if reported at all).
- Require that hospital boards maintain a permanent "tax-exempt compliance" committee responsible for review, monitoring, and reporting on charity care policies and provision, other community benefits, collection policies, executive compensation, and joint venture arrangements, as well as the transparent reporting of such activities to the public and the IRS. The committee should regularly review hospital bad debt collection practices and collection rates, develop means of assessing billing and collection impact on the health of patients, and develop policies that reducing any negative effects found.

These guidelines would not be onerous for the many hospitals seeking to behave appropriately. However they would set forth more clearly than does current law what behaviors are expected of our charitable hospitals.

Some might argue that defining a higher standard of behavior for charitable tax-exempt status gives for-profit hospitals a competitive advantage over exempt hospitals, or might encourage some exempt hospitals to convert to for-profit status rather than comply with the standard. However this ignores the fact that in today's environment, having no effective charitable standard has resulted in a relatively small number of nonprofit hospitals shouldering the bulk of the charitable burden for vulnerable communities. This puts them at a huge disadvantage relative to their nonprofit competitors who fail to acknowledge such charitable obligations. It is time to level the charitable playing field with an enforceable and clear charitable standard reflective of society's expectations.

Responses to Written Questions for the Record From Committee Members
Senate Finance Committee
Hearing on September 13, 2006 on Hospital Tax Exemption and Community Benefit

Nancy M. Kane, DBA
Professor of Management
Harvard School of Public Health

Question 1 from Senator Santorum

1. Some outside of health care have advocated a mandatory minimum charity care requirement in addition to or in place of the community benefit standard. For those on the panel who have advocated this position, what has your research shown will be the financial impact on the nonprofit hospitals—specifically in terms of their ability to continue to offer such care going forward?

Response

I have not done research on the financial impact of a mandatory minimum charity care requirement. As far as I am aware, there is no mandatory minimum charity care requirement imposed on hospitals in any state, so it is not possible to do such an analysis. Texas, the only state that I know has a charity care "requirement," allows a hospital to meet any one of the following standards:

"Charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;" or

"Charity care and government sponsored indigent health care are provided in an amount equal to at least 100% of the hospital or hospital system's tax-exempt benefits, excluding federal income tax;" or

"Charity care and community benefits are provided in a combined amount equal to at least five percent of the hospital or hospital system's net patient revenue provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue." (Texas Health and Safety Code, Subtitle F, Chapter 311, Subchapter D, Section 311.044)

The Texas code, besides allowing hospitals to provide charity care commensurate with the hospital's resources, also allows hospitals to reduce the level of community benefit (including charity care) if the financial reserves of the hospital are "reduced to such a level that the hospital would be in violation of any applicable bond covenants, or when necessary to prevent the

hospital from endangering its ability to continue operations." (Section 311.043 of the above cited statute)

With the safeguards in place in Texas, it is unlikely that a charity care requirement could have a significantly harmful financial impact on hospitals.

Question 2 from Senator Santorum

2. We have heard some contend that while a nonprofit hospital's charity care policy may be sound, that patients are not aware of this policy and thus it is ineffective. At least in my state, the policies are required to be posted in key public areas, and generally a copy is given to the patient and conversations can be initiated by the patient or the hospital to determine if a patient is eligible any time in the payment or collections process. In addition the Hospital Association of Pennsylvania put out guidelines on charity care and financial aid in July 2004 that include a section on implementation, such as communicating the availability of the policy, training staff on the policy and administering the policy fairly, respectfully, and consistently. Without requiring every patient to be pre-screened for eligibility, what other specific points do you think should be added?

Response

These suggestions may be encompassed in the Pennsylvania guidelines. It is important to provide charity care information in the languages representing those spoken in the hospital service area; also that any bills sent to patients (both uninsured and those with high deductibles) include information on how to apply for charity care discounts.

In addition, it would be useful to have some means of enforcing or at least evaluating whether or not hospitals are in compliance with the guidelines. If you have not seen it, you might like to read the 2003 report from Community Catalyst titled "Not There When You Need It: The Search for Free Hospital Care," for more detailed information on how to evaluate what hospitals are actually providing to patients seeking free care (*http://www.communitycat.org/resource.php?doc_id=267*).

Question 3 from Senator Santorum

3. How do you balance the desire to get patients enrolled in plans or qualified for the charity care policies without forcing patients to provide personal and financial information that they may not want to provide?

Response

This is not my area of specialized knowledge; but I recommend asking this question of The Access Project (e-mail to *info@accessproject.org*) or Community Catalyst (*www.community catalyst.org*). Both organizations have done extensive work with uninsured individuals and understand the sensitivities of these populations.

Question 4 from Senator Santorum

4. In the Commonwealth there is a requirement that nonprofit hospitals certify annually to the Department of Public Welfare that they have a charity care program, their efforts to seek collection of all claims, and attempts to obtain health coverage for patients. If we continue to provide charity care above a certain level—such as 400% of the poverty level—does that not discourage the purchase and maintenance of health insurance?

Response

There is some evidence that higher levels of charity care are associated with less propensity to purchase health insurance (*see* Herring, B., 2005, "The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance," *Journal of Health Economics* 24.2, pp. 225–252). There is also evidence that many healthy people don't see the value in buying health insurance regardless of the availability of hospital-based charity care (*see* Alan Monheit's NBER paper on health insurance enrollment decisions at *http://www.nber.org/cgi-bin/author_papers.pl?author=alan_monheit*).

Getting people to buy health insurance when the expense is increasingly high and the value declining (e.g., to make premiums affordable, the deductibles and co-pay/coinsurance levels are rising) is definitely a challenge today. I believe that the only way to make more people voluntarily buy health insurance, especially when it is not subsidized, is to seek ways to control the underlying medical costs that are driving premiums.

Question 5 from Senator Santorum

5. Community benefit is a concept that will vary greatly from hospital to hospital and area to area. I understand that some have argued that all community benefit should be limited to charity care or specific standardized items. In my experience the community benefit of the Children's Hospital of Pennsylvania offering training for parents on how to properly use child safety seats in cars and the low-income health clinics by our research hospitals both serve the community. How do we continue to ensure there is community benefit but take into consideration the differences between types of hospitals, charitable missions, size, and location?

Response

The Catholic Healthcare Association guidelines for how hospitals should go about planning and implementing community benefit programs explicitly states that hospitals must tailor their programs to community needs, using community needs assessments and planning processes that involve community advocacy groups and service agencies as well as providers such as community health centers with particular awareness of the needs of vulnerable populations. The Texas statute cited above acknowledges the value of incorporating community needs into creating "eligible" community benefits.

Question 1 from Senator Rockefeller

Topic: IRS Determination of Tax Exempt Status

It has been suggested by some that the 1969 IRS Community Benefit standard for determining tax exempt status is too broad and was wrongly decided. However, it is true that nonprofit hospitals contribute to their communities in a variety of ways. Some nonprofit hospitals focus almost exclusively on providing charity care.

Others, such as teaching hospitals, focus more on scientific research that will lead to treatments and cures for diseases. Other nonprofit hospitals provide invaluable education services to their communities.

We have a Children's Health Van at Marshall University in West Virginia, which I helped create, that provides vital health education services to children and their families. Most of these families would have no contact with the health care system otherwise. I think that is a huge community benefit.

(a) Don't you agree that nonprofit hospitals benefit communities in a variety of ways—from charity care to scientific research to capital investment and infrastructure development?

Response

Yes, I do agree. The challenge is to separate out what nonprofits do to benefit communities that is distinctly different from what tax-paying organizations do (for instance, capital investment and infrastructure, as well as scientific research, is done by for-profits).

(b) Who else is going to make the investment in health care that we are going to need as our population ages?

Response

A lot of investment in health care is made by both tax-paying and tax-exempt organizations. I don't agree that recognizing a charitable commitment to vulnerable populations puts tax-exempt hospitals at great risk of being unable to invest in health care. I do get concerned when nonprofit hospital investment tends to "follow the money" rather than respond to the health care needs of their local communities. Too many tax-exempt hospitals invest in excess capacity for profitable services like cardiology and orthopedics while shunning unprofitable but greatly needed services like psychiatric care or gerontology units.

Question 2 from Senator Rockefeller

Topic: Nonprofits Offer Checks Within Our Health System

In your testimony last year before the Ways and Means Committee, you discussed the abuses that have been uncovered at some for-profit hospital centers, such as inappropriate Medicare billing, violations of anti-kickback rules, and the ordering of unnecessary procedures.

You concluded that creating quarterly earnings pressure and the possibility for private gain at all our hospitals could encourage more widespread abuse. I would like to explore this issue a bit. It seems to me that nonprofit hospitals provide an important check within our health care system. They are not focused solely on the bottom line, and therefore have much less incentive for abuses such as ordering extra tests or procedures.

Can you imagine a system with only for-profit hospitals in which the standard of care steadily escalated to include more expensive and-high margin procedures than were really necessary?

To the extent that nonprofit hospitals provide this check on the standard of care, isn't that a valuable public benefit that cannot be quantified? Doesn't the public have more confidence in health care when they know that there is not a profit motive involved in the treatment?

Response

Nonprofit status does not protect us from greed, excessive treatment, or fraudulent acts by providers in the health care system. I am hopeful that payment incentives and public information systems can be improved such that both for-profit and nonprofit hospitals are rewarded for providing high quality, necessary care in an efficient manner, and are penalized for excessive, unnecessary, low quality, high-cost care. Any hospital, regardless of ownership, should not be allowed to provide more expensive, high-margin procedures than necessary.

The public is often unaware of whether their local hospital is exempt or not. I remember hearing about a survey undertaken by a Catholic health care group (could have been the Catholic Healthcare Association, but this was a while ago) asking residents if they knew the ownership status of hospitals in their areas. Most people did not have a clue. It is hard for your average citizen to consider a nonprofit hospital as truly not-for-profit when you get a bill for 3–4 times the cost of the service, or get mercilessly dunned for unpaid balances.

Question 3 from Senator Rockefeller

Topic: Nonprofit Hospital Tax Exemption Recommendations

In your testimony this morning you make a number of recommendations for a higher standard for a federal tax exemption. Your first suggestion is that nonprofit hospitals be required to provide charity or discounted care equal to the value of their tax exemption. I am concerned about what such a strict standard would mean for other public benefits that hospitals currently

provide. Let me list just a sample of the other community benefits that members of West Virginia's Hospital Association provide:

- free health screenings;
- cancer education programs;
- wellness classes and support groups;
- scientific research;
- in-kind donations of equipment, pharmaceuticals, and medical supplies; and
- workforce development.

It seems to me that a "community benefit" standard that considers only charity care disregards many of the other extremely valuable functions that nonprofit hospitals provide our communities. Why shouldn't those other contributions be considered in determining tax-exempt status? And how accurately can we possibly quantify the value of those services to the community?

Response

I believe I said that I strongly supported the definition of Community Benefit put forth by the Catholic Healthcare Association, which is broader than the provision of charity care alone. That said, I do think some minimum amount of charity care should be required as long as there are uninsured and underinsured people in a hospital service area; to me, charity care should take precedence over the types of benefits you listed, many of which are done by exempt and non-exempt organizations alike. Would you exempt pharmaceutical companies from taxes because they do scientific research? Many tax-paying organizations do workforce development; should they be made exempt too?

Unless and until we resolve the fact that 46 million (and growing) people are without health insurance, I would weight charity care much more heavily than scientific research, medical education, or wellness classes and support groups as justification for tax-exempt status. I would like to find ways to encourage the redirection of charity care into primary and preventive programs whenever possible, so that uninsured people don't have to become acutely ill to become eligible for care and hopefully so that overall costs of care can be reduced.

Question 1 from Senator Bingaman

Over the past several years, attention on the issue of how hospitals handle charitable care and community benefits has clearly had a positive impact, as hospitals across this country have revised their policies and made those very policies more transparent to the public.

This hearing was rightly focused largely on issues around "charitable care" and "community benefits" and the "tax-exempt status" of certain hospitals in the country.

I would like to bring to the table another issue that is of importance to my state and those of the Chairman and Ranking Member and that has to do with the Medicaid and Medicare disproportionate share hospital (DSH) programs. These programs are also under the jurisdiction of the Senate Finance Committee, and I think that we should also think carefully about the billions of dollars spent on those programs and the impact they have on charitable care and community benefit.

First, due to the historical nature of the DSH program, there are profound differences in the amount of federal Medicaid DSH dollars that go to provide assistance to hospitals that care for a disproportionate share of low-income Medicaid and uninsured patients based on state boundaries. States such as New Mexico, Iowa, Montana, Arkansas, Oregon, North Dakota, Idaho, Utah, and Wyoming receive less than an estimated $82 per uninsured individual in DSH funding compared to over $650 per uninsured individual in New Hampshire, Louisiana, Rhode Island, Maine, and Missouri. In other words, federal Medicaid DSH dollars are flowing to certain states to help hospitals deal with the uninsured at more than eight times the level than nine states represented on the Senate Finance Committee.

What should the Senate Finance Committee do to improve the fairness within the Medicaid DSH program and the equity in funding that goes to help hospitals address uncompensated care in their communities and states?

Should DSH funds follow the uninsured patient so that hospitals are not, what some might call "double-dipping," by both collecting DSH funding and then billing the uninsured patient separately?

On a related matter, the Medicare DSH program has a formula that has the paradoxical effect, while intended to target money to safety net and charitable hospitals, of actually reducing funding to hospitals as they provide more and more uncompensated care. The formula is flawed in that uncompensated care is not reflected in the numerator but only in the denominator. Thus, for every increase in uncompensated care at a hospital, the formula has the perverse effect of actually reducing Medicare DSH dollars to that hospital. "The DSH payment formula rewards hospitals that treat poor patients who have health insurance but penalizes hospitals for treating patients who do not have health insurance," says Sean Nicholson at AEI in a report entitled *Medicare Hospital Subsidies*. "Ironically, the structure of the DSH payment formula may . . . reduce the supply of hospital care to the (low-income) uninsured, the group that arguably faces the greatest barriers to medical care." Mr. Samuelson estimated that, in addition to losing revenue through uncompensated care on uninsured patients, hospitals lose an additional $171 per uninsured admission, on average, due to reductions in Medicare DSH payments.

In recognition of this problem, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations in the past regarding revising the Medicare DSH formula, including:

- The low-income share measure should reflect the cost of services provided to low-income patients in both inpatient and outpatient settings. This, of course, would help rural hospitals greatly, as they provide a larger volume of their care is such settings.

- In addition to Medicare SSI and Medicaid patients, the low-income share measure should include uninsured and underinsured patients represented by uncompensated care and also other patients sponsored by other state and local indigent care programs. This would help eliminate disparities in Medicare DSH payments caused by differences in Medicaid eligibility rules across states.

- Medicare DSH should be concentrated among hospitals with the highest shares of low-income patients. A minimum threshold should be established below which a hospital receives no DSH payment but there should be no "notch" that would provide substantially different payments to hospitals just above and below the minimum threshold.

Mr. Nicholson argued that the MedPAC proposals "correct most of the problems with the structure of the DSH program. The more inclusive measure of care provided to the poor would direct more DSH funds to hospitals that provide a substantial amount of uncompensated care but have a relatively low volume of Medicaid and Medicare/SSI patients. . . . The proposed index would also eliminate the perverse incentive that currently exists of penalizing hospitals that increase the number of uninsured patients they treat. Under the recommended formula, admitting more uninsured patients would increase rather than decrease DSH payments."

As such, when the federal government is investigating the issue of charitable care and community benefit provided by hospitals, should the federal government also reassess a funding formula in the Medicare program that actually has the perverse incentive of penalizing hospitals for caring for uninsured and underinsured patients?

In addition, what do the witnesses think about the recommendations made by MedPAC in 1998, 1999, and 2001 and summarized in the bullets above to revise the Medicare DSH formula, and do they agree with Mr. Nicholson that they would improve the Medicare DSH formula?

And finally, to what extend should DSH funds be targeted on core safety net providers that are financially vulnerable?

Response

I agree that the DSH programs in both Medicare and Medicaid need to be better targeted to hospitals serving the uninsured and underinsured. I agree with the MedPAC recommendations in this area as summarized by Senator Bingaman.

I also agree that core safety net hospitals would become more financially vulnerable if DSH payments are redirected to "follow the patient" or subsidize low-income workers' health insurance premiums rather than going directly to those institutions traditionally dedicated to treating the uninsured. While it may be more ideologically comfortable to have the DSH dollars following the patient (enables greater patient choice and probably forces safety net hospitals to be more responsive to the needs of vulnerable populations), the implementation of such policy is likely to cause serious transition problems for core safety net hospitals, and also could shift

additional resources into private insurer pockets rather than going directly to providers. There is a lot to be said for preserving the expertise and competencies that safety net hospitals and hospital systems have developed for serving economically disadvantaged or otherwise marginalized populations. If Congress were to try to shift the DSH program toward financing broader eligibility standards or benefits for the Medicaid program, or toward insurance subsidies for low-income workers purchasing private insurance, it should do so very gradually and allow time for safety net hospitals to adapt to a more competitive environment. Knowing how hard it is for a major policy change to be implemented in accordance with its initial goals over a long period of time, I would vote to keep the DSH funds going to safety net institutions, but perhaps add quality, cost, and satisfaction performance criteria or standards to insure that we are not institutionalizing inadequate care systems. The VA health system has achieved remarkable cost and quality objectives over the last decade or so; part of their secret was a commitment to performance measurement and accountability.

Testimony

Sr. Carol Keehan, DC

President and Chief Executive Officer

Catholic Health Association of the United States

The U.S. Senate Committee on Finance

"Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals"

September 13, 2006

The Catholic Health Association has been actively involved in the issue of community benefit for nearly twenty years and is pleased to provide the following testimony. By community benefit, I mean those programs and activities that nonprofit hospitals provide continuing to demonstrate they deserve the privilege of tax-exemption. It includes free and discounted care to low-income uninsured individuals, improving access to health care services for all, and making communities healthier places to live, work and raise families.

Community benefit activities include outreach to low-income and other vulnerable persons; health education and illness prevention; special health care initiatives for at-risk school children; free or low-cost clinics; training for physicians and nurses, and efforts to improve and revitalize our communities. These activities are very often provided in collaboration with community members and other community organizations. In many cases, nonprofit hospitals are able to be catalysts in helping to organize community health resources to improve access to health care and improve community health.

Other types of community benefit include subsidizing services such as mental health and hospice programs, and trauma units that are truly needed but are high cost and provide low reimbursement. Our organizations routinely open or sustain these needed services, even if they result in a financial loss.

It is important for the committee to know, however, that we do not provide these community benefits in order to "prove" we deserve tax exemption. We do so because of who we are - organizations established (some as long as 200 years ago) and continuing to serve our communities. Our heritage based on Catholic social teaching calls us to continue the healing ministry of Jesus Christ by reaching out to persons in need, and healing not only persons who are ill but also to address those conditions in our communities that contribute to illness.

Our board took to heart the issues that the Committee and other leading policymakers have raised about the accountability of not-for-profit tax-exempt organizations. Namely, that governing bodies were not holding managers accountable and that there was not enough public information about hospitals' charitable activities. The CHA board of trustees also realized we could not give you or anyone a coherent description of how we were fulfilling our tax-exempt charitable purpose. This was because our organizations have had multiple ways of keeping track of and reporting community benefit.

The CHA board appointed a community benefit task force comprised of our hospital, system and sponsor leaders. They concluded that to be more accountable, we must:

- Make sure our members' governing boards and senior managers understand the legal basis of the community benefit standard.
- Commit our organizations to reporting community benefit in a standardized way using state of the art accounting practices, and
- Ensure that all Catholic hospitals post very publicly the availability of their charity care and discounting policies.

Our first step was to significantly revise our guidelines on community benefit and publish in May 2006, with the cooperation of VHA, Inc. and the support of 8 national health and financing organizations, *A Guide for Planning and Reporting Community Benefit.* To date, we have distributed more than 5,700 copies. This guide included a detailed definition of community benefit that is based on the IRS hospital Revenue Ruling and audit instructions and the best thinking of community benefit and finance leaders. It also included comprehensive guidelines for accounting for community benefit developed in consultation with the Healthcare Financial Management Association and the American Institute of Certified Public Accountants. In the past, we have given this guide to our members as an aid. This year we asked much more, that they follow the guidelines consistently.

The task force also developed a packet of information to clearly explain throughout the Catholic health ministry – at each level having responsibility - the current IRS requirements about community benefit and tax-exemption. That packet was sent to sponsors and members system and hospital CEOs. As of today, the informational video included in the packets on the importance of accountability has been viewed by more than 4,000 ministry colleagues including board members, senior managers and sponsors. We distributed over a thousand packets to sponsors, system leaders and 625 hospital members. As of today, the DVD in the packet has been viewed by over 4,000 ministry colleagues including over 1,500 board members, over 2,000 senior managers, and approximately 400 sponsors.

In addition, CHA asked each governing board to pass a resolution committing their institution or institutions to using the guidelines consistently and to use the professional accounting methodology. The packet also included a pledge that management was asked to sign committing them to carryout out the board resolution. The resolution and pledge also committed organizations to be more attentive to putting notices, in key areas of the facility, of the availability of charity care for low-income persons who are uninsured or whose insurance is not adequate.

I am pleased to report that this initiative was welcomed and affirmed by governing boards and system and hospital CEOs at CHA member organizations. As of today, the board resolution and management pledges committing to the community benefit guidelines have been received from 95 percent of CHA member health systems and 90 percent of the member hospitals, and additional commitments are being received daily as various governance boards meet.

In addition, as we complete fiscal year 2006 in all our institutions, CHA hopes to be able to give a report to you and to our communities of the magnitude of the contributions of Catholic healthcare across this nation.

While we are committed to community benefit and reaching out to persons who are low-income, we still face serious challenges. Our organizations are being overwhelmed by the growing number of low-income uninsured persons who, without our emergency rooms and free and low-cost clinics, might have no access to health care. At the local level, many of our members are working with physicians and other community partners to creatively address the health problems of the uninsured and underinsured. But this is a problem that demands national public attention.

Another challenge we face is identifying those patients and their families in need of financial assistance and distinguishing persons who *will not pay* their health care bills from those *unable to pay*.

All of our organizations have financial assistance standards and policies. We had previously provided to Chairman Grassley a fairly comprehensive list of the charity care and discount policies of many of our systems for low-income uninsured persons and those who experience catastrophic medical expenses. As we explained at that time, these differ among different hospital systems and regions of the country, as is appropriate to meet the needs of populations in areas that have vastly cost of living and median incomes.

Some of these compassionate and generous financial assistance policies include:

- Providing charity care for patients earning up to 200 percent of the federal poverty level (FPL). (Some organizations use HUD or other poverty guidelines that are more appropriate to their areas)
- Providing discounted care that does not exceed a certain percentage of the patient's adjusted gross income.
- Offering sliding scale discounts to patients earning anywhere from 300 to 500 percent of FPL.

But it is one thing to have policies in place, and quite another to implement them.

Our members face significant challenges in identifying all patients who meet financial eligibility criteria. Our members have committed to publicly posting financial assistance policies, but often patients do not tell us they are unable to afford their bills. For example, when patients come to us in emergency situations, they may be in no condition to discuss their financial situation. Other patients are reluctant to tell us they cannot afford to pay, perhaps erroneously worried that they will not get care or will get substandard care. Some simply refuse to fill out paperwork or cooperate in doing it. This could be because they are mentally ill, worried about their legal status, too embarrassed or a host of other reasons.

Identifying who is eligible for financial assistance is important for two reasons. Most importantly, while hospitals like all providers of services have a responsibility to collect fees owed, we do not want to pursue patients and families who clearly do not have the resources to pay. Patients should have the peace of mind of knowing that the cost of their care has been forgiven or that a reasonable payment plan has been set up.

In addition, our accounting guidelines require hospitals to separate charity care from bad debt, and report only charity care as community benefit. While in the past it may not have mattered to business offices whether uncompensated care was charity or bad debt, organizations now wanting to report community benefit according to our guidelines have a strong incentive to identify those who qualify for financial assistance.

Some of the steps our members take to identify those eligible for charity care and discounting include:

- Appointing "patient advocates" to work with patients in emergency room and with those who have been admitted or discharged. These patient advocates are responsible for helping patients enroll in programs for which they are eligible and to help complete paperwork for the hospital's financial assistance program.
- Sending notices in all patient bills that financial assistance is available and providing guidance on how to apply.
- Taking out newspaper ads telling patients to contact the hospital if they have received a bill they cannot pay.
- Writing to all patients who have outstanding bills, informing them of the availability of financial assistance.
- Conducting in-service education programs for all billing and administrative workers on the hospital's policies and expectations that all patients are to be treated with the utmost dignity, no matter what their financial status.
- Instructing outside collection agencies to let the hospital know if they discover a patient is unable to pay his or her hospital bill.

I want to point out, however, that community benefit is much more than providing charity care and discounted care to low-income uninsured persons. We also have a responsibility to the whole community. As I said earlier, we have put considerable effort into defining what to count as community benefit. We want hospital community benefit reports to accurately describe our contribution to the community and to be consistent, standardized and credible.

Accordingly, we define community benefit as programs or activities that provide treatment and/or promote health and healing as a response to community need and meet at least one of the following criteria:

- Generate a low or negative margin.
- Respond to the needs of special populations.
- Supply services or programs that would likely be discontinued (or would need to be provided by another nonprofit or government provider) if the decision were made on a purely financial basis.
- Respond to public health needs.
- Involve education or research that improves overall community health.

We have identified the following categories of community benefit:

- **Charity Care at cost**.

- **Shortfalls** from government indigent care programs, such as Medicaid and SCHIP (but not Medicare).

- **Community Health Services**: clinics, support groups, support services, and prevention and health promotion activities.

- **Health Professional Education**: training for physicians, nurses, and other health professionals to address unmet community needs.

- **Subsidized Services**: trauma services, hospice and palliative care programs, and behavioral health.

- **Health Research**: clinical research, and studies on community health and health care delivery.

- **Donations**: cash, grants, and in-kind services.

- **Community-Building Activities**: neighborhood improvements, housing programs, coalition building, and advocacy for community health improvement.

We realize that there are many other ways in which hospitals contribute to the well-being of our communities, but these are the categories we recommend reporting as community benefit.

Also, we do not count as community benefit:

- Bad debt.
- The shortfall from Medicare payments.
- Programs provided primarily for marketing purposes.

Catholic hospitals consider it a privilege to serve our communities and a privilege to be tax exempt in order to better serve our communities. We realize that both of these privileges require accountability. We also realize that as dollars invested in health care have grown, government authorities, such as this committee, are responsible for scrutinizing how these dollars are used. I hope that today I have helped to describe the steps we have taken to demonstrate accountability.

In summary, I believe we have:

- Sponsors and governing boards that are fully engaged in their organizations' community benefit responsibilities and programs.
- Executive leaders who are being held accountable for the community benefit programs of their organizations.
- Community benefit reports that are credible and understandable.
- Greater transparency regarding financial assistance policies.

We are pleased with the progress we have made. We believe that the combination of this concerted effort to secure commitment of our leaders, the availability of definitive guidelines for planning and reporting community benefit and a comprehensive education effort positions us not only to do community benefit but to be accountable for it.

In conclusion, the community benefit tradition in Catholic and other nonprofit health care organizations has been reinforced by efforts to achieve greater consistency and standardization in reporting and accountability. Our long-term commitment to the people in our communities is being demonstrated every day. We believe that the nonprofit health care sector continues to deserve tax exemption.

Over a decade ago, a former chairman of this committee, Senator Daniel Moynihan said, "A distinguishing feature of American Society is the singular degree to which we maintain an independent sector – private institutions in the public service. This is no longer true in most of the democratic world; it was never so in the rest. It is a treasure, a distinguishing feature of the American democracy."

It is important to us in Catholic health care that we continue that tradition of service and live up to the expectation that we are community benefit organizations. That is our mission and our commitment to you as well as to the communities we serve.

Attachments:

Resolution of the Board
Pledge Letter
Letter to Senator Grassley
Community Benefit Guide Executive Summary

Resolution of the Board

WHEREAS, in keeping with our commitment to our mission, _____ recognizes our continuing responsibility to provide sustainable and effective community benefit programs to better serve the community, especially persons who lack access and resources for the health care they need; and

WHEREAS, the Board has viewed a presentation explaining the Catholic Health Association of the United States' revised "Guide for Planning and Reporting Community Benefit" (the "Community Benefit Guide") which contains standard definitions related to community benefits and guidance on how to achieve consistency in planning, implementing, and reporting community benefits; and

WHEREAS, based on the presentation, the Board understands that it is imperative to establish a voluntary, ministry-wide method of reporting community benefit that is consistent and transparent; and

WHEREAS, the Board has determined that it is in the best interest of the community we serve for _____ to use the standard definitions and reporting guidelines contained in the Community Benefit Guide and to communicate our charity care and discounting policies to the community in ways that are clear and accessible;

NOW THEREFORE, IT IS RESOLVED, that _____ hereby voluntarily commits to use the standard definitions and reporting guidelines contained in the Community Benefit Guide to report our community benefit activities and to demonstrate to the community that our charity care policies are clear and accessible; and

IT IS FURTHER RESOLVED, that the management of _____ is hereby authorized and directed to take such steps and devote such resources as it deems necessary and appropriate to carry out the intent of the foregoing resolution.

Adopted at a duly called Meeting of the Board of _____, this ____ day of _____, 2006.

_____

Secretary

COMMUNITY BENEFIT

CHA
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Please return completed resolution to:

Sr. Carol Keehan, DC
Catholic Health Association
1875 Eye St., NW
Suite 1000
Washington, DC
20006-5409

System Pledge Letter

_____ and its member facilities recognize our continuing responsibility to provide sustainable and effective community benefit programs to better serve our communities, especially persons who lack access and resources for the health care they need.

The Catholic Health Association of the United States has developed a revised "Guide for Planning and Reporting Community Benefit" (the "Community Benefit Guide") which contains standard definitions and reporting guidelines regarding community benefits. Use of the Community Benefit Guide will further our community benefit efforts and will support the establishment of a ministry-wide method of reporting community benefits that is consistent and transparent.

Accordingly, on behalf of _____ and its member facilities, I hereby pledge our commitment to using the standard definitions and reporting guidelines contained in the Community Benefit Guide, and to communicating our charity care and discounting policies to the communities we serve in ways that are clear and accessible.

_____
President and Chief Executive Officer

_____
Date

CHA
THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Please type this on your letterhead and, at your earliest convenience, send to:

Sr. Carol Keehan, DC
Catholic Health Association
1875 Eye St., NW
Suite 1000
Washington, DC
20006-5409

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

SR. CAROL KEEHAN, DC
President and Chief Executive Officer

April 13, 2006

The Honorable Charles E. Grassley
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you very much for your letter of March 8, 2006 regarding charity care and community benefit provided by non-profit hospitals. I appreciate your recognition of the work that CHA has been doing for the more than fifteen years in the area of community benefit and welcome this opportunity to provide you with information about CHA and its members, and to highlight our members' leading practices in the areas outlined in your letter. My hope is that once you have reviewed this material, you will be reassured that CHA members take their responsibilities as tax-exempt organizations seriously.

Let me first address the questions raised in your letter about CHA, our members, and our governance and organizational structure.

1. Who are CHA's members and what is CHA's current membership level?

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-5409
Direct Phone 202-721-6015
Direct Fax 202-721-6017
ckeehan@chausa.org

The Catholic Health Association of the United States (CHA) represents the nation's largest group of non-profit health care sponsors, systems, and facilities. Catholic health care facilities provide a wide range of services across the continuum of care—from birth to death—to patients of all ages, races, and religious beliefs. One in six people hospitalized in the United States is cared for in a Catholic hospital each year, and Catholic health care facilities provide a wide range of community benefits to assist individuals, families and the broader community. Often, Catholic health care providers are the "safety net" to thousands of patients in the communities we serve who cannot afford health care coverage.

CHA's membership is comprised of almost all of the Catholic health care providers in the United States. As of February 2006, our membership includes 57 health systems; 572 hospitals; 633 long-term care/continuing care ministries; 262 sponsors; and 221 other types of Catholic entities.

2. What is CHA's governance structure and how are board members selected?

CHA is governed by a 25-person Board of Trustees, including (as ex officio members with vote) the Chairperson of the Board, the Speaker of the Membership Assembly, the President, the Vice-Chairperson/Chair-elect, and the Secretary/Treasurer. Board members are elected to serve for three-year terms, and may not be elected for more than two consecutive three-year terms.

CHA Board members and officers (other than the President, who is appointed by, and serves at the pleasure of, the Board) are elected by the CHA Membership Assembly, which is comprised of representatives of CHA's members. The CHA Nominating Committee, which selects the nominees for the CHA Board and officers (other than the President), is elected by the CHA membership, not by the CHA Board. The Nominating Committee receives broad input on potential candidates for the Board through a member-wide Call for Candidates process. A profile of CHA's current Board is attached for your information.

CHA's bylaws provide that nominees for CHA's officers and Board members must be individuals who (1) possess the capacity and willingness to represent and provide leadership to areas of Association interest and activity; (2) have demonstrated their awareness of an interest in health related issues; and (3) have distinguished themselves through service and dedication to their chosen avocation. In addition, the Nominating Committee pays particular attention to diversity of both gender and ethnicity, as well as to specific competencies needed to address the issues facing the Catholic health ministry.

CHA also has the following Board-level committees that participate in governance: Executive Committee; Finance Committee, Audit and Compliance Committee; Bylaws/Membership Committee; and Advocacy and Public Policy Committee.

3. What are CHA membership fees and what are the benefits of CHA membership?

Representative membership dues are assessed annually and are based on a single dues rate of 20.74 cents per $1,000 of total operating expenses as shown on the most recent audited, consolidated financial statements. CHA members form a community of faith-based health care providers. They work together to address ethical issues confronting our ministry, promote the mission of Catholic health care, and carry out an advocacy agenda that includes as the number one priority quality health care for all persons in this country. Our members have an opportunity to accomplish together what individual organizations could not do alone, such as working with the broader Church and developing resources based on collective experience and information exchange.

As is the case with other membership associations, benefits of membership include such items as educational programming, member advocacy, opportunities for national convenings and member consultations. In addition, CHA provides its members with a wide range of publications and written resources designed to highlight topical issues and explore the latest developments in health care and related ethical issues surrounding health care delivery and access. Our educational programs are designed to foster a greater knowledge of Catholic health care and its mission and provide leadership forums and resources in areas of interest to our ministry. CHA also provides members with the latest information on federal laws, regulations and policies. Additionally, the association represents our member's interest before Congress and federal administration departments and agencies. Membership benefits include access to CHA events such as the annual Catholic Health Assembly and specialized programs around a topical issue. Members also can access staff expertise on a variety of theological, ethical and public policy issues that effect health care delivery. Finally, member benefits include subscriptions to CHA's publications *Health Progress* and *Catholic Health World*; participation in affinity group meetings such as General Counsels or System Community Benefit network; and the ability to work together to share leading practices such as the recently completed *Core Elements in Sponsorship: A Reflection Guide*, to assist sponsors with accountability in governance of their health ministries.

4. What are CHA policies and procedures for ensuring members comply with CHA guidelines and what sanctions does CHA impose on members who do not comply with CHA guidelines?

CHA does not impose sanctions or measures of compliance upon its members—we are a voluntary organization of health care systems and facilities that share common principles based on Catholic social teaching and the Church's long tradition of reaching out to those in need in the surrounding community. As Catholic, mission-based organizations, the systems and facilities that make up CHA are bound by their commitment to fulfill those missions not to act in any way contrary to them or contrary to the long-established social justice traditions of the Church. As both a membership organization in the traditional sense and a representative of the Church's health care ministry, our goal at CHA is to promote among members a common understanding of who they are and how they should operate as Catholic health care providers, and to update as often as needed our voluntary guidelines as the situations and circumstances of health care delivery change in the United States. CHA sponsors and cosponsors programs to help improve the understanding of and compliance with the Community Benefit guidelines. As an example, in March 2006 more than 300 hospital leaders attended a three-day conference on Community Benefit guidelines cosponsored by CHA and VHA.

An important step CHA has taken this year has been creation of a Community Benefit Task Force comprised of CEOs and governing Board leaders to work with the entire ministry to get an even greater public commitment to consistent and transparent reporting. Their work has been well received by system CEOs and sponsors.

5. Does CHA have any plans to reach out to the Internal Revenue Service or the Financial Accounting Standards Board to improve accounting and reporting practices?

In response to the IRS's continued focus on community benefit issues, CHA met with IRS officials in February 2006 to discuss our long-standing work regarding standardized and consistent reporting and accounting for community benefits. Since that time, we have maintained contact with IRS staff and have shared with them our Community Benefit Reporting Guide. We also discussed the plans IRS has to address community benefits in the future and how CHA may be of help as it continues to explore this issue. CHA also worked with the Health Care Financing Management Association throughout 2005 to develop principles and standards for accounting for community benefit. Additionally, we are in discussions with the American Institute of Certified Public Accounts' health committee as they revise their auditing guidelines in order to promote consistent accounting methodologies.

Leading Practices

Your letter also raised questions about CHA's members' leading practices with respect to a variety of areas. Before addressing these in detail as you requested, I thought it might be helpful to provide some context in which these practices have been developed and are implemented. As you know, tax-exempt health care providers in the United States are subject to a myriad of federal, state and local laws. Compliance with these is of the utmost importance to CHA's members. Certainly, there are areas in which our ministries can improve, and we have discussed many of these areas within the membership. However, I think that the "leading practices" described below should provide you with a better understanding of the numerous policies, processes, and practices that demonstrate our members' commitment to "doing the right thing."

Some of the leading practices of our members include the following:

- **Joint Ventures**
  In order to further their charitable mission of promoting health, most of our members enter into joint ventures. In today's environment, there are many benefits for communities in having health care services provided as part of a joint venture relationship. Joint venturing offers the potential to strengthen collaborative efforts with partners who have common commitments to quality, excellence and efficiency.

In most cases, the joint ventures undertaken by our members are of a clinical nature, often with other non-profit organizations. When deciding whether to enter into a joint venture, our members generally undertake a discernment process that includes consideration of some or all of the following criteria:

- The opportunity to create or expand services to address unmet needs in the community
- Enhancement of quality and delivery of health services
- Compatibility with joint venture partners in areas of mission, vision and quality
- Enhancement of access to capital for expensive technology
- Consideration of the joint venture's ability to:
  - Adopt and implement a charity care policy
  - Provide services to Medicare and Medicaid and charity care patients on a nondiscriminatory basis
  - Have safeguards in place so that the charitable purposes will override profit motive

A common practice of our members is to require their joint ventures to adopt a charity care policy (often the same as that of the hospital involved) and to accept Medicare and Medicaid patients. In addition, many require their clinical joint ventures to participate in their corporate compliance programs, and, in some cases, are subject to the hospital's internal audit processes. Of course, these safeguards are in addition to structuring the joint ventures to comply with Anti-Kickback, Stark and other applicable legal requirements.

- **Taxable Subsidiaries**
  Some of our members have established taxable subsidiaries within their health care systems. These usually have been established to conduct activities that are related to, complimentary or supportive of, the charitable mission of the health care system, but do not qualify as exempt activities. Because these activities would generate unrelated business income if conducted by an exempt organization, the IRS has generally approved the establishment of properly structured separate corporations (which pay applicable federal taxes) to conduct these types of activities. Some examples of the types of activities conducted within these taxable subsidiaries include laundries, medical office buildings, outpatient pharmacies and paging services.

  In instances where our members have taxable subsidiaries they generally are subject to the same oversight/accountability as described above with respect to joint ventures. The criteria most often considered in determining whether to create a taxable subsidiary includes (1) would it help ensure the quality of a product or service

used by the Catholic health ministry that otherwise would have to be purchased from a third party; (2) does it pursue activities that are important to our ministry; and (3) is it in accordance with our mission and values?

- **Contracts for Management and Administrative Services**
  As is necessary in today's environment, most of our members do have contracts with third parties for a variety of services. Where services are to be performed by those who are in a position to refer patients, our members have robust compliance programs in place to make sure that such arrangements comply with Stark, Anti-Kickback and other applicable laws. In 2000 CHA, in conjunction with its members and PricewaterhouseCoopers, LLP, developed an on-line compliance training program known as Complistar, which is widely used throughout the ministry to educate employees on a variety of compliance-related topics including Fraud and Abuse, Stark, HIPAA, Coding, Laboratory Administration, Home Health, Hospice, DME, Physician and Nursing Documentation. We also are currently developing a new EMTALA course. To date, ministry colleagues have completed more than one-half million of these on-line compliance courses.

  With respect to contracts with vendors and other third parties for routine services such as food services, supply chain management, management of specific clinical services by those with expertise (such as rehabilitation), housekeeping, security, etc., our members have various processes and procedures in place to determine compliance with Rev. Proc. 97-13 regarding the use of bond finance space. These include maintenance of a list of "private use" of bond-financed space; periodic audits of space use; conducting due diligence reviews with bond counsel; and development of a "bond manual" and template contracts which comply with the term limits and other requirements of Rev. Proc. 97-13 for use throughout the system.

- **Executive Compensation**
  As the Committee is aware, in implementing Section 4958 of the Internal Revenue Code, the IRS has set forth a detailed process for establishing a "rebuttable presumption" of reasonableness when setting the compensation of "disqualified persons," which includes at least the Chief Executive Officer of an exempt organization. As we understand it, most of our members follow this process in a very deliberate manner, including the establishment of Compensation Committees comprised completely of independent directors to set the compensation of "disqualified persons." In most cases where outside compensation consultants are used, the consultant is hired by and reports directly to the Compensation Committee, not management.

Another leading practice involving executive compensation is establishing explicit goals within the executive performance review and/or executive compensation programs that are tied to the organization's achievement of its charitable mission and community benefit. In many cases, an executive's variable compensation is directly dependent on achievement of these mission-based goals.

- **Travel and Expense Reimbursement**
  Our members employ a range of travel and expense reimbursement policies, all of them aimed at providing adequate reimbursement for legitimate business costs while encouraging reasonable and appropriate uses of travel services and other expenses. These policies generally restrict air travel to coach or economy class (some policies do provide for business class travel on overseas flights), and many of them recommend IRS guidelines for travel, including mileage reimbursement. As is common practice, our members ensure compliance with their individual policies through an internal audit process. In almost all cases, the same travel policies apply to our members' board members as well as their employees.

- **Billing and Collection Practices**
  This issue is one of great concern to all our members. To ensure that Catholic health care facilities continue a tradition of providing service to such vulnerable populations as the uninsured and underinsured, CHA members continue to strive for the improvements necessary so that billing and collection practices are as fair, equitable and as transparent as possible.

  Our members have established standards regarding billing and collection practices. These standards vary between differing hospital systems and regions of the country, as is appropriate in meeting the needs of differing populations in areas that have vastly different costs of living and median incomes from one another. That said, some general commonalities and practices should provide you with the range of our member's response to billing and collection issues. Many of our members' billing policies specify that charity care be provided for patients earning up to 200 percent of the Federal Poverty Level (FPL) who are uninsured and ineligible for any publicly funded health insurance program. Others specify charity care for this group in a range of 100-200 percent of the FPL and/or provide for discounted care that should not exceed a certain percentage of the patient's adjusted gross income. For those above 200 percent of FPL, most policies employ a sliding scale of discounts ranging from 200 to anywhere from 300 to 500 percent of FPL. Some policies include additional billing discounts such as special rules for catastrophic care charges exceeding certain percentages of income. Other policies utilize

the Department of Housing and Urban Development's income guidelines for discounting decisions.

Regarding collection practices, many members employ outside collection services where appropriate to assist in handling unpaid bills. These members utilize several methods to ensure that the collection services uphold standards and methods of treating patients that are reflective of our members' missions. Some specific examples include instructions against "body attachments" and prohibitions against certain foreclosures and liens, such as those on homes. Others specify a review period and prior approval by an entity outside the collection agency before undertaking legal action. These services are monitored by our members in various ways, including audits, reviews, logging/recording of communications between agency employees and patients, and creation of "ghost accounts."

Patients receive information about our members' billing and collection policies through a variety of means, including posting them in public areas of hospitals; in brochures and other printed material available in admission areas; and notices on billing statements. Additionally, these materials are almost always available in languages other than English, particularly in areas served wherein the predominant language is one other than English. In addition to providing information about an individual hospital or health system's billing policies, many of our hospitals proactively work with uninsured patients to ascertain whether they would be eligible for enrollment in publicly funded programs.

In addition to the above, many of our members have long operated clinics and other outreach clinical programs which provide free care for the very poor and sliding scale payments for the working poor.

CHA's revised Community Benefit Guidelines recommend that health care organizations make every effort to identify persons unable to pay for their care and to separate those accounts from those of persons unwilling to pay (bad debt). The guidelines, developed in consultations with the Healthcare Financial Management Association, further recommend that identification of persons unable to afford care be accomplished as soon as possible. However, when early identification is not possible because of lack or information, the determination can be made at any time during the care or billing process. In addition, the guidelines recommend that all employees who come in contact with patients, especially admissions and billing staff, be well acquainted with the organization's charitable mission and its financial assistance policies. The CHA website, referenced in the guidelines, features a sample PowerPoint presentation that can be used in an educational program for these staff members.

Charity Care and Discount Policies for the Uninsured

To help you understand how these work in various communities, I am enclosing several examples of the discounting policies of a number of our health systems in multiple areas of the country. I believe they will show that the primary concern of our ministries toward the uninsured population is for the uninsured that are poor, and those made poor by catastrophic medical expenses. And while the policy details reflect the differing circumstances among these systems, I also assure you that our members provide several resources such as patient advocacy programs and financial counseling to help our uninsured patients understand all the options available to them.

System #1 – its policy is free care for the uninsured below 200% of the Federal Poverty Level (FPL). Between 201%-400% FPL there is a significant discount given, and for the uninsured that have an income greater than 401% FPL the discounts are similar to those given commercial payers. This system also provides special discounts in the event of a catastrophic illness that could overwhelm a family normally able to afford its medical expenses.

System #2 – its policy is 100% write off for the uninsured earning up to 200% FPL. For those patients that make between 200%-399% of the FPL there is a sliding scale. To give you some idea of how this sliding scale works, for outpatient care where the charges are below $5,000 the sliding scale is a 0%-100% discount at a rate of 1% discount for each 2% of household income that is below 400% FPL. For inpatient charges and outpatient charges that are greater than $5,000 the discount is equal to the greatest discount given to any managed care plan or the overall managed care realization rate, whichever produces the higher discount for the patient. For those over 400% FPL outpatient charges below $5,000 do not receive a discount while inpatient and outpatient charges greater than $5,000 receive the lowest discount given to a managed care plan.

System #3 – its policy is free care for uninsured families making below 200% FPL. Those making between 201% - 300% are charged the Medicare rate. Those between 301%-500% FPL are charged the prevailing rate of managed care and commercial care but it can not be more than 50% higher than the Medicare rate. Those greater than 500% FPL may be eligible for a discount, especially if the illness is a catastrophic illness.

System #4 – its policy is a 100% discount for the uninsured under 200% FPL. Between 200%-300% FPL there is a sliding scale based on the ability to pay but the charges can never be more than the Medicare rate. Greater than 300% there is a sliding scale based on the

ability to pay and consideration of assets, but the charge can never be more than the private pay discounting services amount.

System #5 - At less than 120% FPL there is a 100% write-off. Between 121%-300% FPL there is a sliding scale. To give you some idea of how this sliding scale works the system takes the average income amount of the household minus 120% FPL divided by 300% of FPL minus 120% FPL equaling X. Then 1 minus X times 100 equals the percentage discount. As an example:

Family of 6 earning $60,000.

$60,000 - $30,252 = $29.748
(120%FPL)

$29,748 ÷ $72,630 - $30,252 = .65
(300% FPL) (120%FPL)

1 - .65 x 100 = 35% discount

System #6 – its policy is 100% write off for the uninsured making less than 100% FPL. For those between 100%-200% FPL there is a deep discounted sliding scale. For those greater than 200% FPL there is a sliding scale program tailored to the individual community in which the local hospital resides. For other uninsured who are able to pay, charges are discounted to the highest payer the local hospital has with the ability to add up to 5% more on top of that to account for the prompt pay discount large insurers receive. However, this discount must also be offered to the uninsured for prompt payment.

System #7 - bases its charity care eligibility on HUD's 130% of Very Low Income Guidelines based on geography. The system believes that the HUD Very Low Income Guidelines are more responsive to the communities it serves, and offers the uninsured write off eligibility ranging from 25%-100% of charges. An example of this based on the HUD Very Low Income Guidelines is a family of four with a gross annual income that does not exceed $35,815, which would be eligible for a 100% charity write off. Those with incomes up to $41,720 would be eligible for a 75% discount from charges, with lesser discounts offered to those with incomes above that amount.

These examples are illustrative of the commitment and compassion of many of our systems. I will certainly be happy to provide you with other examples if you are interested. I would also point out that the vast majority charge no interest on amounts due from patients who have payment plans extended over a long period of time.

- **Conflict of Interest and Other Governance Issues**
  CHA members have adopted conflict of interest policies that require members of boards and certain employees in management or executive positions to adhere to those entities' standards governing conflicts of interest. These policies include various means to ensure compliance, such as requiring annual statements to ascertain potential conflicts and requiring prompt disclosure of changes in status during the intervening period. Most of our members have voluntarily taken steps to enhance their governance in the spirit of the Sarbanes-Oxley law, such as through the establishment of a separate, independent Audit Committee: the rotation of audit partners; the limitation of non-audit work by outside auditors; required executive sessions without management present. Compliance is monitored through audit committees or the work of general counsels and compliance officers, and those with potential conflicts are excluded from discussions or decisions regarding the conflicting topic.

  Other governance issues that may be of interest to the Committee include the socially responsible investing policies adopted by most of our members. Our members also are increasing their commitments to transparency following the increase in the past several years in electronic availability of financial forms and statements. Many of our members already make this type of information publicly available, often through their websites, while others have indicated their intention to move in this direction in the near future. Of course, our members follow the IRS Form 990 public disclosure requirements, and, as I am sure you are aware, this information is available on www.guidestar.org.

  In addition, most of our members distribute annual reports describing the various ways that they have contributed to the health of the communities they serve. We recommend to our members that these reports include:
  - Executive summary and one-page community benefit summary
  - A description of core values and social teaching that guide the organization
  - A history of an organization's commitment to the community and its development over time
  - A description of community needs and resources
  - Objective measures of community benefit, including dollars spent, numbers served, and the impact on the community
  - A narrative report to explain the value of the services provided beyond the dollars spent or numbers served

The above leading practices are meant to be illustrative rather than an exhaustive list of everything our members do to make sure that their

operations are in compliance with applicable laws and regulations. Highlighting these examples should not be read to suggest that organizations that do not have some or all of these practices in place are not also committed to their obligations as tax-exempt entities. Instead, it is my hope that these illustrations will give you and the Committee a better understanding of how our members are striving to uphold their responsibilities as tax-exempt entities and, most importantly, as health care providers for those who are often the most vulnerable in our society.

CHA

As the Committee staff is aware, CHA is finalizing the revised Community Benefit Guidelines. The staff has been very helpful as we made the revisions, and I would like to express our thanks to them. I look forward to sharing a copy with you when they are published in May.

I would very much appreciate the opportunity to meet with you in person to discuss the points in this letter in more detail, and to answer any further questions that you may have. Let me thank you again for this opportunity to provide you with this information on behalf of the more than 2,000 Catholic health care sponsors, systems, facilities, and related organizations in the United States.

Sincerely,

Sr. Carol Keehan, DC

cc: Senator Max Baucus
Senator Ron Wyden

Executive Summary

This publication, *A Guide for Planning and Reporting Community Benefits*, is a revision of CHA's Social Accountability Budget, released in 1989. This Guide's purpose is to help not-for-profit mission-driven health care organizations develop, enhance, and report on their community benefit programs.

Community benefit programs are organized to work collaboratively with others in the community to address specific community health needs and improve the health of everyone in the community. The programs include services for persons who face barriers accessing health care and initiatives for improving health in the broader community.

Providing community benefits demonstrates that not-for-profit health care organizations are fulfilling their mission of community service and meeting their charitable tax-exempt purpose as community benefit organizations.

When Catholic health care and other not-for-profit health care organizations began in this country, there was a clear understanding that they provided community benefit. Today, however, the community service role of not-for-profit health care is not well understood by policymakers and the public. As a result there is a growing need for not-for-profit health care organizations to tell their community benefit story.

Foundational Beliefs

A Guide for Planning and Reporting Community Benefit is based on six foundational beliefs:

- Those who live in poverty and at the margins of our society have a moral priority for services.
- Not-for-profit mission-driven health care organizations have a responsibility to work toward improved health in the communities they serve.

- Community members and organizations must become actively involved in the health care facility's community benefit programs.
- Health care organizations must demonstrate the value of their community services.
- Community benefit programs must be integrated throughout health care organizations.
- Leadership commitment is required for successful community benefit programs.

Essential Components

The following components are interrelated and should be integrated with other key functions of the organization—planning, communications, and clinical services—not isolated in a separate department.

The essential components of community benefit programs, described in this Guide, include:

Building a Sustainable Infrastructure
Sustaining community benefit programs requires that health care organizations have a clear mission to serve their communities and a solid community benefit program infrastructure. An explicit reference to responding to community need must be in the organization's mission, and leaders must be made accountable for meeting community benefit goals. Maintaining this infrastructure includes building collaborative relationships with community members and organizations, securing adequate staffing and financial resources, and developing policies that are clearly understood and consistently practiced.

Planning for Community Benefit
Planning for community benefit programs should be as serious and visible as planning for any other strategic initiative. Integrate planning for community benefits with other health care organization planning functions, including strategic, communications, and financial planning. Integrate the organization's community benefit plan with community-wide efforts to improve health in the community. Assess problems and assets within a defined community, identify priority areas that merit programmatic response, and establish criteria for determining the effectiveness of community benefit programs.

Determining What Counts as Community Benefit
Defining community benefit and developing standard approaches to accounting and reporting are essential to the effectiveness of these programs. Community benefit leaders have spent considerable effort identifying what should and should not be counted as community benefit. This Guide incorporates standard definitions and guidelines that have been developed by community benefit, mission, and

finance leaders and that have been agreed upon by many national organizations. They are also consistent with Internal Revenue Service rulings. The guidelines include the following categories of community benefit: charity care, subsidized government indigent care programs, community health services, health professional education, subsidized health services, research, financial contributions, and community building activities.

Accounting for Community Benefits
Using standardized principles and policies helps account and budget for community benefits and tell the community benefit story. Accurate and consistent accounting for the cost of programs and services allows organizations to budget for these in future community benefit plans. Standardized accounting methods assure that quantitative reports of community benefit are credible, accurate, and comparable to reports from other organizations.

Evaluating Community Benefit Programs
Evaluating community benefit programs and making warranted adjustments are fundamental to effective community benefit programs. The development of methods to assess the effectiveness of services and activities in improving health in the community is a major advancement in the field of community benefit. This Guide describes ways to evaluate the overall community benefit program and individual initiatives by establishing specific objectives and indicators of effectiveness.

Communicating the Community Benefit Story
Throughout this document, users are reminded that community benefit programs should be closely connected with all aspects of an organization's communications. All phases of community benefit programs, from building relationships in the community to evaluating effectiveness, rely on well-thought-out communication

WHAT IS COMMUNITY BENEFIT?

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes. A community benefit must meet at least one of the following criteria:

- Generates a low or negative margin
- Responds to needs of special populations, such as persons living in poverty and other disenfranchised persons
- Supplies services or programs that would likely be discontinued—or would need to be provided by another not-for-profit or government provider—if the decision was made on a purely financial basis
- Responds to public health needs
- Involves education or research that improves overall community health

THE COMMUNITY BENEFIT LOGO

This Guide is one of many resources that CHA provides to its members to help them become more effective community benefit organizations and to educate and prepare them for the many challenges facing tax-exempt organizations today. To easily identify CHA's community benefit-related resources and articles we have developed a new symbol which can be seen on the title page of this Guide. The logo represents our ministry's community benefit mission of promoting wellness for all persons and communities with our faith-tradition at its core. The rays of light or halo *illuminate* the spirituality of our commitment to communities, the *aura* of out reaching out,and the *radiant energy* of our work. Members are welcomed to use the logo on their community benefit documents and/or website in order to identify their use of these guidelines in their community benefit reporting. Additional information on accessing the logo is available on the CHA community benefit website at **www.chausa.org/communitybenefit**.

strategies and therefore should be integrated into communications plans and all forms of messaging. Communications and community benefit staff must work together in developing, planning, tracking, and evaluating community benefit programs in order to tell the community benefit story.

The Importance of Using This Guide

An organized approach to planning, reporting, and evaluating community benefits is more important today than it ever has been, for several reasons:

- It helps identify community needs and provides the information required to make prudent choices as to the use of scarce resources to best help those in need.
- Proactive budgeting and the use of standardized accounting will make the financing of the community benefit program more predictable, sustainable, comparable, and credible.
- A deliberate approach will facilitate building important relationships in the community and lead to involvement in community-wide efforts to improve access to services and community health.
- Finally, this approach will help make not-for-profits accountable to their communities and demonstrate that these organizations continue to be valuable community assets.

October 31, 2006

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

Senator Charles E. Grassley
Chairman, Committee on Finance
United States Senate
Washington, DC 20510 -6200

Dear Chairman Grassley,

I am pleased to have the opportunity to offer additional information and views as follow-up to the September 13 hearing on not-for-profit hospitals. The thoughtful questions submitted by Senators Santorum, Rockefeller and Bingaman reflect their appreciation of the challenges faced by today's faith-based and other not-for-profit hospitals.

Questions from Senator Santorum:

Question 1: I have talked with many of the hospitals in Pennsylvania and a number have charity care policies in place that provide free care to our most needy (under 200% of the federal poverty line), reduced care for those who have some ability to pay (above 200% but less than 400% of the poverty line), and even work with patients to qualify them for programs that will cover their medical expenses retroactively. However, to remain fiscally viable-even as a nonprofit-a medical facility has to make ends meet. The question then is how to balance the charitable mission of an organization with the need to remain financially stable to continue to serve your communities. How has your organization truck that balance? Is there a difference in how you reach that balance based on whether the nonprofit is a faith-based organization or a secular one? What is done with "margins"?

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How does a medical facility balance its charitable mission of community service and the need for financial stability?

Senator Santorum is correct that hospitals must navigate a careful path between community service and financial stability. They must balance long-term viability with their daily mission of serving those in need and providing justice for employees in terms of fair wages, benefits and pensions. They must also consider the need for investment in technology and advanced treatments to maintain high quality of care as well as the need to reserve funds for future needs. This is a delicate balance that leaders of Catholic and other not-for-profit hospitals must strive to achieve in their facilities and their systems.

Some observers have described this phenomenon as hospitals needing to maintain two bottom lines, one measured in dollars, the other in service. These bottom lines are not an either/or scenario to the Catholic health ministry. Both are critically important because

our mission of community service is the reason we began and continue our health and social service ministries, and we must have financial stability in order to continue to serve our communities and be equitable employers over the long term.

To specifically address Senator Santorum's first question, Catholic hospitals work hard to reach this balance in many ways, by measuring and monitoring financial and service performance and by utilizing billing and collection policies that will allow them to serve the greatest number of patients in a fair way while also keeping the organization itself healthy for the current period and into the future.

In addition, Catholic health care organizations are becoming increasingly innovative in responding to community need in cost-effective ways. For example:

- Some hospitals are using "global budgeting" for community benefit by taking funds budgeted for charity care and redirecting them to primary care services for uninsured persons to avoid preventable emergency room visits and inpatient admissions, thereby reducing the overall need for charity care.
- Hospitals in Cincinnati, Austin, Albany and other cities are "enrolling" uninsured persons in chronic disease management programs, helping them find donated primary and specialty medical care and providing ongoing management of their conditions. This strategy also reduces the charity care burden.
- Some hospitals maximize their community contribution by providing start-up funds for programs that community groups continue. We recently reported in our member newspaper, *Catholic Health World,* that Avera Health provided seed money to Communications Services to the Deaf (CSD) in Sioux Falls, South Dakota, to develop health educational materials for deaf and hard of hearing persons. With these start-up funds, CSD will sustain the program and make it available on a national basis.
- The use of volunteers also helps stretch community benefit dollars. In Ft. Lauderdale, for example, a Catholic hospital funds parish nurses who serve many parishes of various denominations, all with large numbers of low-income older persons. These nurses recruit, train and supervise community volunteers who make it possible to address the needs of a large number of older persons.

- Increasingly, our hospitals are turning to philanthropy to fund their community benefit programs. The Perry Family Health Center, for example, the source of primary care for very low-income and uninsured persons in northeast Washington, DC, is funded through monies raised by the Providence Hospital Foundation. (It is important to note that when funds are raised specifically for a community benefit program, the expense of the program is offset by the restricted donation and does not appear in the hospital's quantitative report of community benefit.)

Is this balance reached differently by faith-based organizations?

This "balancing act" between mission and financial stability is part of the tradition of the Catholic health ministry. The religious sisters who established our first hospitals and nursing homes were resourceful in finding ways to provide service and maintain financial viability. They begged, sold "shares" of health services (the original capitated managed care plans) taught the children of affluent families in order to serve the poor and used other strategies. Seeking creative solutions to funding

community programs is part of our history and continues today. We also have been impressed with the ingenuity of other not-for-profit, community oriented health care organizations as well.

Question 2: We have heard some contend that while a nonprofit hospital's charity care policy may be sound, patients are not aware of this policy and thus it is ineffective. At least in my state, that policies are required to be posted in key public areas, and generally a copy is given to the patient and conversations can be initiated by the patient or the hospital to determine if a patient is eligible any time in the payment or collections process. In addition, the Hospital Association of Pennsylvania put out guidelines on charity care and financial aid in July 2004 that includes a section on implementation such as communicating the availability of the policy, training staff on the policy and administering the policy fairly, respectfully and consistently. Without requiring every patient to be pre-screened for eligibility, what other specific points do you think should be added?

The Hospital Association of Pennsylvania guidelines described by Senator Santorum are excellent, as are the Healthcare Financial Management Association's *Patient Friendly Billing* guidelines, which we advise our members to implement.

It is clear that patients will use financial assistance only to the extent they are aware that a hospital offers such assistance. We are pleased to inform Senator Santorum and the committee that 95 percent of CHA's member health care systems have committed to posting the availability of their charity care and financial assistance policies in publicly accessible areas (and this figure is increasing as boards meet this fall).

In addition, other strategies our hospitals use include:

- Appointing "patient advocates" to work with patients in emergency rooms and with those who have been admitted or discharged. These patient advocates are responsible for helping patients enroll in coverage programs for which they are eligible and completing paperwork for the hospital's financial assistance program.
- Sending notices in all patient bills that financial assistance is available and providing guidance on how to apply.
- Running newspaper ads telling patients to contact the hospital if they have received a bill they cannot pay.
- Writing to all patients who have outstanding bills and informing them of the availability of financial assistance.
- Conducting in-service education programs for all billing and administrative workers on the hospital's policies and expectations that all patients are to be treated with the utmost dignity, regardless of their financial status.
- Instructing outside collection agencies to inform the hospital if they discover a patient is unable to pay his or her hospital bill and asking them not to pursue collection.

Question 3. How do you balance the desire to get patients enrolled in plans or qualified for the charity care policies without forcing patients to provide personal and financial information that they may not want to provide?

This is a significant problem for *all* hospitals, especially as they step up efforts to identify all persons eligible for charity care and remove them from bad debt rolls. We believe this is important, not only

for more accurate hospital financial and community benefit records, but also for the peace of mind of persons unable to pay their medical bills.

At least four strategies are being used at Catholic hospitals. First, our facilities try to explain to patients and their families the advantages of enrollment. They train staff on how to approach the issues and they often ask multiple staff members to talk with the patient and family, establishing trust so the patient cooperates.

Second, new technology is becoming available to help our facilities gather information from various publicly available sources other than directly from the patient and has been of great help. Please let us know if interested in more information on how technology is assisting hospitals in this way.

Third, our organizations are learning how to make financial assistance determinations with less than perfect information. Financial assistance committees are being formed to assess whatever information is available (past hospital bills, income potential, housing situation) and to make the financial assistance determination based on it.

Finally, many of our hospitals provide charity care in collaboration with attending physicians. If the physician waives his or her fee because of medical indigency, the hospital does so as well.

Question 4: In the Commonwealth there is a requirement that nonprofit hospitals certify annually to the Department of Public Welfare that they have a charity care program, their efforts to seek collection of all claims and attempts to obtain health coverage for patients. If we continue to provide charity care above a certain level-such as 400% of the poverty level-does that not discourage the purchase and maintenance of health insurance?

It is important to realize that the reason Catholic hospitals provide charity care is because we believe that the human dignity of all persons depends on their ability to access needed health care. Persons seeking care without financial resources may be a worried parent, a patient who is sick and frightened, or a person in pain. They are our primary concern.

In response to Senator Santorum's question, this has been an issue the Catholic Health Association since we first began to concentrate on community benefit in the 1980s. The leaders who guided our early work were concerned that encouraging the establishment of free and discounted clinics and expanded charity care policies would mask the problem of millions of persons lacking health insurance. Our leaders worried that if America's not-for-profit hospitals address some of the problems faced by uninsured persons, there would be insufficient political will to address larger, systemic problems. Because of this, our number one advocacy issue is affordable and accessible health care for everyone.

Even more to the point raised by this question, we <u>are</u> concerned that some employers may drop health insurance if they believe their workers will be covered by financial assistance policies. However, hospital care is not the only or even the most important reason to have health insurance. Health insurance provides regular access to appropriate sources of care and helps keep people healthy, a benefit for both public health and systemic cost reduction.

Question 5: Community benefit is a concept that will vary greatly from hospital to hospital and area to area. I understand that some have argued that all community benefit should be limited to charity care or specific standardized items. In my experience the community benefit

of the Children's Hospital of Pennsylvania offering training for parents on how to properly use child safety seats in cars and the low-income health clinics by our research hospitals both serve the community. How do we continue to ensure there is community benefit but take into consideration the differences between types of hospitals, charitable missions, size and location?

It is our firm belief that community benefit is multidimensional, extending well beyond charity care. We identify the following categories of community benefit:

- **Charity Care**
- **Shortfalls** from government indigent care programs, such as Medicaid and SCHIP (but not Medicare).
- **Community Health Services**: clinics, support groups, support services, and prevention and health promotion activities.
- **Health Professional Education**: training for physicians, nurses, and other health professionals to address unmet community needs.
- **Subsidized Services**: trauma services, hospice and palliative care programs, and behavioral health.
- **Health Research**: clinical research, and studies on community health and health care delivery.
- **Donations**: cash, grants, and in-kind services.
- **Community-Building Activities**: neighborhood improvements, housing programs, coalition building, and advocacy for community health improvement.

This classification, we believe, takes into consideration differences not only in hospitals but in community needs as well.

Questions from Senator Rockefeller:

Question 1: I think the real issue facing all hospitals, but primarily nonprofit hospitals, is the problem of the uninsured. The Census Bureau just reported last month that, in 2005, the number of uninsured adults rose to 46.6 million. And, the number of uninsured children rose for the first time since 1998 to 8.3 million.

As I understand it, nonprofit hospitals have a hard time trying to shoulder the uncompensated health care burden caused by lack of health insurance. In West Virginia, nonprofit hospitals had $442 million in uncompensated health care in 2005. By comparison, the uncompensated health care burden of WV's for-profit hospitals was only $64 million.

With the added costs of Medicare and Medicaid cuts as well as cuts to health professions training programs, many nonprofit hospitals struggle to keep their doors open. And, their tax exempt status is the only thing that allows then to stay afloat.

Sr. Keehan, Mr. Duke and Mr. Lofton, can you talk a little bit about he challenges faced by your hospitals because of the lack of health insurance? You can't just move costs around, can you?

It is accurate that the nation's hospitals "shoulder the uncompensated health care burden caused by the lack of health insurance." An important part of the mission of our organizations is to help maintain the health care safety net until our nation adequately addresses the need for everyone to have health care coverage.

As Senator Rockefeller suggests, however, there is never enough. Hospitals cannot compensate for the more than 46 million persons who have no health insurance. In fact, the growing number of uninsured and underinsured persons is the primary challenge facing our institutions today. Growing uncompensated care burdens take their toll on our programs, our ability to expand and upgrade services and to maintain a stable workforce with fair compensation for our employees. Particularly at risk are programs used in high volumes by uninsured patients: emergency and trauma services, some maternity programs and mental health services which must be subsidized by hospitals. Eventually, we fear, the problem of the uninsured will weaken the health care infrastructure.

It is important to point out that the problem of the uninsured is not just a practical problem, but a moral problem. It is a national disgrace that more than 15 percent of persons in this country do not have health insurance. We also believe that shifting costs from one group of patients to another is an irresponsible way to finance healthcare. This cost shift is increasingly progressive and is reaching intolerable levels. We urge this committee to make insurance coverage for everyone a priority in the next Congress.

Senator Rockefeller also cites Medicare and Medicaid cuts as a source of financial distress for hospitals. Such cuts hurt hospitals that rely on these dollars to treat elderly and low-income populations, which often comprise the majority of patients in not-for-profit hospitals. When these programs are scaled back or under-funded, it is not only the hospitals that are impacted, but patients and communities as well. It is unacceptable that some patients are unable to find a physician who will accept Medicare or Medicaid because of low reimbursement levels, when we have made a public policy commitment to cover these patients.

Question 2: It has been suggested by some that the 1969 IRS Community Benefit standard for determining tax exempt status is too broad and was wrongly decided. However, it is true that nonprofit hospitals contribute to their communities in a variety of ways. Some nonprofit hospitals focus almost exclusively on providing charity care.

Others, such as teaching hospitals, focus more on scientific research that will lead to treatments and cures for diseases. Other nonprofit hospitals provide invaluable education services to their communities.

We have a Children's Health Van at Marshall University in West Virginia, which I helped create, that provides vital health education services to children and their families. Most of

these families would have no contact with the health care system otherwise. I think that is a huge community benefit.

Don't you agree that nonprofit hospitals benefit communities in a variety of ways-from charity care to scientific research to capital investment and infrastructure development?

We agree with Senator Rockefeller that not-for-profit hospitals benefit communities in a ways that extend well beyond charity care. We are convinced that the 1969 IRS Community Benefit Standard was and continues to be appropriate because it encourages tax-exempt hospitals to address the greatly different needs in various communities with the unique expertise and capabilities of different hospitals. We believe that hospitals enjoy a unique perspective on the health needs of their communities that the IRS could not be expected know.

As we said earlier, it is our firm belief that community benefit is multidimensional, extending well beyond charity care. Therefore we identified the following categories of community benefit:

- Charity Care
- Shortfalls from government indigent care programs
- Community Health Services
- Health Professional Education
- Subsidized Services
- Health Research
- Donations
- Community-Building Activities

Who else is going to make the investment in health care that we are going to need as our population ages?

As the nation's population ages, we believe that the not-for-profit health sector will be needed more than ever. We partner with a number of nonprofit organizations dedicated to serving older persons such as the Alzheimer's Association and other groups addressing specific conditions and population, homes and services for the aging, and other voluntary service organizations,

It is the tradition and commitment of the nonprofit service sector to provide and adapt services as community needs change. With the growing numbers of older and frail person, our health and aging service organizations will be increasingly involved in chronic care, senior housing, home and community based services, and programs for serving persons with dementia.

These are needs that the market alone is unlikely to address adequately. We believe that our country will need a robust not-for-profit service sector with health and human service providers who will adapt to changing needs over time, find creative solutions to emerging problems, and be advocates on behalf of older persons and other vulnerable populations who cannot speak for themselves.

Question 3: It is my understanding that nonprofit hospitals are required to participate in Medicare as a condition of training tax exempt status. However, from year to year, nonprofit hospitals experience shortfalls in Medicare reimbursements as well as Medicaid reimbursement. In West Virginia, the underpayments by state and federal governments for treating Medicaid patients cost hospitals an additional $100 million annually.

My question, Sister Keehan and Mr. Lofton, is why shouldn't shortfalls in Medicare and Medicaid reimbursement-assuming they can be accurately calculated-be included in a nonprofit hospital's community benefit calculation?

CHA's community benefit guidelines and standard definitions identify Medicaid shortfalls but not Medicare shortfalls as community benefit.

Medicaid: As a poverty program, Medicaid is designed to help meet the health needs of lowest income persons in our communities. Nearly every provider participating in the Medicaid program does so knowing that program reimbursement is unlikely to cover costs. In some cases, such as cancer treatment, the program leaves significant deficits for health care providers. Participation in Medicaid is most certainly community benefit, and shortfalls should be counted as such.

Medicare: By contrast, Medicare was originally designed to fairly reimburse efficient providers. Participation in Medicare does not distinguish not-for-profit hospitals, and when a loss is experienced it may be viewed more as the cost of doing business than community benefit. Therefore, we recommend that Medicare shortfall not be counted as community benefit.

At the same time, we realize that many efficient hospitals continually experience Medicare shortfalls. This is especially true for hospitals that: 1) offer services that are under-reimbursed by Medicare, 2) serve patients whose costs of care are not adequately recognized by the Medicare payment system and/or 3) are in areas of the country where the wage adjustment is inadequate.

For these hospitals, we recommend reporting and explaining the financial loss of the Medicare shortfall, but not calling that loss community benefit. We also strongly recommend that the Senate Finance Committee look into the issue of inadequate Medicare funding for hospitals and other providers.

Questions from Senator Bingaman:

Over the past several years, attention on the issue of how hospitals handle charitable care and community benefits has clearly had a positive impact, as hospitals across this country have revised their policies and made those very policies more transparent to the public.

This hearing was rightly focused largely on issues around "charitable care" and "community benefits" and the "tax-exempt status" of certain hospitals in the country.

I would like to bring to the table another issue that is of importance to my state and those of the Chairman and Ranking Member and that has to do with the Medicaid and Medicare disproportionate share hospital (DSH) programs. These programs are also under the jurisdiction of the SFC, and I think that we should also think carefully about the billions of dollars spent on those programs and the impact they have on charitable care and community benefit.

First, due to historical nature of the DSH program, there are profound differences in the amount of federal Medicaid DSH dollars that go to provide assistance to hospitals that care for

a disproportionate share of low-income Medicaid and uninsured patients based on state boundaries. States such as New Mexico, Iowa, Montana, Arkansas, Oregon, ND, Idaho, UT, and Wyoming receive less than an estimated $82 per uninsured individual in DSH funding compared to over $650 per uninsured individual in NH, LA, RI, ME and MO. In other words, federal Medicaid DSH dollars are flowing to certain states to help hospitals deal with the uninsured at more than eight times the level than nine states represented on the SFC.

For the information of Mr. Hartz, Virginia also receives less than $100 per uninsured individual form the federal Medicaid DSH program.

What should the SFC do to improve the fairness within the Medicaid DSH program and the equity in funding that goes to help hospitals address uncompensated care in their communities and states?

Medicaid disproportionate share hospital (DSH) payments are vital to institutions—including those in our membership—that are committed to the care of all patients regardless of their ability to pay. Catholic hospitals have a long and distinguished history of service to the poor. Our institutions provide essential health care services to millions of Medicaid and uninsured patients every year.

Since 1981, Medicaid DSH payments have recognized the unique circumstances of hospitals serving a 'disproportionate number' of low-income patients—both Medicaid and uninsured patients. Payment rates have been adjusted to help these institutions remain financially viable and ensure access for vulnerable populations. As you know, legislative changes since 1997 have imposed caps on the amount of DSH payments to an individual hospital and on the total amount of federal matching funds available for DSH payments (the state DSH allocation).

As a result, the distribution of federal DSH dollars varies greatly across the states, essentially reflecting the size of a state's DSH program in 1991. These 15-year old circumstances are not, in our view, a sound basis for the allocation of federal DSH funds. CHA supports a change in federal policy to increase the allotment that states receive under the DSH program that reflect recognition of the growing number of uninsured patients as well as the unreimbursed costs of care provided to Medicaid beneficiaries.

All hospitals—such as those in our membership with significant uncompensated care—should be fairly compensated under a federal DSH policy regardless of their location or form of organization.

Should DSH funds follow the uninsured patient so that hospitals are not what some might call "double-dipping," by both collecting DSH funding and then billing the uninsured patient separately?

CHA has comprehensive guidelines for reporting uncompensated care that would not permit hospitals to claim uncompensated care costs for patients from whom they are able to collect payment. The majority of Catholic hospitals have discount and charity care policies that provide free care for patients with income and resources up to 200 percent of the Federal Poverty Level and discounted care for patients with higher incomes. Based on our survey, since the majority of our hospitals do not require patients below 200 percent of FPL to pay for the cost of their care, the possibility of "double-dipping" is unlikely. Unfortunately, it is not possible for the Medicaid DSH program to absorb or pay for all of the costs of serving the 46 million uninsured in our country, so DSH is unable to reimburse for the full cost of treating the uninsured. We believe it is time for

Congress to address the growing number of uninsured and work to ensure everyone in our country has access to affordable health care coverage.

On a related matter, the Medicare DSH program has a formula that has the paradoxical effect of, while intended to target money to safety net and charitable hospitals, of actually reducing funding to hospitals as they provide more and more uncompensated care. The formula is flawed in that uncompensated care is not reflected in the numerator but only in the denominator. Thus, for every increase in uncompensated care at the hospital, the formula has the perverse effect of actually reducing Medicare DSH dollars to that hospital.

"The DSH payment formula rewards hospitals that treat poor patients who have health insurance but penalizes hospitals for treating patients who do not have health insurance," says Sean Nicholson at AEI in a report entitled *Medicare Hospital Subsidies.* "Ironically, the structure of the DSH payment formulas may . . . reduce the supply of hospital care to the (low-income) uninsured, the group that arguably faces the greatest barriers to medical care." Mr. Samuelson estimated that, in addition to losing revenue through uncompensated care on uninsured patients, hospitals lose an additional $171 per uninsured admission, on average, due to reductions in Medicare DSH payments.

In recognition of this problem, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations in the past regarding revising the Medicare DSH formula, including:

- **The low-income share measure should reflect the cost of services provided to low-income patients in both inpatient and outpatient settings. This, of course, would help rural hospitals greatly, as they provide a larger volume of their care is such settings.**

- **In addition to Medicare SSI and Medicaid patients, the low-income share measure should include uninsured and underinsured patients represented by uncompensated care and also other patients sponsored by other state and local indigent care programs. This would help eliminate disparities in Medicare a DSH payments caused by differences in Medicaid eligibility rules across states.**

- **Medicare DSH should be concentrated among hospitals with the highest shares of low-income patients. A minimum threshold should be established below which a hospital receives no DSH payment but there should be no "notch" that would provide substantially different payments to hospitals just above and below the minimum threshold.**

Mr. Nicholson argued that the MedPAC proposals "correct most of the problems with the structure of the DSH program. The more inclusive measure of care provided to the poor would direct more DSH funds to hospitals that provide a substantial amount of uncompensated care but have a relatively low volume of Medicaid and Medicare/SSI patients. . . . The proposed index would also eliminate the perverse incentive that currently exists of penalizing hospitals that increase the number of uninsured patients they treat. Under the recommended formula, admitting more uninsured patients would increase rather than decrease DSH payments."

As such, when the federal government is investigating the issue of charitable care and community benefit provided by hospitals, should the federal government also reassess a

funding formula in the Medicare program that actually has the perverse incentive of penalizing hospitals for caring for uninsured and underinsured patients?

The failure of the Medicare DSH policy to fully take into account the value of services rendered to patients who are unable to pay for their care is a long-standing inequity for the hospitals bearing this burden. As Senator Bingaman points out in this question, it is not just that the hospitals bearing these uncompensated care costs do not receive an increase in their Medicare DSH payment. Because of flaws in the funding formula, the hospital's DSH payments actually are reduced. Similar to our comments on Medicaid DSH, the Medicare program must recognize the costs of the growing number of underinsured and uninsured patients.

We hope that Congress will address the Medicare DSH formula issue, and urge that any changes in Medicare policy is focused on offsetting the charity care obligations that hospitals currently incur.

In addition, what do the witnesses think about the recommendations made by MedPAC in 1998, 1999, and 2001 and summarized in the bullets above to revise the Medicare DSH formula and do they agree with Mr. Nicholson that they would improve the Medicare DSH formula?

CHA shares MedPAC's goal of improving Medicare DSH payments. While there is not at this time broad agreement on the design of a new Medicare DSH formula, including the MedPAC recommendations referenced above, we believe this issue must be addressed. Given Medicare's very significant role in financing care in private hospitals, any change in the DSH formula must not impede hospitals' ability to continue to provide care to those without insurance or the means to pay for their care.

As recommended by MedPAC, we believe that the cost of services provided to low-income patients in both inpatient and outpatient settings should be considered. Large numbers of low-income patients are served in outpatient settings, and these costs should not be ignored. Additionally, we believe that all hospitals providing uncompensated care above a minimal level should continue to be eligible to receive Medicare DSH payments, and not be cut off by an arbitrary threshold.

In summary, it is essential that any modification to the Medicare DSH formula take into account the financial vulnerability of all hospitals caring for low income and uninsured patients. In our view, this calls for recognizing the critical role that is played by the nation's private, nonprofit hospitals as safety net providers. DSH payments should be based on an accurate measure of a hospital's costs to serve uninsured and low-income patients, as well as the scope of services provided to those patients. CHA looks forward to working with the Finance Committee and MedPAC to ensure equitable hospital payments under the Medicare DSH program.

And finally, to what extent should DSH funds be targeted on core safety net providers that are financially vulnerable?

As we have stated above, hospitals that are bearing significant costs for serving low-income Medicare, Medicaid and uninsured patients are in our view financially vulnerable. We believe it is essential to consider the entire financial commitment of hospitals that provide access to vital health services to their communities. We believe this means recognizing the critical role that is played by the nation's private, nonprofit hospitals as safety net providers. Again, DSH funds should be based on an accurate measure of a hospital's uninsured and low-income patients as well as the scope of services provided to those patients.

We appreciate the opportunity to provide these responses to your questions, and I will be happy to provide any further information should you require it.

Sincerely,

Sr. Carol Keehan, DC
President and CEO

cc: Senator Rick Santorum
Senator Jay Rockefeller
Senator Jeff Bingaman

Statement of Senator John Kerry (D-MA)
Finance Committee Hearing
"Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals"
September 13, 2006

Mr. Chairman, I am concerned as much about what's not on the agenda for today's hearing as what is on it. The number of uninsured Americans continues to grow. It's now up to 46.6 million. Yet, there's no mention today of what Congress in general and this Committee, in particular, should be doing to address this growing crisis.

Instead, we are here today to talk about nonprofit hospitals and whether they are meeting their obligations as tax-exempt institutions. I am aware that some hospitals have been criticized for aggressive billing and collection practices and this issue should be addressed. However, I understand that hospitals have taken and acted on pledges to reform those practices. I hope hospitals implement these pledges and that their actions sufficiently address the issue.

Nonprofit hospitals in my state provide services that we find nowhere else in our communities. In addition to charity care and financial assistance, they offer a wide range of community benefit programs that respond to their needs of their communities. One hospital in my state that does so is Morton Hospital and Medical Center in Taunton, MA. They have a primary health center focused squarely on treating uninsured adults. By implementing preventive care, they are providing an effective alternative to expensive emergency care. Morton Hospital is an excellent example of non-profit hospitals fulfilling the mission to care for those who do not have the ability to pay. I am opposed to rushing to judgment on this issue. If this Committee decides that legislation is needed, any proposal to change the community benefit standard needs to be thoroughly vetted by the committee. Nonprofit hospitals are too important to our communities to act quickly on legislation that would have a major impact on our health system.

I believe that this Committee should do everything possible to provide insurance to the uninsured, especially the 8.3 million uninsured children in our country should have health coverage. Period. Through my Kids First legislation, we can provide comprehensive insurance coverage to our most vulnerable population, our children. It's a travesty that any child is uninsured in a country where we spend $1.7 trillion per year on our healthcare system. Let's role up our sleeves and do the real work our country needs and insure Americans.

HEARING BEFORE THE
SENATE FINANCE COMMITTEE
(September 13, 2006)

COMMENTS OF PHILL KLINE, ATTORNEY GENERAL OF THE STATE OF KANSAS

ON THE STATUS OF HIS OFFICE'S INTERACTION WITH THE HEALTH CARE INDUSTRY IN KANSAS

Chairman Grassley and members of the committee:

Good morning. My name is Phill Kline and I have the honor of serving as the Attorney General for the state of Kansas. I am honored to appear before this committee and thank you for the opportunity to discuss my review of the processes and policies relating to the billing and collections of the under and uninsured persons who obtain services from the non-profit health care delivery system in Kansas.

On the day that I was sworn in to office, a little less than four years ago, I was greeted with a lawsuit filed by a $1 billion tax-exempt, integrated healthcare delivery system serving Kansas and Missouri. That lawsuit sought to deny the Kansas Attorney General's office, and thereby the people of Kansas, of the authority to regulate Health Midwest's conversion of non-profit to for-profit status.[1]

We won that lawsuit. As a result the good citizens of Kansas now enjoy a brand new $110 million foundation that is currently providing grants assisting the medically indigent in Eastern Kansas. This timely litigation drove home the very important point that non-profit hospitals have -- no matter how successful they become or the median income of their communities -- a duty and social mandate to fulfill through charity care programs. In fact, it is the unique partnership that government exercises with non-profits and fidelity to their stated mission that serves as the

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[1]For a more detailed description of the litigation, see Kline, Stephan, Holbrook, "*Protecting Charitable Assets in Hospital Conversions: An Important Role for the Attorney General*," 13 SPG Kan.J.L. &Pub. Pol'y 351 (2004).

foundation for the authority of my office to review such matters and that gives rise to the common law Cy Pres authority of the office of Attorney General. Before moving on to my review of our state's non-profit treatment of the medically indigent, I would like to review briefly one issue that arose in the Health Midwest conversion – excessive executive compensation.

In the Health Midwest conversion, the CEO of the non-profit hospital negotiated himself a $7 million "Golden Parachute." This remuneration package strikes me and my predecessor as unconscionable. It was unfortunate that the Kansas court concluded that it lacked jurisdiction to address our challenge to that Golden Parachute. The sale of that not- for-profit hospital to a for-profit corporation was consummated with the CEO receiving his $7 million benefit. The case was a great victory for Kansas except as to that sticking point.

As the Committee is aware, recent studies have revealed health care costs to be a major cause of personal bankruptcies and family indebtedness across the country. As our population ages, the health care delivery system will play an even greater role in our economy. Kansas law affords the Attorney General Cy Pres authority and responsibility to ensure that charitable assets are utilized for their intended purposes. For the aforementioned reasons I established a Task Force dedicated to inquiring into the billing, charity care and collection practices of non-profit hospitals in Kansas. This action was also taken due to various complaints received by my office regarding such practices. I launched this Task Force with the goal of initiating a cooperative review of current practices and procedures and as an effort to avoid media sensation or litigation threats.

I have found that in almost all instances, those engaged in charitable health care have a strong dedication to the needs of those they serve and operate in a professional and appropriate manner. There are exceptions and as in all human endeavors, institutions sometimes develop practices and procedures that do not reflect their initial mission or the heart of those involved. It was my hope that in my approach I would avoid tarnishing an industry while identifying the obstacles and procedures to the fulfillment of the mission of non-profit health care systems. This is what we are now very close to achieving.

Our discussions were initiated and at one point in the process it was necessary to selectively auditing the largest non-profit hospitals in the state to afford me a better understanding of how billing and debt collection practices impact the uninsured and the under insured of Kansas.

Former Attorney General Robert T. Stephan is serving my office as a Special Assistant Attorney General and has been deeply involved in this process from the very beginning. He heads up the Task Force addressing the issue of non-profit hospital billing and collection practices. My office was fortunate to also have the cooperation of the Kansas Hospital Association. Former General Stephen worked with the KHA to conduct a survey of its entire membership. The results of that survey convinced me that a more formal methodology was necessary to fully investigate the processes and procedures being used by the non-profit hospitals of Kansas.

On April 25, 2006, my Consumer Protection Division served investigative subpoenas upon nine non-profit hospitals. I have included a copy of the subpoena that was delivered to this subset of Kansas hospitals in the materials filed with this Committee. This subpoena was designed to afford our Task Force a better understanding of how billing, charity care, and debt collection practices are managed at some of the larger non-profit hospitals in Kansas.

The immediate response to the subpoenas was a large gathering of hospital representatives in Overland Park, Kansas. These representatives of the nine subpoenaed hospitals were brought together through the leadership of the Kansas Hospital Association.

This proved to be only the first in a series of meetings that the subpoenas engendered. In the initial meetings my Task Force and representatives of the targeted hospitals discussed the sensitive nature of the information to be reviewed. Both privacy laws and the protection of pricing structures had to be agreed upon before the hospitals could respond to the formal inquiry. We have had numerous subsequent, individual meetings with representatives of the KHA and the hospitals. These discussions culminated in a Memorandum of Understanding which is included among the documents I have filed with the Committee this day.

Each of the nine hospitals that entered into the Memorandum of Understanding tendered a notebook of information responsive to the subpoena. This information was compiled into a database and processed on a spread sheet, allowing my Task Force the ability to efficiently compare data from each hospital against data from all hospitals. The analysis of this comparative data has proved quite useful in discussions with the individual hospitals.

Three of the subpoenaed hospitals voluntarily appeared, with their Chief Financial Officer, to discuss the subpoena responses and answer questions generated by the comparison of data. My Task

Force learned a great deal about the billing, charity care, and collection practices of representative Kansas hospitals during these productive meetings.

This eventual cooperative approach by the Kansas health care industry was not unforeseen. My office has generally received few complaints regarding non-profit hospitals when considering the nature of the services provided and the scope of this industry. I suspected that this was true because such hospitals in Kansas operate with a high degree of integrity and dedication to their core mission. This is the case. We have together, however, identified some practices, policies and procedures that should be utilized by all non-profit health care delivery systems in Kansas. We are formulating these changes, and in some instances current practices, into another agreement relating establishing a best practices model.

The "best practices" model formulated with the Kansas Hospital Association toward the goal of ensuring that all non-profit hospitals in Kansas treat the indigent and under insured in a manner consistent with their charitable mission while not forfeiting their ability to deliver services to the general population. This model strives to set a new, higher standard of care among Kansas hospitals when it comes to billing, charity care and collection practices. This model addresses issues such as excessive billing, consumer education, financial support, visitation and designation issues and services to the indigent and a prohibition on certain collection practices.

It is anticipated that this model will be promoted by both the Attorney General's Task Force and the Kansas Hospitals Association and will, due to its collaborative authorship, result in substantive improvements in a health care delivery system that is already functioning at a level better than the national average. I commend this collaborative and investigative model to any of my peers interested in a similar result. I have included in the attachments to this testimony a print out of the PowerPoint presentation demonstrating the evolution of this model as well as a copy of the current iteration of this model. The model included is nearly final. It has been approved by Former General Stephen and my Task Force. I have not yet given final approval and counsel for the Kansas Hospital Association has yet to review the document. It is very close to being approved, and a final, approved copy should be available by this time next month.

I want to thank the Committee for allowing me to present the fine work that my Task Force and the KHA has accomplished while addressing this important topic.

STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION AND ANTITRUST DIVISION

PHILL KLINE
ATTORNEY GENERAL

120 SW 10TH AVE., 2ND FLOOR
TOPEKA, KS 66612-1597
(785) 296-3751 • FAX (785) 291-3699
CONSUMER HOTLINE (800) 432-2310
WWW.KSAG.ORG

March 13, 2006

[redacted]

RE: Charity Care of Non-Profit Hospitals in Kansas

Dear [redacted]:

The undersigned are, pursuant to the directives of Attorney General Phill Kline, establishing a task force dedicated to inquiring into the billing, "charity care" and collection practices of non-profit hospitals in the State of Kansas. The immediate goal of this task force is to selectively audit the largest non-profit hospitals in the state and thus better understand how billing and debt collection practices impact the uninsured and the under insured of Kansas.

According to K.S.A. 50-629, the Attorney General has the authority and responsibility to make inquiry into economic patterns and practices that visit negative consequences upon Kansas consumers. Recent studies reveal health care costs to be a major cause of personal bankruptcies and family indebtedness. Complaints filed with the Consumer Protection Division of the Office of Attorney General reveal debt collection issues to be one of the fastest growing areas of concern among Kansas consumers. Both national debate and the complaints of Kansas residents thus well recommend an inquiry into the genesis of medical debt, "charity care" systems and medical debt collection practices among the non-profit hospitals of Kansas.

The Office of Attorney General has previously worked with the Kansas Hospital Association (KHA) toward the goal of surveying the KHA's 121 non-profit members. The survey was helpful and the role that the KHA played in that survey was greatly appreciated.

The facts gathered in the informal KHA survey have recommended a more formal process. The enclosed subpoena has been delivered to a subset of Kansas' 122 non-profit hospitals to afford our task force a better understanding of how billing, "charity care" and debt collection practices are managed at some of the larger non-profit hospitals of Kansas. The responses to the enclosed will also serve as an audit of those same processes.

While this inquiry is mandatory by operation of K.S.A. 50-631, we invite [redacted] to seize this imitative as an opportunity to willingly work with the Office of

Attorney General toward the goal of defining the best practices that should be utilized in Kansas regarding medical billing, "charity care" and debt collection. It is the hope of our task force that our audit and inquiry accrues to the benefit of both those with medical debt and those seeking remuneration for services rendered.

Sincerely,

OFFICE OF THE ATTORNEY GENERAL
PHILL KLINE

Bryan J. Brown
Deputy Attorney General

ATTORNEY GENERAL OF THE STATE OF KANSAS
CONSUMER PROTECTION DIVISION

In the Matter of Medical Costs &	)
Collection Practices in Regard to	)
the Uninsured & Underinsured	)
	)

SUBPOENA DUCES TECUM

TO: [redacted]

Pursuant to K.S.A. 50-631 and KSA 50-629, you are hereby DIRECTED to FORTHWITH furnish and identify to the undersigned, a duly appointed, qualified and acting Deputy Attorney General of the State of Kansas, Consumer Protection/Antitrust Division, 120 S.W. 10th Avenue, 2nd Floor, Topeka, Kansas, 66612-1597, the subject matter and evidence requested. You are to identify each answer and/or document by corresponding question number.

DEFINITIONS

As used in these Interrogatories, the following terms have the meanings described below:

1. "Hospital" shall refer to [redacted] and when used in either format shall mean all of the hospitals, clinics, divisions, and subdivisions, including any merged or acquitted predecessors, successors, subsidiaries, affiliates or other organizations in which [redacted] has a managing or controlling interest.

2. "Identify" when referring to a *person* shall be deemed a request to include the full legal name, title, position or relationship to the business and telephone number where that person can be reached during normal business hours, in addition to a home address.

3. "Identify" when referring to any *non-person entity*, shall be deemed a request to include the full legal name of the entity, a description of the type of entity (i.e., whether a partnership, corporation, L.L.C, etc.), a complete and current address, and a telephone number that may be used to contact a representative of the entity. A telephone number that is answered by an electronic, digital or other artificial voice, or does not permit direct access to a live person, is not a sufficient response.

4. "Identify" when referring to a *document* shall be deemed a request for a true and accurate copy of the document itself, and a request to identify the custodian of the document.

5. "Tender" shall mean to produce a copy in written or electronic format.

6. "Document" shall be deemed to include any means of storing, displaying or recording the subject matter being sought in the request, whether such subject matter is on paper, or in any other format, to include, but not be limited to, digital, magnetic or electronic formats.

7. "Relating to" or "regarding" shall mean referring, discussing, referencing, concerning or pertaining in any way, directly or indirectly.

8. "Agreement" or "contract" shall mean any oral or written contract, arrangement or understanding, whether formal or informal, between or among two or more persons, together with all modifications or amendments thereto.

9. "Charity Care" shall mean the programs and policies affording

discounted medical care to the uninsured and/or underinsured as defined against the backdrop of Section I of Schedule C, Form 1023, of IRS Code 501(C)(3).

General Interrogatories and Requests for Production

1. Identify the individual providing answers and/or documents in response to the following: including name, title or position held, address and telephone number.

2. Provide the full legal name of the hospital and the address and telephone number of the principle place of business.

3. What is [redacted] mission statement?

4. Tender a corporate organizational chart documenting all of [redacted] entities, divisions and subdivisions as of December 31, 2005.

5. Tender a corporate organizational chart documenting all of [redacted] entities, divisions and subdivisions on January 1, 2003.

6a. Who was on the [redacted] Board of Directors in 2005?
6b. Who was on the [redacted] Board of Directors in 2004?
6c. Who was on the [redacted] Board of Directors in 2003?

7a. On what dates did the Board of Directors meet in 2005?
7b. On what dates did the Board of Directors meet in 2004?
7c. On what dates did the Board of Directors meet in 2003?

8a. What was [redacted] total revenue for 2005.
8b. What was [redacted] total revenue for 2004.
8c. What was [redacted] total revenue for 2003.
8d. What is [redacted] total revenue projected for 2006?

9a. What was [redacted] net income for 2005.
9b. What was [redacted] net income for 2004.
9c. What was [redacted] net income for 2003.
9d. What is [redacted] net income projected for 2006?

10a. List the top ten (as to dollars processed on behalf of [redacted] patients) insurance programs with which [redacted] contracted in 2005.

10b. List the top ten (as to dollars processed on behalf of [redacted] patients) insurance programs with which [redacted] contracted in 2004.

10c. List the top ten (as to dollars processed on behalf of [redacted] patients) insurance programs with which [redacted] contracted in 2003.

11a. List the top ten (as to gross revenue) insurance companies with which [redacted] contracted in 2005.

11b. List the top ten (as to gross revenue) insurance companies with which [redacted] contracted in 2004.

11c. List the top ten (as to gross revenue) insurance companies with which [redacted] contracted in 2003.

General Cost Interrogatories and Requests for Production

12. List the top 25 CPT codes that [redacted] billed in 2005.

13. What is [redacted] standard charge for:
    a. a semi-private room.
    b. a private room.

14. What is [redacted] standard surgical center charge per hour for:
    a. an appendectomy.
    b. a c-section.
    c. hip replacement surgery.
    d. gall bladder surgery.
    e. heart bypass surgery.

Charity Care Interrogatories and Requests for Production

15. Define and describe [redacted] Charity Care program.

16. In which Board meeting minutes since January 1, 2003 is found record of the Board addressing [redacted] Charity Care program?

17. Attach any and all documents tendered to the Internal Review Service since January 1, 2003 describing [redacted] Charity Care program.

18a. How did [redacted] publish and/or promote its Charity Care policy in 2005?
18b. How did [redacted] publish and/or promote its Charity Care policy in 2004?
18c. How did [redacted] publish and/or promote its Charity Care policy in 2003?

19a. How many accounts were paid-in-full in 2005 under [redacted] Charity Care program?
19b. How many accounts were paid-in-full in 2004 under [redacted] Charity Care program?
19c. How many accounts were paid-in-full in 2003 under [redacted] Charity Care program?

20a. How many accounts were paid-in-part in 2005 under [redacted] Charity Care program?
20b. How many accounts were paid-in-part in 2004 under [redacted] Charity Care program?
20c. How many accounts were paid-in-part in 2003 under [redacted] Charity Care program?

21a. How much in revenue was "charged off" in 2005 under [redacted] Charity Care program?
21b. How much in revenue was "charged off" in 2004 under [redacted] Charity Care program?
21c. How much in revenue was "charged off" in 2003 under [redacted] Charity Care program?

22a. What policies and/or procedures did [redacted] utilize in 2005 to identify the amount of benefit that qualifying patients could receive through [redacted] Charity Care program?
22b. What policies and/or procedures did [redacted] utilize in 2004 to identify the amount of benefit that qualifying patients could receive through [redacted] Charity Care program?
22c. What policies and/or procedures did [redacted] utilize in 2003 to identify the amount of benefit that qualifying patients could receive through [redacted] Charity Care program?

23a. Provide copies of all reports provided to [redacted] Board of Directors regarding the operation of the Charity Care program in 2005.

23b. Provide copies of all reports provided to [redacted] Board of Directors regarding the operation of the Charity Care program in 2004.

23c. Provide copies of all reports provided to [redacted] Board of Directors regarding the operation of the Charity Care program in 2003.

24a. What policies and/or procedures did [redacted] utilize in 2005 to identify the amount of patients who qualified for Charity Care benefits any qualifying patient was to receive?

24b. What policies and/or procedures did [redacted] utilize in 2004 to identify the amount of patients who qualified for Charity Care benefits any qualifying patient was to receive?

24c. What policies and/or procedures did [redacted] utilize in 2003 to identify the amount of patients who qualified for Charity Care benefits any qualifying patient was to receive?

25a. What documents, resources and/or programs did [redacted] utilize to train those who assessed patients for the Charity Care program in 2005?

25b. What documents, resources and/or programs did [redacted] utilize to train those who assessed patients for the Charity Care program in 2004?

25c. What documents, resources and/or programs did [redacted] utilize to train those who assessed patients for the Charity Care program in 2003?

26a. Provide the application and documents that a patient seeking Charity Care from [redacted] had to fill out and was expected to read in 2005.

26b. Provide the application and documents that a patient seeking Charity Care from [redacted] had to fill out and was expected to read in 2004.

26c. Provide the application and documents that a patient seeking Charity Care from [redacted] had to fill out and was expected to read in 2003.

27a. What did [redacted] report to the IRS in 2005 in response to the IRS's requirement that Charity Care policies actually yield significant health care services to the indigent?

27b. What did [redacted] report to the IRS in 2004 in response to the IRS's requirement that Charity Care policies actually yield significant health care services to the indigent?

27c. What did [redacted] report to the IRS in 2003 in response to the IRS's requirement that Charity Care policies actually yield significant health care services to the indigent?

28a. What amount of Charity Care did [redacted] report to governmental authorities in 2005?

28b. What amount of Charity Care did [redacted] report to governmental authorities in 2004?

28c. What amount of Charity Care did [redacted] report to governmental authorities in 2003?

Debt Collection Interrogatories and Requests for Production

29a. What policies and/or procedures did [redacted] have in place in 2005 governing the placing of accounts with debt collection agencies and/or non-staff attorneys who are not directly employed by [redacted]?

29b. What policies and/or procedures did [redacted] have in place in 2004 governing the placing of accounts with debt collection agencies and/or non-staff attorneys who are not directly employed by [redacted]?

29c. What policies and/or procedures did [redacted] have in place in 2003 governing the placing of accounts with debt collection agencies and/or non-staff attorneys who are not directly employed by [redacted]?

30a. List all [redacted] employees charged with managing the outsourcing of accounts to debt collection agencies and/or non-staff attorneys in 2005.

30b. List all [redacted] employees charged with managing the outsourcing of accounts to debt collection agencies and/or non staff attorneys in 2004.

30c. List all [redacted] employees charged with managing the outsourcing of accounts to debt collection agencies and/or non staff attorneys in 2003.

31a. Tender the written policy that [redacted] had in place in 2005 regarding the filing of debt collecting litigation against patients of [redacted].

31b. Tender the written policy that [redacted] had in place in 2004 regarding the filing of debt collecting litigation against patients of [redacted].

31c. Tender the written policy that [redacted] had in place in 2003 regarding the filing of debt collecting litigation against patients of [redacted]

32a. Who at [redacted] was authorized to make the decision to file debt collecting litigation against patients of [redacted] in 2005?

32b. Who at [redacted] was authorized to make the decision to file debt collecting litigation against patients of [redacted] in 2004?

32c. Who at [redacted] was authorized to make the decision to file debt collecting litigation against patients of [redacted] Center in 2003?

33a. Tender any and all written contracts or agreements addressing debt collection that [redacted] entered into with debt collection agencies and/or non-staff attorneys in 2005.

33b. Tender any and all written contracts or agreements addressing debt collection that [redacted] entered into with debt collection agencies and/or non-staff attorneys in 2004.

33c. Tender any and all written contracts or agreements addressing debt collection that [redacted] entered into with debt collection agencies and/or non-staff attorneys in 2003.

34a. Tender any and all written reports or accountings addressing debt collection that were tendered to [redacted] by debt collection agencies and/or non-staff attorneys in 2005.

34b. Tender any and all written reports or accountings addressing debt collection that were tendered to [redacted] by debt collection agencies and/or non-staff attorneys in 2004.

34c. Tender any and all written reports or accountings addressing debt collection that were tendered to [redacted] by debt collection agencies and/or non-staff attorneys in 2003.

35a. List all of the debt collection agencies and/or non-staff attorneys who were authorized to collect on more than $1000 in patient debt by [redacted] in 2005.

35b. List all of the debt collection agencies and/or non-staff attorneys who were authorized to collect on more than $1000 in patient debt by [redacted] in 2004.

35c. List all of the debt collection agencies and/or non-staff attorneys who were authorized to collect on more than $1000 in patient debt by [redacted] in 2003.

36a. For each debt collection agency listed above for year 2005, reveal the amount of the monies collected by each entity on behalf of [redacted]

36b. For each debt collection agency listed above for year 2004, reveal the amount of the monies collected by each entity on behalf of [redacted]

36c. For each debt collection agency listed above for year 2003, reveal the amount of the monies collected by each entity on behalf of [redacted]

37a. What is the total number of accounts turned over to debt collection agencies and/or non-staff attorneys in 2005?

37b. What is the total number of accounts turned over to debt collection agencies and/or non-staff attorneys in 2004?

37c. What is the total number of accounts turned over to debt collection agencies and/or non-staff attorneys in 2003?

38a. What is the total amount of billing, excluding any collection fees, that [redacted] sought to have collected by debt collection agencies and/or non-staff attorneys in 2005?

38b. What is the total amount of billing, excluding any collection fees, that [redacted] sought to have collected by debt collection agencies and/or non-staff attorneys in 2004?

38c. What is the total amount of billing, excluding any collection fees, that [redacted] sought to have collected by debt collection agencies and/or non-staff attorneys in 2003?

39a. What is [redacted] internal procedure and/or policy for determining the debts that are referred to collections?

39b. How was this policy developed?

39c. What internal oversights are employed to ensure compliance with this policy?

40a. What is the total amount of money that [redacted] actually realized as a result of the efforts of debt collection agencies and/or non-staff attorneys in 2005?

40b. What is the total amount of money that [redacted] actually realized as a result of the efforts of debt collection agencies and/or non-staff attorneys in 2004?

40c. What is the total amount of money that [redacted] actually realized as a result of the efforts of debt collection agencies and/or non-staff attorneys in 2003?

41a. How much did [redacted] pay debt collection agencies and/or non-staff attorneys in 2005 for the debt collection efforts?

41b. How much did [redacted] pay debt collection agencies and/or non-staff attorneys in 2004 for the debt collection efforts?
41c. How much did [redacted] pay debt collection agencies and/or non-staff attorneys in 2003 for the debt collection efforts?

42a. List the defendants named in all debt collecting litigation filed by [redacted] in 2005.
42b. List the defendants named in all debt collecting litigation filed by [redacted] in 2004.
42c. List the defendants named in all debt collecting litigation filed by [redacted] in 2003.

43a. Identify, by amount per each account and the purchaser, any and all patient accounts or debt [redacted] sold or otherwise alienated in 2005.
43b. Identify, by amount per each account and the purchaser, any and all patient accounts or debt [redacted] sold or otherwise alienated in 2004.
43c. Identify, by amount per each account and the purchaser, any and all patient accounts or debt [redacted] sold or otherwise alienated in 2003.

44a. How much debt did [redacted] "write off" as uncollectible in 2005?
44b. How much debt did [redacted] "write off" as uncollectible in 2004?
44c. How much debt did [redacted] "write off" as uncollectible in 2003?

45a. How many written complaints did [redacted] receive regarding its debt collection efforts, either in-house or outsourced, in 2005?
45b. How many written complaints did [redacted] receive regarding its debt collection efforts, either in-house or outsourced, in 2004?
45c. How many written complaints did [redacted] receive regarding its debt collection efforts, either in-house or outsourced, in 2003?

46a. Tender any and all written policies that [redacted] had in 2005 regarding the discussion of patient accounts after the accounts had been outsourced for debt collection activity.
46b. Tender any and all written policies that [redacted] had in 2004 regarding the discussion of patient accounts after the accounts had been outsourced for debt collection activity.

46c. Tender any and all written policies that [redacted] had in 2003 regarding the discussion of patient accounts after the accounts had been outsourced for debt collection activity.

47a. Tender any and all internal or external audits of [redacted] debt collecting activity completed in 2005.
47b. Tender any and all internal or external audits of [redacted] debt collecting activity completed in 2004.
47c. Tender any and all internal or external audits of [redacted] debt collecting activity completed in 2003.

48a. Tender the policy that [redacted] had in place in 2005 addressing debt collection on accounts that were denied by an insurance carrier due to [redacted] untimely tendering of the necessary documents to the insurance provider.
48b. Tender the policy that [redacted] had in place in 2004 addressing debt collection on accounts that were denied by an insurance carrier due to [redacted] untimely tendering of the necessary documents to the insurance provider.
48c. Tender the policy that [redacted] had in place in 2003 addressing debt collection on accounts that were denied by an insurance carrier due to [redacted] untimely tendering of the necessary documents to the insurance provider.

49a. Tender the policy that [redacted] had in place in 2005 addressing debt collection on accounts that were denied by an insurance carrier due to patients untimely tendering of the necessary documents or information to the insurance provider.
49b. Tender the policy that [redacted] had in place in 2004 addressing debt collection on accounts that were denied by an insurance carrier due to patients untimely tendering of the necessary documents or information to the insurance provider.
49c. Tender the policy that [redacted] had in place in 2003 addressing debt collection on accounts that were denied by an insurance carrier due to patients untimely tendering of the necessary documents or information to the insurance provider.

Identify specifically the answer or documents by corresponding question number.

All requests to identify documents are intended to include documents for which a claim of privilege or confidentiality is asserted. As to any such document, please provide sufficient information so that the identity of the document can be determined for purposes

of in camera inspection and include a full statement of the factual and legal basis for the asserted privilege or confidentiality.

You are not to disclose the existence of this directive except to any attorney you may consult or retain to represent you. Any such disclosure could impede the investigation being conducted and thereby interfere with the enforcement of the law.

Any questions pertaining to the subpoena should be called to the attention of Natalie Hogan, Special Agent, Joseph N. Molina, Assistant Attorney General, or Bryan J. Brown, Deputy Attorney General, Consumer Protection/Antitrust Division, Office of the Attorney General, 120 S.W. 10th Avenue, 2nd Floor, Topeka, Kansas, 66612, (785) 296-3751.

FAILURE TO COMPLY with this subpoena within thirty (30) days may make you liable for such penalties as are provided by law.

WITNESS MY HAND at Topeka, Kansas, this 13th day of March, 2006.

Bryan J. Brown

Bryan J. Brown, #17634
Deputy Attorney General
Office of the Attorney General
120 SW 10th Avenue, 2nd Floor
Topeka, Kansas 66612-1597
(785) 296-3751

CERTIFICATE OF MAILING

I hereby certify that the above and foregoing document was sent by U.S. Mail, certified, return receipt requested, postage prepaid, on the 13TH day of March, 2006, addressed to:

[redacted]

Natalie Hogan

Natalie Hogan, Special Agent
Consumer Protection Division

ANDREW RAMIREZ
(913) 451-5113
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BUILDING 82, SUITE 1000
10851 MASTIN BOULEVARD
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(913) 451-5100, FAX (913) 451-0875

May 1, 2006

Hon. Robert T. Stephan, Special Assistant Attorney General
Bryan J. Brown, Deputy Attorney General
Consumer Protection Division
Office of the Attorney General
120 SW 10th Ave., 2nd Floor
Topeka, Kansas 66612-1597

Re: Subpoena Duces Tecum

Dear Attorneys General:

You met with us on April 17, 2006 to explore the possibility of a studied and collaborative approach to accomplish your stated objective of establishing best billing and collection practices (the "Policy") for all Kansas hospitals versus the adversarial and resource intensive course that is presented by the formal subpoena process. We appreciated your willingness to set aside the subpoena and sit down and discuss the best questions to ask our respective hospital clients to establish the Policy. The purpose of this letter is to outline our understanding of the process that we agreed to follow and to present to you our initial thoughts on providing you with the data necessary to achieve this goal.

In our meeting you suggested that we should tell you what is relevant and what is not. Responding to your leadership we met with a number of our hospitals' financial administrators and representatives of the Kansas Hospital Association ("KHA") on April 25, 2006 to get to the information that is readily available and relevant to a meaningful discussion of the stated goal. We have attached a Memorandum of Voluntary Production which sets forth the results of our clients' efforts to outline the materials which would be useful in developing the Policy.

You indicated in our meeting that the responses to the subpoena would be stayed until after Memorial Day, which we understood to mean May 30, 2006. You expected a good faith effort on the part of the hospitals to get meaningful data to you before then. The hospitals that received your subpoena will respond by voluntarily producing

information necessary to formulate the Policy pursuant to the terms of the attached Memorandum of Understanding. Given the disparity in the size of the facilities that received the subpoena some of the hospitals are more readily able to provide information than others. Some will produce information within the next two (2) weeks while others will need at least thirty (30) days to produce all of the information set forth in the Memorandum of Voluntary Production. We believe however that once you see the direction and scope of information/materials produced under this voluntary process you will be satisfied with the effort. We trust that if this effort is satisfactory you will withdraw the subpoena altogether.

We believe that the Kansas Hospital Association ("KHA") has a unique role in this effort. KHA will by separate letter explain the efforts that it will take on behalf of all of the one hundred twenty-one (121) not-for-profit community based member hospitals to immediately form a working group to develop the Policy. KHA will continue to work with its legal counsel, Reid Holbrook.

We have requested that Dick Hay act as the hospitals' personal contact with you to coordinate our efforts. We appreciate your thoughtful consideration of this matter.

Very truly yours,

By: [redacted]
Stephen Adams
BLACKWELL SANDERS PEPER MARTIN LLP
on behalf [redacted]

By: [redacted]
Murray E. Anderson
on behalf of [redacted]

By: [redacted]
Gary L. Ayers
FOULSTON SIEFKIN LLP
on behalf of [redacted]

By: [redacted]
Edward L. Barker
[redacted]
on behalf of [redacted]

By: [redacted]
Charles R. Hay
GOODELL, STRATTON, EDMONDS & PALMER, L.L.P.
on behalf of [redacted]

By: [redacted]
Gary E. Knight, Vice President of Legal Affairs and

General Counsel,
[redacted]on behalf of [redacted]

By:
David B. Pursell
SHUGHART, THOMSON & KILROY
on behalf of [redacted]

By:
Jeffrey O. Ellis
LATHROP & GAGE L.C.
on behalf of [redacted]

By:
Andrew R. Ramirez
LATHROP & GAGE L.C.
on behalf of [redacted]

By:
G. Mark Sappington
KUTAK ROCK LLP
on behalf of [redacted]

nb

cc: Tom Bell, Kansas Hospital Association
Reid F. Holbrook, Esq.

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding ("MOU") is made and entered into effective the day of May, 2006, by and among the Attorney General of the State of Kansas ("AG"), and the [redacted] (collectively referred to as the "Hospitals").

Recitals

WHEREAS, the AG has caused the issuance of subpoenas to the Hospitals; and

WHEREAS, the AG's stated main purpose in issuing the subpoenas to the Hospitals is to secure the data necessary to arrive at "the goal of defining the best practices that should be utilized in Kansas regarding medical billing, 'charity care' and debt collection" (the "Policy") before September 1, 2006; and

WHEREAS, the Hospitals believe that responding to the subpoenas would generate unnecessary work for the Hospitals and would not further the goal of establishing the Policy; and

WHEREAS, it is the desire of the Hospitals to provide the AG relevant information in an orderly and timely manner; and

WHEREAS, the AG has agreed to stay the subpoenas in order to allow the AG and the Hospitals to collaborate.

NOW, THEREFORE, in consideration of the mutual covenants and conditions herein contained, the parties hereby agree as follows:

Covenants

1. **Purpose.** The purpose of the MOU is set forth in the recitals, which are incorporated herein.

2. **Voluntary Production.** The Hospitals will disclose the information set forth in the Memorandum of Voluntary Production, dated May 12, 2006 within the times specified in that document. If necessary, the Hospitals will continue to collaborate with the AG in producing relevant information by agreed written addendum to the Memorandum of Voluntary Production.

3. **Staying the Subpoenas.** The AG does hereby stay the subpoenas issued to the Hospitals and reserves the right to lift said stay in the future if the data provided under the Memorandum of Voluntary Production is insufficient to meet the stated goal of establishing the Policy.

4. **Reservation of Rights.** The Hospitals reserve the right to challenge the subpoenas now or in the future.

5. **Use of Information, Confidentiality.** The AG agrees that the non-public information produced pursuant to the Memorandum of Voluntary Production will only be used for

the purposes stated herein. Certain information provided may be proprietary or confidential to the Hospitals and public disclosure thereof will not be made nor disseminated among the individual hospitals but will be maintained as confidential. Upon the AG's completion of the purposes stated here the voluntarily produced information will be returned to the attorney representing the individual hospital that provided the information to the AG, with no copies or generated reports remaining in the files of the AG. This memo shall remain in all files and be subject to disclosures made under the Kansas Open Records Act.

6. **Settlement.** The AG and Hospitals agree that the procedures implemented by this MOU shall be regarded as settlement negotiations. Any communication, written or verbal, relating to the subject matter of the MOU made during this process by any participant or any other person shall be regarded as confidential communication. No admission, representation, statement or other confidential communication made in implementing the MOU, not otherwise discoverable or obtainable, shall be admissible as evidence or subject to discovery in accordance with either K.S.A. 60-452a or Rule 408, Fed. R. Evid.

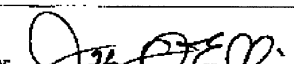
7. **Patient Privacy.** The AG and the Hospitals acknowledge an ongoing legal and ethical requirement to maintain the privacy rights of patients. No information will be provided to the AG in violation of patients privacy rights. If in the opinion of the a Hospital's counsel it becomes necessary to secure a Qualified Protective Order or secure such other authorizations required by law to facilitate the voluntary production of information the AG and the Hospitals will work together to secure a Qualified Protective Order or such other authorizations required by law.

Date:_____

ATTORNEY GENERAL OF THE STATE OF KANSAS

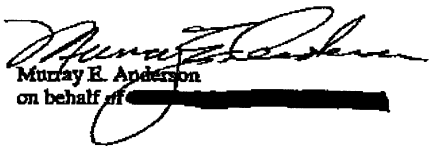
By:

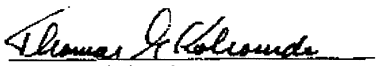
Deputy Attorney General Bryan J. Brown

By: 
Jeffrey O. Ellis
LATHROP & GAGE L.C.
on behalf of [redacted]

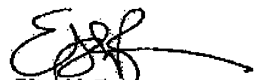
By: 
Andrew R. Ramirez
LATHROP & GAGE L.C.
on behalf of [redacted]

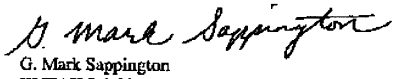
By: 
Gary L. Ayers
FOULSTON SIEFKIN LLP
on behalf [redacted]
and [redacted]

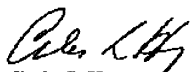
By: 
Murray R. Anderson
on behalf of [redacted]

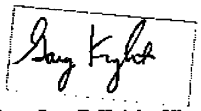
By: 
Thomas G. Kokoruda
SHUGHART THOMSON & KILROY
on behalf of [redacted]

By: 
David B. Pursell
SHUGHART, THOMSON & KILROY
on behalf of [redacted]

By: 
Edward L. Barker
[redacted]
on behalf of [redacted]

By: 
G. Mark Sappington
KUTAK ROCK LLP
on behalf of [redacted]

By: 
Charles R. Hay
GOODELL, STRATTON, EDMONDS & PALMER, L.L.P.
on behalf of [redacted]



By: Gary E. Knight, Vice President of Legal Affairs and General Counsel, [redacted] on behalf of [redacted] and [redacted]

MEMORANDUM OF VOLUNTARY PRODUCTION

TO: Kansas Attorney General

FROM: Counsel Defending AG Subpoena

DATE: May 12, 2006

On April 25, 2006, representatives from the Kansas Hospital Association and representatives from the hospitals and healthcare systems that received subpoenas issued pursuant to the Kansas Consumer Protection Act and their counsel met. They discussed the data to be produced to your office that would address the goals expressed by the Attorney General and lead to the development of best practices in patient billing and collection to be implemented in the state of Kansas. This memorandum is intended to identify the data to be provided to your office within 30 days of signing a Memorandum of Understanding to assist in this effort regarding:

(a) Use of the information;
(b) Protection of patient privacy;
(c) Confidentiality regarding not sharing the information with competitors.

I. Notebook with recent literature/materials re: billing and collection practices.

II. Subpoena topic: financial performance.

1. Net Operating Revenue of each hospital.

2. Each hospital's Mission Statement.

III. Subpoena topic: debt collection.

1. Each hospital will prepare a notebook containing a narrative of how debt collection took place in 2005 (and how it takes place today, if different) from date of service through collection or write off. Each hospital will supplement the narrative with supporting exhibits. The narrative or exhibits will include:

   a. Policies and written procedures regarding debt collection practices.

   b. Collection notifications, letters, payment agreements and other standard written collection communications.

   c. Contracts with collection agencies and with law firms performing collection services.

d. Payment plan information.

e. Charity care policy statement(s).

f. Amount of charges written off as bad debt.

g. Amount of charges attributable to charity care, not paid from any source, but not written off as bad debt.

h. Amount of charges discounted for self-pay patients (not received by hospital, not attributable to charity care, and not written off as bad debt) (e.g., self-pay discount, prompt pay discount).

i. Amount of unreimbursed costs from Medicare and Medicaid.

2. Number of patient admissions and out-patient visits in 2005. This same data is prepared and submitted each year to the KDHE.

3. Number of patients (or accounts) sent to collection in 2005; raw number; percentage.

4. Comparison between number of visits or number of patients and number of patients from whom collected, or number of accounts collected, in 2005.

5. Fees paid to third-parties to qualify patients for public assistance in 2005.

6. Number of patients (or dollars) who/that qualify for public assistance in 2005.

7. Number of patients (or dollars) who/that qualified for charity care in 2005.

IV. Litigation/Bankruptcy

In addition to the above, the Hospitals that have the existing capability to track and generate the information will provide data regarding patient bankruptcy. To the extent capable, these hospitals will also show a total number of accounts that have been written off due to bankruptcy being filed and a percentage of these claims that were $1,000 or under.

V. Insurance Reimbursement for Certain Procedures

A. The Hospitals will provide the following information for claims related to Diagnosis Related Group (DRG) Code number 391 (Normal Newborn), DRG 089 (Simple Pneumonia and Pleurisy) and DRG 127 (Heart Failure and Shock) for the

months of January and July 2005. The data may be provided in the standard UB-92 claim form and/or such other format as is available to the Hospitals under their respective coding and accounting systems:

1. the total charge related to the DRG for each patient account;

2. the total dollar amount that was reimbursed by any third party payor for each patient account;

3. the name of the third party payor to whom the amount in 2 above was submitted and reimbursed;

4. the amount that was the responsibility of each patient after reimbursement from third party payors; and

5. the status of each of those patient bills as of May 1, 2006.

B. Each Hospital will list the top ten (10) third party payors and the total amount of payments received by the top ten (10) third party payors for all claims in 2005.

Phill Kline
ATTORNEY GENERAL
120 S.W. 10TH AVE, 2ND FL
TOPEKA, KANSAS 66612-1597

DRAFT

Recommended Billing, Financial Assistance and Collection Practices

Endorsed by the
Kansas Hospital Association

PREAMBLE

Kansas hospitals exist to provide essential health care services for their communities, twenty-four hours a day, every day of the year. These essential services are provided regardless of a person's ability to pay; however, individuals have an obligation to pay for the services they receive or seek financial assistance when needed. It is the duty of hospitals to collect from those who have the ability and the resources to pay using ethical collection practices that are allowed under Kansas and federal laws. Financial assistance programs offered by the hospital should not lessen the need to find solutions to expand access to appropriate health care coverage for all persons.

I. Guiding Principles

The following principles and guidelines should be used to develop hospital billing, financial assistance and collection practices:

A. Access to Health Services. A responsible party's inability to pay should not be a barrier to receiving essential health services. The inability to pay a hospital bill should never prevent any Kansan from seeking necessary health services. The hospital should communicate this message to all responsible parties and local health and community service organizations.

B. Mission and Values. The hospital should have billing, financial assistance and collection policies that are consistent with the mission and values of the hospital. These policies, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.

C. Communication. The hospital should communicate all billing, financial assistance and collection policies in a manner that is clear, understandable, respectful and in language(s) appropriate to the communities, patients and/or responsible parties served.

D. Legal Compliance. The hospital is responsible for communicating its collection policies and practices to both relevant hospital staff and to its internal collection departments. These policies should be respectful and comply with all applicable state and federal laws.

E. Personal Responsibility. Financial assistance and collection policies are not substitutes for personal responsibility. Eligible responsible parties may be expected to access public or private insurance options in order to qualify for financial assistance. All responsible parties are expected to contribute to the cost of care based on their ability to pay. Responsible parties should comply with the application requirements, including the production of necessary information to determine financial assistance eligibility.

II. Financial Assistance

The hospital's board of directors should adopt financial assistance policies consistent with the hospital's mission and values as well as local community standards. Hospitals should develop policies to aid those individuals who do not otherwise have the ability to pay in a timely manner for health care services received. Hospitals should review and evaluate all financial assistance policies on a regular basis. Hospital financial assistance is not a substitute for employer-sponsored, public, private or individually purchased insurance.

Hospitals should consider the following when adopting financial assistance policies:

A. Communication. The hospital should maintain understandable, written financial assistance policies for low income and uninsured patients. The hospital should provide financial assistance counseling in a clear and concise manner to all responsible parties without regard to race, ethnicity, gender, religion or national origin. The hospital should communicate these policies in a manner that is respectful and in language(s) appropriate to the communities, patients and/or responsible parties served. Attachment A is an example of such communication.

The hospital should post and/or distribute financial assistance information or literature. If posted, these notices should be placed in visible locations throughout the hospital such as admitting/registration, billing office and emergency department. Financial assistance applications should be readily available to responsible parties, and should clearly state the eligibility criteria and the process used by the hospital to determine whether a patient is eligible for financial assistance.

B. Financial Assistance for Low-Income Individuals. The hospital should establish criteria to provide financial assistance to low income and uninsured patients using guidelines such as the Federal Poverty Level (FPL). The hospital should base the amount of the assistance on the demographics of the patient population served by the hospital, and the hospital's financial ability to provide the assistance. These criteria should be evaluated on an annual basis to determine the appropriate level of assistance available.

C. Financial Assistance for Self-Pay Individuals. Uninsured patients should not be charged at a rate exceeding the maximum rate that the hospital actually bills any insurance company for the same product or service. The hospital should be encouraged to provide a self-pay discount. The hospital should base the amount of the assistance on the

demographics of the patient population served by the hospital, and the hospital's financial ability to provide the assistance

D. Financial Evaluation. The hospital should consider the responsible party's assets in determining eligibility. In addition to the hospital's standard financial assistance evaluation process, the hospital should take into consideration various financial factors, including all outstanding medical bills of the patient at that hospital. The hospital should also evaluate the responsible party's prior hospital accounts to determine if financial assistance was previously authorized, and if so, attempt to utilize the financial information previously provided by the responsible party. The hospital should also access the responsible party's financial situation utilizing the information the responsible party can reasonably provide.

E. Extraordinary Circumstances. **The hospital should identify, on a case-by-case basis responsible parties whose medical expenses, in relationship to their income, would make them medically indigent if they were forced to pay full charges. For the purposes of these guidelines, "medically indigent" shall mean patients whose resources, including any health insurance coverage, do not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income and other assets, would make them indigent if they were forced to pay full charges for their medical services.**

III. Billing and Collection Policies – Hospital Responsibilities

Hospitals should consider the following when adopting billing and collection policies:

A. Communication. **The hospital should provide information about the availability of financial assistance to responsible parties. The hospital is responsible for providing its financial assistance policy to all relevant hospital staff and third-party collection agencies engaged in the collection of debts.**

When sending any statement to a patient, hospitals should include (1) a statement indicating that if the responsible party meets certain requirements the responsible party may be eligible for financial assistance from the hospital; and (2) a statement providing the patient with a telephone number the department or office from which the patient may obtain information about the hospital's financial assistance policies and how to apply for such assistance.

B. Timely Filing. **The hospital should timely file insurance claims, provided the responsible party timely provides the hospital with proof of insurance and any other additional information necessary to file the claim. If a claim is denied based on improper insurance information, the hospital should attempt to resubmit the claim with the appropriate insurance information. When possible, the hospital should reference patient billing information previously obtained to determine the proper insurance information. If the hospital bears responsibility for the untimely filing of a claim, the hospital should attempt to collect from the responsible party only that portion which would have been owed had the party's insurance claim been timely filed.**

C. Payment Plans. The hospital should counsel the responsible party in an effort to develop a payment plan, which allows the party to pay the account over a reasonable amount of time based on the party's ability to pay. The hospital should provide an agreed upon payment plan to the responsible party in writing. Any interest rate charged should be clearly stated.

D. Retroactive Financial Assistance When attempting to collect on any open account, the hospital should allow financial assistance to be applied if it is deemed a responsible party would have qualified for previously undetermined financial assistance when services were rendered.

E. Collection Agents. The hospital should define the policies and practices to be used by outside collection agents acting on the hospital's behalf, and require such agents to agree to these standards in writing. The hospital should make reasonable efforts to contact a responsible party regarding payment options prior to assigning the account to a third party collection agency. Hospitals should develop fair and consistent written policies regarding when and under whose authority patient debt is referred for external collection. The hospital should encourage all third-party collection agencies to include notice regarding the hospital's financial assistance programs on all written communications to responsible parties.

F. Collection Terms and Reporting. No hospital should enter into any contracts with debt collectors that include bonuses, contingencies or any other incentives that are paid out against a temporal deadline.

All hospitals should publish to the community, on an annual basis, the identity of all collection firms or attorneys, the amounts collected by each, and the fees paid to each by the reporting hospital.

G. Legal Action. The hospital should require written approval by the hospital's Chief Financial Officer, or his/her designee, before legal action is commenced against a responsible party. A collection agent should not be allowed to file a lawsuit against a responsible party without the hospital's prior written consent.

IV. Responsible Party Obligations

The responsible party is expected to cooperate with the hospital by:

A. Communication. Responsible party should inform the hospital of the need for financial assistance as soon as the need is identified.

B. Pre-designation. When possible, the patient should clearly pre-designate the responsible paying party at the time of initial treatment or admission.

When possible, the patient should clearly pre-designate all authorized visitors for inpatient stay. For the purposes of visitation eligibility and visitors hours, 'family' refers to persons who play a significant role in the patient's life. This may include a person(s) not legally related to the patient. Decisions concerning visitation rights and privileges

should be made by the patient or the patient's chosen designate. Patients should be encouraged to designate those persons who should be granted primary visitation rights and any persons who should not be granted visitation rights before or during the admission process. Hospitals are encouraged to educate the community on this pre-designation process and the benefits of such legal instruments as durable powers of attorney. The above provision is subject to all demands of federal and state law and does not apply to hospital staff.

C. Timely Application. When possible, the responsible party should make a timely application to the hospital if financial assistance is needed.

D. Asset and Financial Disclosure. When available, the responsible party should provide requested information in a timely manner such as available income and assets, household size and other pertinent data in order to establish a workable payment plan with the hospital. If required, the responsible party will provide the hospital with any and all financial and other information needed to enroll in a publicly or privately sponsored program (e.g., Medicaid, Health Wave, MediKan, private grants or SCHIP).

E. Notification of Changes. When possible, the responsible party should inform the hospital regarding any change in their financial situation that may impact their ability to pay their hospital bill or to honor the provisions of their payment plans.

F. Payment. The responsible party should honor any mutually agreed upon payment plan established with the hospital.

V. Implementation

In order to properly implement financial assistance policies, the Kansas Hospital Association recommends that hospitals identify and educate appropriate hospital personnel to administer the policies.

SUMMARY

Kansas hospitals are committed to providing the best possible health care services for the citizens of their communities regardless of their ability to pay. But, because of the growing number of uninsured and underinsured in the state, it is becoming an ever greater financial challenge to assist patients with limited financial resources. The Kansas Hospital Association encourages hospitals to use this document as a guide to build upon their current financial assistance practices and policies.

The Kansas Hospital Association and its member hospitals are committed to working with federal and state government, payers, businesses and consumer groups to address the underlying problems caused by the lack of health insurance coverage. Further, we would encourage other providers of health care such as surgical centers, imaging centers and other health care providers in the state to adopt similar patient-centered billing and collection practices.

Attachment A

Sample Patient Notice of Financial Assistance
(Developed by the Kansas Hospital Association)

[NAME OF HOSPITAL] is proud of its mission to provide quality care to all who need it. If you do not have health insurance or are concerned that you may not be able to pay in full for your care, we may be able to help. **[NAME OF HOSPITAL]** provides financial assistance to responsible parties based on their level of income, assets, and needs. In addition, we may be able to help you identify other available resources or work with you to arrange a manageable payment plan. It is important that you let us know if you will have trouble paying your bill. Federal law requires hospitals to apply their billing and collection criteria consistently to all. Unpaid bills may ultimately be turned over to a collection agency, which could affect your credit status. For more information, please contact **[NAME OF PERSON]** in our financial counseling office at **[PHONE NUMBER]**. We will treat your questions with confidentiality and courtesy.

Hospital Billing Task Force

- KHA's Recommendations

- Kansas Attorney General's Recommendations

Preamble

- Kansas hospitals exist to provide essential health care services for their communities, twenty-four hours a day, every day of the year. These essential services are provided regardless of a person's ability to pay; however, individuals have an obligation to pay for the services they receive or seek financial assistance when needed. It is the duty of hospitals to collect from those who have the ability and the resources to pay using collection practices that are allowed under Kansas and federal laws. Financial assistance programs offered by the hospital should not lessen the need to find solutions to expand access to appropriate health care coverage for all persons.

I. Guiding Principles

- The following principles and guidelines should be used to develop hospital billing, financial assistance and collection practices:
  - A. Access to Health Service
  - B. Mission and Values
  - C. Communication
  - D. Legal Compliance
  - E. Personal Responsibility

I. Guiding Principles

A. Access to Health Services

- A responsible party's inability to pay should not be a barrier to receiving essential health services. Hospitals should convey this message to responsible parties and local health and community service organizations.

- A responsible party's inability to pay should not be a barrier to receiving essential health services. Fear of a hospital bill should never prevent any Kansan from seeking health services. The hospital has the responsibility to convey this message to all responsible parties and local health and community service organizations.

I. Guiding Principles
B. Mission and Values

Hospitals should have billing, financial assistance and collection policies that are consistent with the mission and values of the hospital. The policies should take into consideration the responsible party's ability to contribute to the cost of the patient's care as well as the hospital's financial ability to provide the care.

- The hospital should have billing, financial assistance and collection policies that are consistent with the mission and values of the hospital. These policies, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.

I. Guiding Principles
C. Communication

- Billing, financial assistance and collection policies should be communicated in a manner that is clear, understandable, respectful and in language(s) appropriate to the communities and patients and/or responsible parties served.

- The hospital is responsible for communicating all billing, financial assistance and collection policies in a manner that is clear, understandable, respectful and in language(s) appropriate to the communities, patients and/or responsible parties served.

I. Guiding Principles
D. Legal Compliance

- Collection policies and practices, for both hospital staff and external collection agents, should be respectful and comply with all applicable state and federal laws.

- The hospital is responsible for insuring that all collection policies and practices, for both hospital staff and third-party collection agencies, are respectful and comply with all applicable state and federal laws.

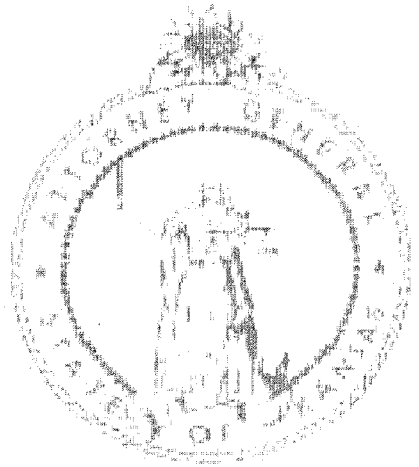
I. Guiding Principles
E. Personal Responsibility

- Financial assistance and collection policies are not substitutes for personal responsibility. Eligible responsible parties may be expected to access public or private insurance options in order to qualify for financial assistance. All responsible parties are expected to contribute to the cost of care based on their ability to pay.

- Financial assistance and collection policies are not substitutes for personal responsibility. All responsible parties are expected to contribute to the cost of care based on their ability to pay. Responsible parties should comply with the application requirements, including the production of necessary information to determine financial assistance eligibility. If required, the responsible party will provide the hospital with any and all financial and other information needed to enroll in a publicly or privately sponsored program (e.g., Medicaid, Health Wave, MediKan, private grants or SCHIP).

Responsibilities of Hospitals and Responsible Parties

- The collection of hospital bills is a complex task. While it is incumbent upon hospitals to have and uniformly implement financial assistance policies for the responsible parties least able to pay, it is equally incumbent upon responsible parties to cooperate with the hospital's need for accurate and detailed financial and insurance information at the earliest possible time. Therefore, hospitals should clearly state that any responsible party seeking financial assistance must comply with the application requirements, including the production of necessary documentation. If required, the responsible party will provide the hospital with any and all financial and other information needed to enroll in a publicly or privately sponsored program (e.g., Medicaid, Health Wave, MediKan, private grants or SCHIP).



II. Financial Assistance

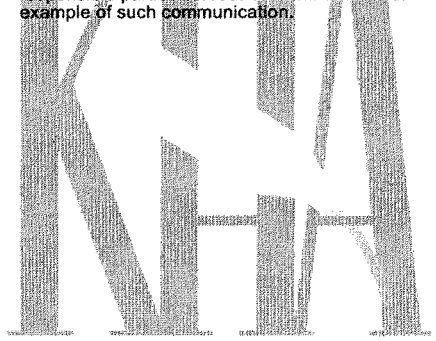
- The hospital's board of directors should adopt financial assistance policies consistent with the hospital's mission and values as well as local community standards. Hospitals should develop policies to aid those individuals who do not otherwise have the ability to pay in a timely manner for health care services received. Hospitals should review and evaluate financial assistance policies on a regular basis. Hospital financial assistance is not a substitute for employer-sponsored, public, private or individually purchased insurance.
- Hospitals should consider the following when adopting financial assistance policies:
  - A. Communication
  - B. Financial Assistance for Low-Income Individuals
  - C. Asset Evaluation
  - D. Extraordinary Circumstances

The hospital's board of directors should adopt financial assistance policies consistent with the hospital's mission and values as well as local community standards. Hospitals should develop policies to aid those individuals who do not otherwise have the ability to pay in a timely manner for health care services received. Hospitals should review and evaluate all financial assistance policies on a yearly basis. Hospital financial assistance is not a substitute for employer-sponsored, public, private or individually purchased insurance.

- Hospitals should consider the following when adopting financial assistance policies:
  - A. Communication
  - B. Financial Assistance for Low-Income Individuals
  - C. Financial Assistance for Self Pay Individuals
  - D. Financial Evaluation
  - E. Extraordinary Circumstances

II. Financial Assistance
A. Communication

- Provide financial assistance and counseling in a clear and concise manner to all responsible parties without regard to race, ethnicity, gender, religion or national origin. Hospitals should communicate these policies in a manner that is respectful and in language(s) appropriate to the communities and the patients and/or responsible parties served. Attachment A is an example of such communication.



- The hospital should maintain understandable, written financial assistance policies for low-income and uninsured patients. The hospital should provide financial assistance counseling in a clear and concise manner to all responsible parties without regard to race, ethnicity, gender, religion or national origin. The hospital should communicate these policies in a manner that is respectful and in language(s) appropriate to the communities, patients and/or responsible parties served. Attachment A is an example of such communication.
- The hospital should post financial assistance notices in visible locations throughout the hospital such as admitting/registration, billing office, emergency department and other outpatient settings. Financial assistance applications should be readily available to responsible parties, and should clearly state the eligibility criteria and the process used by the hospital to determine whether a patient is eligible for financial assistance.

II. Financial Assistance

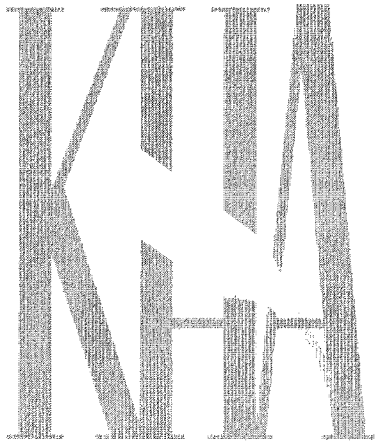
B. Financial Assistance for Low-Income Individuals

- Establish criteria to provide financial assistance to low income individuals using guidelines such as the Federal Poverty Level (FPL) with collection practices that recognize limited financial capacity. The hospital should base the amount of the assistance on the demographics of the patient population served by the hospital and the hospital's financial ability to provide the assistance. For example, it might be appropriate for one hospital to provide assistance to anyone at or below 200% of the FPL, while it might be appropriate for another hospital to provide assistance to anyone at or below 100% of the FPL.

- The hospital should establish criteria to provide financial assistance to low-income and uninsured patients using guidelines such as the Federal Poverty Level (FPL). The hospital should also base the amount of the assistance on the demographics of the patient population served by the hospital, and the hospital's financial ability to provide the assistance. These criteria should be evaluated on a yearly basis to determine the appropriate level of assistance available.

II. Financial Assistance

C. Financial Assistance for Self-Pay Individuals.



- Uninsured patients should not be billed at a rate exceeding the maximum rate that the hospital actually bills any insurance company for the same product or service. Hospitals are encouraged to introduce programs that reduce this maximum rate to the mean rate actually billed to insurance companies.

II. Financial Assistance
D. Asset/Financial Evaluation

- D. Asset Evalution
- Consider whether to use the responsible party's assets in determining eligibility.

- D. Financial Evaluation
- The hospital should consider the responsible party's assets in determining eligibility. The hospital should also take into consideration all outstanding medical bills of the patient at that hospital. The hospital should evaluate the responsible party's prior hospital accounts to determine if financial assistance was previously authorized, and if so, attempt to utilize the financial information previously provided by the responsible party. The hospital should assess the responsible party's financial situation utilizing the information the responsible party can reasonably provide.

II. Financial Assistance
E. Extraordinary Circumstances

- Identify on a case-by-case basis responsible parties whose medical expenses, in relationship to their income, would make them medically indigent if they were forced to pay full charges. For the purposes of these guidelines, "medically indigent" shall mean patients whose resources, including any health insurance coverage, do not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income and other assets, would make them indigent if they were forced to pay full charges for their medical services.

- The hospital should identify, on a case-by-case basis, responsible parties whose medical expenses, in relationship to their income, would make them medically indigent if they were forced to pay full charges. For the purposes of these guidelines, "medically indigent" shall mean patients whose resources, including any health insurance coverage, do not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income and other assets, would make them indigent if they were forced to pay full charges for their medical services.

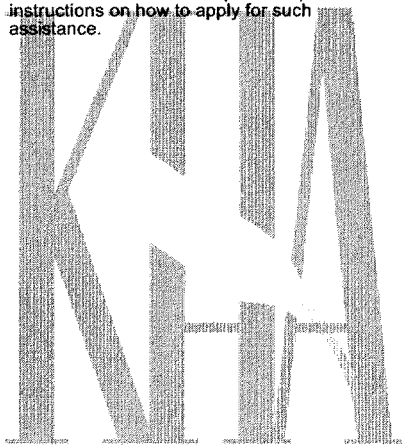
III. Billing and Collection Policies – Hospital Responsibilities

- Hospitals should consider the following when adopting billing and collection policies:
  - A. Communication
  - B. Timely Filing
  - C. Payment Plans
  - D. Collection Agents
  - E. Legal Action

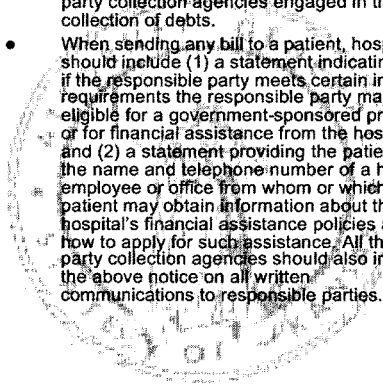
- Hospitals should consider the following when adopting billing and collection policies:
  - A. Communication
  - B. Timely Filing
  - C. Payment Plans
  - D. Retroactive Financial Assistance
  - E. Collection Agents
  - F. Collection Terms and Reporting
  - G. Legal Action

III. Billing and Collection Policies – Hospital Responsibilities
A. Communication

- Provide information about the availability of financial assistance to responsible parties and instructions on how to apply for such assistance.

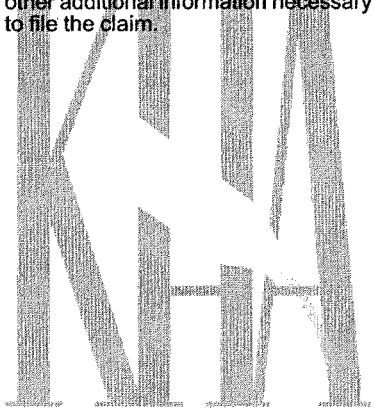


- The hospital should provide information about the availability of financial assistance to responsible parties. The hospital is responsible for providing its financial assistance policy to all hospital staff and third-party collection agencies engaged in the collection of debts.
- When sending any bill to a patient, hospitals should include (1) a statement indicating that if the responsible party meets certain income requirements the responsible party may be eligible for a government-sponsored program or for financial assistance from the hospital; and (2) a statement providing the patient with the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's financial assistance policies and how to apply for such assistance. All third-party collection agencies should also include the above notice on all written communications to responsible parties.

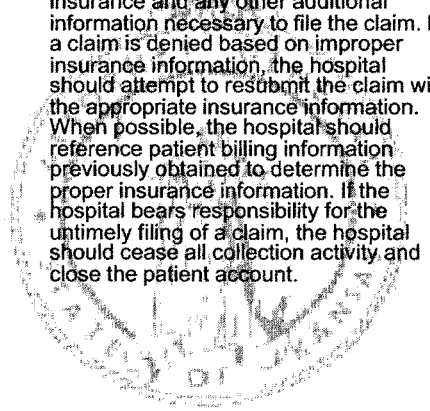


III. Billing and Collection Policies – Hospital Responsibilities
B. Timely Filing

- Timely file insurance claims, provided the responsible party timely provides hospital with proof of insurance and any other additional information necessary to file the claim.



- The hospital should timely file insurance claims, provided the responsible party timely provides the hospital with proof of insurance and any other additional information necessary to file the claim. If a claim is denied based on improper insurance information, the hospital should attempt to resubmit the claim with the appropriate insurance information. When possible, the hospital should reference patient billing information previously obtained to determine the proper insurance information. If the hospital bears responsibility for the untimely filing of a claim, the hospital should cease all collection activity and close the patient account.

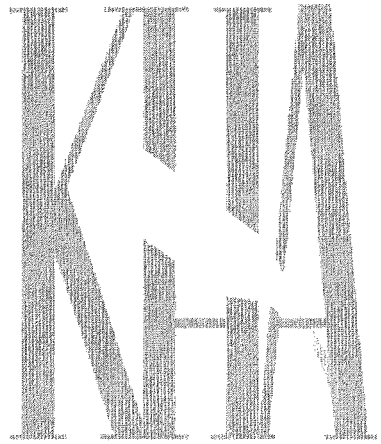


III. Billing and Collection Policies – Hospital Responsibilities
C. Payment Plans

- Develop payment plans to allow responsible parties to pay their bills over a reasonable amount of time. Any interest rate charged should be clearly stated.

- The hospital should counsel the responsible party in an effort to develop a payment plan which allows the party to pay the account over a reasonable amount of time based on the party's ability to pay. The hospital should provide an agreed upon payment plan to the responsible party in writing. Any interest rate charged should be clearly stated.

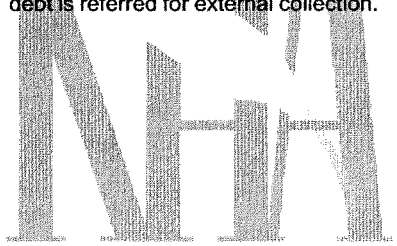
III. Billing and Collection Policies – Hospital Responsibilities
D. Retroactive Financial Assistance



- When attempting to collect on any open account, the hospital should allow financial assistance to be applied if it is deemed a responsible party would have qualified for financial assistance when services were rendered.

III. Billing and Collection Policies – Hospital Responsibilities
E. Collection Agents

- Define the policies and practices to be used by outside collection agents acting on the hospital's behalf and require such agents to agree to these standards in writing. Before the account is assigned to a collection agent, the hospital should make reasonable efforts to contact the responsible party regarding payment options. Hospitals should develop fair and consistent written policies regarding when and under whose authority patient debt is referred for external collection.



- The hospital should define the policies and practices to be used by outside collection agents acting on the hospital's behalf, and require such agents to agree to these standards in writing. The hospital should make reasonable efforts to contact a responsible party regarding payment options prior to assigning the account to a third-party collection agency. Hospitals should develop fair and consistent written policies regarding when and under whose authority patient debt is referred for external collection.
- The hospital should only contract with third-party collection agencies that are members in good standing with the Association of Credit and Collection Professionals. These third-party collection agencies should also abide by the ACA Code of Ethics and Professional Responsibility.

III. Billing and Collection Policies – Hospital Responsibilities
F. Collection Terms and Reporting

- No hospital should enter into any contracts with debt collectors that include bonuses, contingencies or any other such terms that are paid out against a temporal deadline, for such collection terms creative incentives for unconscionable collection practices. Collection contracts should instead be drafted in a manner that cautions against, and creates no incentives for, aggressive collection practices.
- All hospitals should publish to the community, on an annual basis, the identity of all collection firms or attorneys, the amounts collected by each, and the fees paid to each by the reporting hospital.

III. Billing and Collection Policies – Hospital Responsibilities
G. Legal Action

- Develop a process to screen accounts before legal action is commenced against a responsible party. A collection agent should not be allowed to file a lawsuit against a responsible party without the hospital's prior written consent.
- The hospital should require written approval by its Chief Financial Officer, or the equivalent thereof, before legal action is commenced against a responsible party. A collection agent should not be allowed to file a lawsuit against a responsible party without the hospital's prior written consent.
- No litigation should be filed against any patient due to a delinquency in payment unless said patient is first offered, within eight weeks of the filing of the litigation, an opportunity to meet with an agent of the hospital who is not primarily employed as a debt collector and within 48 hours of that meeting tender certified funds against a reasonable payment plan. This plan can include whatever actual costs the hospital has realized or will forfeit due to any previous debt collection activity.

IV. Responsible Party Obligations

- The responsible party is expected to cooperate with the hospital by:
  - A. Communication
  - B. Timely Application
  - C. Asset and Financial Disclosure
  - D. Notification of Changes
  - E. Payment

- The responsible party is expected to cooperate with the hospital by:
  - A. Communication
  - B. Pre-designation
  - C. Timely Application
  - D. Asset and Financial Disclosure
  - D. Notification of Changes
  - F. Payment

IV. Responsible Party Obligations
A. Communication

- Informing the hospital of the need for financial assistance as soon as the need is identified.
- The responsible party should inform the hospital of the need for financial assistance as soon as the need is identified.

IV. Responsible Party Obligations
B. Pre-designation

- When possible, the patient should clearly pre-designate the responsible paying party at the time of initial treatment or admission.
- When possible, the patient should clearly pre-designate all authorized visitors for inpatient stay. For the purposes of visitation eligibility and visitors hours, 'family' refers to persons who play a significant role in the patient's life. This may include a person(s) not legally related to the patient. Decisions concerning visitation rights and privileges should be made by the patient or the patient's chosen designate. Patients should be encouraged to designate those persons who should be granted primary visitation rights and any persons who should not be granted visitation rights before or during the admission process. Hospitals are encouraged to educate the community on this pre-designation process and the benefits of such legal instruments as durable powers of attorney.

IV. Responsible Party Obligations
C. Timely Application

- Making timely application to the hospital if financial assistance is needed.

- When possible, the responsible party should make a timely application to the hospital if financial assistance is needed.

IV. Responsible Party Obligations
D. Asset and Financial Disclosure

- Providing requested information in a timely manner such as available income and assets, household size and other pertinent data in order to establish a workable payment plan with the hospital.

- When available, the responsible party should provide requested information in a timely manner such as available income and assets, household size and other pertinent data, in order to establish a workable payment plan with the hospital.

IV. Responsible Party Obligations
E. Notification of Changes

- Informing the hospital regarding any change in their financial situation that may impact their ability to pay their hospital bill or to honor the provisions of their payment plans.

- When possible, the responsible party should inform the hospital regarding any change in their financial situation that may impact their ability to pay their hospital bill or to honor the provisions of their payment plans.

IV. Responsible Party Obligations
F. Payment

- Honoring any mutually agreed upon payment plan established with the hospital.
- The responsible party should honor any mutually agreed upon payment plan established with the hospital.

V. Implementation

- In order to properly implement financial assistance policies, the Kansas Hospital Association recommends that hospitals identify and educate appropriate hospital personnel to administer the policies.

Summary

- Kansas hospitals are committed to providing the best possible health care services for the citizens of their communities regardless of their ability to pay. But, because of the growing number of uninsured and underinsured in the state, it is becoming an ever greater financial challenge to assist patients with limited financial resources. The Kansas Hospital Association encourages hospitals to use this document as a guide to build upon their current financial assistance practices and policies.
- The Kansas Hospital Association and its member hospitals are committed to working with federal and state government, payers, businesses and consumer groups to address the underlying problems caused by the lack of health insurance coverage. Further, we would encourage other providers of health care such as surgical centers, imaging centers and other health care providers in the state to adopt similar patient-centered billing and collection practices.

Sample Patient Notice of Financial Assistance (Developed by the KHA)

- **[NAME OF HOSPITAL]** is proud of its mission to provide quality care to all who need it. If you do not have health insurance or are concerned that you may not be able to pay in full for your care, we may be able to help. **[NAME OF HOSPITAL]** provides financial assistance to responsible parties based on their level of income, assets, and needs. In addition, we may be able to help you identify other available resources or work with you to arrange a manageable payment plan. It is important that you let us know if you will have trouble paying your bill. Federal law requires hospitals to apply their billing and collection criteria consistently to all. Unpaid bills may ultimately be turned over to a collection agency, which could affect your credit status. For more information, please contact **[NAME OF PERSON]** in our financial counseling office at **[PHONE NUMBER]**. We will treat your questions with confidentiality and courtesy.

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Testimony
of the
American Hospital Association
before the
U.S. Senate
Committee on Finance
on
"Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals"

September 13, 2006

I am Kevin Lofton, chairman-elect of the American Hospital Association (AHA) Board of Trustees. On behalf of the AHA's 4,800 member hospitals and health care systems, and our 33,000 individual members, thank you for the opportunity to testify today.

I also am president and CEO of Catholic Health Initiatives (CHI) in Denver, Colorado, and before that I was the chief executive officer of two different university hospitals. The 66,000 women and men of CHI serve rural and urban communities in 19 states. Taking care of the poor has been key to our mission for more than a century. Last year, we provided nearly $800 million (11.2 percent of total revenues) worth of benefits to the communities we serve through charity care, financial assistance, Medicare underpayment, research, medical education, and many other programs.

Hospitals' Commitment to the Community

Hospitals do more to assist the poor, sick, elderly and infirm than any other entity in the health care sector. In 2004 alone, hospitals delivered more than $27 billion (in costs) in uncompensated care to patients and uncounted billions more in value to their communities through services, programs and other activities designed to promote and protect health and well-being.

Quite simply, America's hospitals are the backbone of the communities they serve. And they are effective in this role for one key reason: they are free to tailor their services to the unique needs of their communities. Pittsburgh's Mercy Hospital, for example, assembles teams of health professionals to locate and provide care for the homeless. In Wilmington, North Carolina, New Hanover Health Network opened a center that

provides physical and mental health services for nearly three-quarters of the area's youth who are uninsured or covered only by public health programs. There are thousands of similar community-based efforts whose commonality is that they are spearheaded by local hospitals ... and that those hospitals are not-for-profit.

Not-for-profit hospitals are distinguished by certain charitable obligations that have evolved over time to keep pace with the needs of the American people. And they are owned and controlled by members of the community who are directly affected by the services and programs provided by the hospitals. The dynamic, community-based hospitals that dot the American landscape today have as their ancestors "pest houses" that took care of sailors with contagious diseases. In the 1700s, hospitals were known as "almshouses" whose mission was to provide basic facilities for indigents, criminals, foundlings, the physically handicapped and the mentally unbalanced. Patients who could afford their care generally were treated at home in order to avoid the harsh and overcrowded conditions that prevailed.

Today, we expect much more from our hospitals. While care of the poor remains a central mission, promoting and protecting the health and well-being of the entire community – through responsive programs and facilities and the highest quality care – is just as key. The immense value that hospitals bring to the communities they serve tracks these evolving expectations. And that is why we urge the Committee to refrain from provoking any change to the standards that govern tax exemption for not-for-profit hospitals that would turn the clock back on their ability to respond to the unique needs of their communities.

Challenges Facing Hospitals: Mix of Community Benefit

Since 1969, not-for-profit hospitals have been able to fulfill their charitable obligations through an appropriate mix of charity care, financial assistance to low-income patients, subsidized health care, research, health professions education and other community-building activities that are tailored to the needs of the communities they serve.

The circumstances that brought the Internal Revenue Service (IRS) to adopt the current community benefit standard reflect the evolution of the hospital field itself. It is consistent with the views of courts and leading commentators that, according to a Montana court decision quoted by Robert Bromberg in a 1977 treatise, *Tax Planning for Hospitals*, "[t]he scope of charity care and the standards under which it is administered are not frozen by the past, but keep pace with the times and new conditions and wants of society."

Over the centuries, hospitals have evolved from custodial institutions for unwanted members of society, particularly the poor, to dynamic organizations that reach beyond their walls to target and address the needs of the entire community. Given that evolution, it is hardly surprising that early standards for tax-exempt hospitals focused solely on care for the poor. Views about the charitable obligations of not-for-profit hospitals began

changing as early as the 1920s. A 1925 decision by a Kansas Supreme Court, *Third Order of St. Dominic v. Younkin,* held:

> *"When an institution is incorporated for benevolent purposes without capital stock, and no dividends are declared or paid, and conducts a hospital, and all the earnings of the hospital from pay patients, gifts, bequests or whatever sources are used in the maintenance, extension and improvement of the hospital, and which admits patients without regard to race, creed or wealth, it is uniformly held that such hospital is conducted exclusively for charitable purposes."*

Similarly, a 1960 Virginia Supreme Court decision, *City of Richmond v. Richmond Memorial Hospital,* held:

> *"[n]on-profit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science, are and should be regarded as charities."*

In that decision, the court explicitly rejected using free service as the test for tax exemption:

> *"A tax exemption cannot depend on any such vague and illusory concept as the percentage of free service actually rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on the subject. Thus there would be no certainty or uniformity in the application of the section involved."*

Through a series of decisions spanning the last six decades, the courts have rejected the outdated free-care standard as a meaningful criterion for tax exemption and embraced a broader notion of what constitutes charitable obligations.

The final impetus for the IRS to alter its 1965 ruling requiring a not-for-profit hospital to be operated "to the extent of its financial ability for those not able to pay" came as a response to suggestions from Congress. Uncertainty surrounding whether broad or narrow criteria should be used to determine tax exemption, and the difficulty of administering the then-prevailing financial-ability test for not-for-profit hospitals attributable to IRS rulings and determinations, were among the concerns expressed by Congress. The IRS acted accordingly on Congress' suggestion that "the resolution of such uncertainties could be handled on an administrative basis," according to Bromberg.

The resulting 1969 Revenue Ruling, 69-545, established what is called the "community benefit" standard and remains in force today. That ruling and its progeny establish that "promotion of health in a manner beneficial to the community and free of any private benefits or profits is a charitable purpose." This standard continues to work well for not-for-profit hospitals and, more importantly, the communities they serve. Because it works, it does not need to be changed. The standard permits hospitals to satisfy their community benefit obligations by providing the right mix of programs and services to their communities, so that:

- A hospital in Ogden, Utah can supply its community with a health fair that provides all local children and their families with medical, dental and vision screening as well as necessary follow up care for low-income families.
- A hospital in Helena, Montana can offer local residents an opportunity to visit a cardiologist and be tested for heart disease and related conditions.
- A hospital in Phoenix, Arizona can provide an as-needed day care center for sick children staffed by pediatric caregivers.
- A hospital in rural South Dakota can fund a volunteer ambulance service to help residents get to the hospital in time.

These programs and services are just a few examples of the thousands of ways hospitals across the country determine a community need, and then act to address that need.

We recognize that the full value of many of these community benefit programs and services may be difficult or even impossible to quantify. This concern was reinforced in a recent *Health Affairs* article, whose authors (both prominent health researchers) concluded that:

> *"[a]ssessing the full impact that health care organizations have on communities is difficult, because not all community-benefit activities are readily measurable."*

These same researchers cautioned against the imposition of standard criteria against which nonprofits' performance would be measured, concluding that such criteria would be:

> *"excessively inflexible, substituting decisions by state and federal policymakers or regulators for choices better made in communities."*

Instead, the authors argue for an approach that fosters community involvement. We agree.

After months of consultation with the AHA's members and a review of the way in which many states handle community benefit, in May 2006 the AHA's Board of Trustees unanimously passed a resolution calling on hospitals to take steps to foster additional community involvement and to increase transparency in the service of that benefit. Specifically, the Board called for standardized public reporting of community benefit (as an attachment to Form 990) using the model developed by the Catholic Health Association of the U.S. in cooperation with VHA, Inc. The Board determined that the calculation of community benefit should fully reflect the benefits hospitals provide, and thus include: direct and indirect costs of subsidized health care services, charity care, bad debt and the unpaid costs of government-sponsored health care, including Medicaid, Medicare and public and/or indigent care programs. The Board said:

> *"We believe there is general agreement, albeit not consensus, among the not-for-profit hospital field that the Community Benefit Guidelines [CHA/VHA], with the*

accommodations reflected above, is an appropriate model for achieving standardized community benefit reporting at the federal level."

This approach is consistent with that of many states, including California, Idaho, Illinois, Indiana, Nevada, North Carolina, Pennsylvania, Rhode Island, Texas and Utah.

We appreciate the chairman's recent remarks acknowledging the field's work on this issue and stating that you are not advocating legislation in this area. We agree with you that there are intellectually honest differences within the field regarding reporting that includes or excludes Medicare underpayment or bad debt. But those differences should not and are not preventing not-for-profit hospitals from reporting the value of their community benefit. We look forward to continuing our work with you to ensure that such reporting is useful and complete.

Challenges Facing Hospitals: The Uninsured

The challenges facing hospitals are immense. The Census Bureau recently reported that 46.6 million Americans do not have health insurance, an increase of 1.3 million people from 2004 to 2005, with 400,000 additional children uninsured. And, with insurance premiums rising, the prospects for reversing this harsh trend are dim. Hospitals will continue to care for these people – as they have for generations – regardless of their ability to pay.

AHA has consistently supported legislative and private efforts to expand coverage for all Americans. Until a solution is found, however, hospital charity care will continue to be all that stands "between a thorny policy dilemma and an access crisis for millions of Americans," as PricewaterhouseCoopers put it in a report last year.

We do understand, however, that some policymakers are concerned about the lack of uniformity among hospitals with regard to charity care and financial assistance. To address that concern, the AHA Board's May resolution augments its 2003 Principles and Guidelines on patient billing and collections.

The May resolution calls on all hospitals to provide free care to those below 100 percent of the federal poverty level and financial assistance to those who are between 100-200 percent of that level. For those receiving financial assistance, the price should be no more than the price paid to the hospital under contract by a public or private insurer, or 125 percent of the Medicare rate for applicable services. The Board also called on hospitals to better monitor their collection practices. The complete text of the resolution was included in a May 1 AHA letter to Chairman Grassley (attached).

The vast majority of hospitals already meet or exceed these guidelines. Even so, we recognize that hospitals cannot solve this problem alone. The federal government has a role; for example, the Medicaid program should keep eligibility and benefits at current levels and expand to cover all those below the poverty level. We have pledged to work with the Senate Finance Committee to achieve this important goal. Others with a stake in

the problem should also be called on to assist, including physicians, commercial insurers, industry and policymakers at all levels of government.

Challenges Facing Hospitals: Governance Improvements
The chairman and ranking minority member have asked that the not-for-profit sector review and come forward with suggestions to strengthen governance, ethical conduct and effective practice of public charities and private foundations. In its May resolution, the AHA Board endorsed many of the consensus recommendations of the not-for-profit field, including:

- Have the CEO, CFO or highest ranking officer sign off on Form 990.
- Attach audited financial statements to the Form 990 for hospitals with $1 million or more in annual revenues; for hospitals with revenues of $250,000-$1 million, a required review of submitted financial statements by an independent public accountant; for health systems, allow for a single, system-wide audit.
- Prohibit loans to board members or executives.
- Disclose on Form 990 whether the hospital has a travel policy.
- Disclose on Form 990 whether the hospital has a conflict of interest policy.

We were pleased that the recent Government Accountability Office survey on executive compensation practices at not-for-profit hospitals found widespread adoption of best practices, such as appointment of an executive compensation committee with primary responsibility for approving salary and bonuses, conflict-of-interest policies that extend to all members of the executive compensation committee and consultants, and reliance on market data to make compensation decisions. The IRS is performing a more in-depth review of the executive compensation practices of the entire not-for-profit sector, and we pledge to review any recommendations the IRS might make and to update our resolution as appropriate.

Challenges Facing Hospitals: Greater Transparency
Hospitals are committed to strengthening the health care system – and the communities they serve – by sharing information about the quality of care and the price of that care. Hospitals have taken the lead in reporting quality information, with almost 4,000 hospitals participating in the Hospital Quality Alliance, the public-private initiative that the AHA helped develop to provide information to the public on the quality of care in America's hospitals.

On April 29, the AHA Board of Trustees approved a policy addressing the transparency of hospital pricing. The objectives of the policy are to guide hospitals in presenting information in a way that is easy to access, understand and use; creates common definitions and language describing hospital pricing information for consumers; explains how and why the price of patient care can vary; encourages patients to include price information as just one factor to consider when making decisions about hospitals and

health plans; and directs them to more information about financial assistance with their hospital care.

We believe there are four distinct paths that lead to effective pricing transparency:

- States, working with state hospital associations, should expand existing efforts to make hospital charge information available to consumers. Many states already have mandatory or voluntary hospital price information reporting activities in place, or are working toward that goal.
- States, working with insurers, should make available, in advance of medical visits, information about an enrollee's expected out-of-pocket costs.
- More research is needed to better understand what types of pricing information consumers want and would use in their health care decision-making.
- All parties must agree on consumer-friendly pricing "language" – common terms, definitions and explanations that will help consumers better understand the information provided.

Conclusion

Mr. Chairman, America's hospitals have a proud tradition of taking care of those most in need. And we have built on that tradition in a way that benefits not just the poor and marginalized, but the community as a whole with services, programs and activities tailored to the specific needs of that community. Hospitals are available to their communities 24 hours a day, 7 days a week, 365 days a year. They are ready to assist their communities, no matter what the emergency -- whether it is a man-made or natural disaster, hospitals are there.

In order for not-for-profit hospitals to continue meeting the tremendous demands and challenges they face, while at the same time reaching out to improve health in ways that benefit entire communities, it is critical that the community benefit standard be protected and preserved in its current form.

I again thank you for the opportunity to represent Americans not-for-profit hospitals before you here today. You have the commitment of the entire hospital field that we will work with you not only to take the steps that can help hospitals make communities healthier, but to do so in a way that is open and transparent.

American Hospital Association

Richard J. Davidson
President

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www.aha.org

By E-Mail and U.S. Post

May 1, 2006

The Honorable Charles E. Grassley, Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510-6200

Dear Chairman Grassley:

On behalf of the American Hospital Association's (AHA) 4,800 hospital, health care system, and other health care organization members, and our 35,000 individual members, we thank you for this opportunity to elaborate on our previous conversations with you and your staff on how to address the serious public policy issues that confront hospitals and the people and communities we serve. Specifically, we would like to address the issues raised in your March 8 letter.

First let us say that we appreciate the opportunities we have had to work closely with you and your staff on a variety of issues of concern to our field, including physician-owned limited-service hospitals, protecting community hospitals from Medicare and Medicaid budget cuts, and assisting rural hospitals with the unique challenges they face.

With respect to your request for information … we will address those issues in the order they appear in your letter.

Option 1 – Improving Financial Assistance for Uninsured Patients of Limited Means

The key word here: "uninsured." *More than 46 million Americans have no health care insurance.* From this national crisis flows a myriad of problems that beset the health care field today. The AHA has long supported coverage for all Americans and has advocated for incremental steps that increase coverage, as well as for broad-based changes in coverage policy.

Meanwhile, America's hospitals, as they have done for generations, continue to take care of people regardless of insurance status or ability to pay. In 2004 alone, hospitals provided $27 billion in uncompensated care, a number that reflects the cost of providing that care. According to a 2005 report by PriceWaterhouseCoopers, the availability of charity care at U.S. hospitals is all that stands "between a thorny policy dilemma and an access crisis for millions of Americans."

Federal Policy is Clearer

Federal policy on providing increased financial assistance to uninsured patients of limited means is clearer; some grey area persists, however. Several studies have concluded that hospitals have been justifiably concerned about how discounting charges or failing to maintain vigorous collection policies for uninsured patients of limited means might put them in the crosshairs of the Medicare program and/or Office of Inspector General (OIG). Among these studies:

- *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt,* a 2003 report by the Commonwealth Fund.

- *Acts of Charity, Charity Care Strategies for Hospitals in a Changing Landscape,* a 2005 report by PriceWaterhouseCoopers.

- *Hospitals Share Insights to Improve Financial Polices for Uninsured and Underinsured Patients*, a February 2005 report by the Health Financial Management Association (HFMA) and the AHA.

These concerns were echoed by a former administrator of the Centers for Medicare and Medicaid Services' (CMS) predecessor, the Health Care Financing Administration, in a February 2004 letter to the Department of Health and Human Services (HHS). The letter described the existing Medicare and OIG regulation of hospital billing and collection practices as a "major deterrent to hospitals' implementation of more sensible and more humane policies."

We remain appreciative that in February 2004, HHS – through issuances from CMS and OIG – provided critical guidance on these complicated billing and collection issues. Immediately following those issuances, the AHA urged HHS to supplement these initial efforts by providing a forum for hospitals to directly query federal officials about issues raised by the guidance. To that end, we offered to host a nationwide conference call or work with the agency on any meeting format it found most useful. CMS responded by conducting an Open Door Forum in June 2004 and following up on questions generated at that forum by issuing additional guidance on December 29, 2004, confirming that offering a discount based solely on a patient's uninsured status would not affect a hospital's Medicare payments.

However, "some grey area still exists," as the PriceWaterhouseCoopers report noted. For example, the guidance suggests that if hospital discounts are determined to be too generous, hospitals could be at risk for inducing federal health program business in violation of OIG rules.

AHA Leadership: Billing and Collection Practices

AHA's leadership on these issues includes a white paper on the subject of Medicare policies affecting the uninsured. This paper led to the issuance of the aforementioned HHS guidance in February 2004. During that same period, AHA developed and successfully urged the hospital field to adopt Principles and Guidelines (AHA Guidelines) on hospital billing and collection practices (attached). On the subject of policies to provide increased financial assistance or discounts, the AHA Guidelines state:

> *"Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts . . . Policies should clearly state the eligibility criteria, amount of discount, and payment plan options."*

In addition, to ensure that patients are aware of the assistance offered by hospitals, the AHA Guidelines state:

> *"Hospitals should make available to the public information on hospital-based charity care policies and other known programs of public assistance."*

To date, 4,263 hospitals have signed a pledge – the Confirmation of Commitment – indicating their adherence to the AHA Guidelines or their work toward such adherence in a timely manner.

A 2005 study by the Center for Studying Health System Change (HSC) confirmed that hospitals are responding. *Balancing Margin and Mission: Hospitals Alter Billing and Collection Practices for Uninsured Patients* reported that:

> *"In every HSC community, most hospitals have either recently changed their pricing and collection policies or tried to improve the clarity of information provided to patients. Most of the hospitals interviewed had increased the income threshold for full charity care or discounted services."*

Exploring Options

Your leadership on the issue of public accountability was clear in your remarks to Independent Sector's October 2005 CEO Summit. You urged the hospital field to *"come forward with its own substantive proposals for . . . reforms in areas such as ... charitable care, charges to the uninsured [and] debt collection."*

The AHA proposals in this letter respond specifically to your request. On the topic of charity care and the uninsured of limited means, the AHA calls upon all hospitals to adopt the following policies going forward:

- Provide financial assistance and counseling for uninsured people of limited means, without regard to race, ethnicity, gender, religion or national origin.
    - Financial assistance provided by hospitals to uninsured people of limited means should in no way substitute for the obligation of federal and state governments to provide or expand coverage to the uninsured. At a minimum, state Medicaid programs should be required to sustain a "maintenance of effort" keeping eligibility at least at current levels. Further, the federal government should enact legislation to expand Medicaid coverage to *all* individuals at or below the poverty level. We would like to work with you and other members of the Finance Committee to achieve this important objective

- Until the time that we mutually achieve such comprehensive Medicaid coverage, provide services to uninsured patients below 100 percent of the federal poverty level at no charge. Existing clinical and geographical criteria used by hospitals to determine eligibility for certain services would apply.

- Provide financial assistance to all uninsured patients between 100 percent and 200 percent of the federal poverty level by (based on a hospital's choice) asking them to pay *no more than*:
    - A price paid to the hospital under contract by a public or private insurer; *or*
    - 125 percent of the Medicare rate for applicable services (given that, in the aggregate, Medicare pays less than the cost of care).

  For these patients, hospitals may choose to charge on a sliding scale up to the stated limits. Hospitals also may choose to provide greater assistance.

- Make information about a hospital's financial assistance policy easily available to the public.

In addition, hospitals may offer financial assistance to uninsured patients with incomes in excess of 200 percent of the federal poverty level at the discretion of the hospital.

Cosmetic surgery and other non-medically necessary services would be exempt.

Hospital financial assistance is contingent upon the cooperation of a patient in providing the information necessary for a hospital to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from hospitals shall have a responsibility to pay according to the terms of that policy.

Hospitals that have policies that meet or exceed those listed above should receive immunity from class action lawsuits.

Some of the above elements may be appropriate for legislation, including relief for hospitals that in recent years have been plagued by class action lawsuits challenging their billing and collection practices. As you are aware, nearly all of the class action lawsuits have been dismissed in the federal courts. Several of those opinions severely criticized the class action attorneys for misreading the Constitution and misguidedly bringing suit against hospitals. Having failed in the federal courts, the same class action attorneys are now filing in state courts cases that are very similar to those defeated in federal courts ... even against hospitals whose policies meet or exceed the AHA Guidelines. The diversion of scarce hospital resources required to defend these lawsuits is enormous. Therefore, we strongly urge that immunity from these suits be legislated without delay.

With respect to your question on numbers, by state, of uninsured and those covered by Medicare and Medicaid, we would direct you to the database maintained by the Kaiser Family Foundation that contains most of the requested information. That database can be accessed at http://www.statehealthfacts.org. We are not aware of a database that would provide a comprehensive list of other state or government programs providing medical benefits to low-income individuals.

Option 2 – Uniform Reporting of Community Benefit

How Hospitals Benefit their Communities
Not-for-profit hospitals provide an enormous amount and range of benefit to the communities they serve, beyond the $27 billion worth of uncompensated care provided by all hospitals in 2004. The AHA has traditionally worked with our members and their state hospital associations to foster greater community involvement on all levels, including innovative ways to provide care and services to uninsured patients of limited means.

Among our efforts is support for the Association for Community Health Improvement (ACHI), a national membership association with a mission to strengthen community involvement through education, peer networking and the dissemination of practical tools. ACHI is the premier national association for community health, healthy communities and community benefit. ACHI delivers professional educational programs on community benefit planning and practice to hospitals nationwide, serves as the educational affiliate of AHA's NOVA Community Health Award program, and works with other national organizations on community benefit education. ACHI hosts two public Web pages with community benefit resources for hospitals and leads a national community benefit advisory committee.

AHA's most recent innovative effort on community benefit includes a publication entitled *Community Connections: Making Communities Healthier.* This booklet provides hospitals with numerous examples of model outreach programs that have helped to improve access, coverage and quality of life, address social and basic needs and promote healthier living. The *Community Connections* publication reflects the many ways that hospitals are providing meaningful community benefit. Some examples:

- McKay-Dee Hospital Center in Ogden, Utah – Children's Health Connection is a two-day health fair that provides medical, dental, vision and other screenings as well as necessary follow-up medical visits for children from low-income families.

- The Mercy Hospital of Pittsburgh in Pittsburgh, Pennsylvania – Operation Safety Net® is an innovative outreach program to assist the homeless population by walking the streets with 30 volunteer health professionals who provide medical services, testing and counseling among other services to the homeless.

- St. Peter's Hospital in Helena, Montana – Heart of the Matter is a free community event that provides community residents with the opportunity to visit with cardiologists, to be tested for heart disease, monitor their blood pressure and body fat and participate in demonstrations of CPR and defibrillators.

- John C. Lincoln Health Network in Phoenix, Arizona – Wee Care is a day care facility for sick children that allow parents to have their children cared for by trained pediatric caregivers when they are unable to be at home with them.

The response to the booklet has been gratifying. Since receiving the publication, many hospital leaders, justifiably proud of their teams' work in the community, have asked that their own model community outreach program be included in future *Community Connections* reports.

Beyond these important examples of community benefit, we are encouraged that 97 percent of the hospitals responding to our annual survey reported that the hospital's mission statement includes a focus on community benefit, and that 93 percent reported that they have resources for community benefit activities.

CHA/VHA Model for Reporting Community Benefit
At Independent Sector's CEO Forum, you said:

> *"[t]here is little or no common policy among hospitals. We're finding there aren't even common definitions about such critical areas as charity care and community care."*

You strongly encouraged the hospital field to come forward with its own proposal for "common definitions" and other reforms.

The Catholic Health Association of the United States (CHA) and VHA Inc., have provided leadership in the area of uniform reporting of community benefit and developed reporting guidelines that are published in a document entitled *Community Benefit Reporting, Guidelines and Standard Definitions for Community Benefit Inventory and Social Accountability.* These Community Benefit Guidelines capture the range and diversity of how hospitals benefit their communities and provide a standard platform for identifying, describing, quantifying and reporting this benefit.

Specifically, the Community Benefit Guidelines address three areas.

- They include a general description of what constitutes a community benefit and a list of criteria for determining whether a program or service should be counted.

- They provide a glossary of definitions, so that in identifying, describing or calculating community benefit, hospitals are guided by the same set of terms.

- They provide guidance on how to count and quantify community benefit, recognizing that some benefit is not easily counted and, therefore, is better portrayed through a narrative.

The Community Benefit Guidelines are dynamic, revised periodically to reflect new areas of community benefit and to address questions that may arise about existing areas. They are sufficient to encompass local and regional variations in community benefit as well as variations among different types of hospitals.

Options on Community Benefit
On the topic of community benefit, the AHA calls upon all (private) not-for-profit hospitals to adopt the following policies going forward:

- Conduct a periodic community needs assessment, with a frequency to be determined by the hospital (can be done collaboratively with other community organizations).

- Assign responsibility for a community benefit plan to a hospital employee.

- Calculate community benefit for purposes of reporting using the Community Benefit Guidelines document; when calculating community benefit for each category, however, hospitals should include direct and indirect costs of subsidized health care services, charity care, bad debt, and the unpaid costs of government-sponsored health care (including Medicaid, Medicare and public and/or indigent care programs).

- Report community benefit, as calculated above, as an attachment to the Form 990.

We believe there is general agreement, albeit not consensus, among the not-for-profit hospital field that the Community Benefit Guidelines, with the accommodations reflected above, are an appropriate model for achieving more standardized community benefit reporting at the federal level. The accommodations reflect certain current practices of a number of states, including Texas and Illinois. We recognize that special consideration may be required for hospitals that face particular financial or staffing challenges, and we welcome the opportunity to discuss those issues further at your convenience.

On the question of whether we plan to modify the AHA Annual Survey of Hospitals: We continually review the survey and update it as appropriate in consideration of advances in medicine and other important trends in the hospital field.

On the question of AHA constituency sections, we attach the *Guide to AHA Governance and Policy Development* (AHA Guide), which describes the association's constituency sections.

Option 3 – Recommendations Including Those of the Panel on the Nonprofit Sector

In 2004, you and Senator Max Baucus invited Independent Sector, an organization that represents charities, foundations and other not-for-profit organizations, to convene an independent national panel of experts from the not-for-profit sector (Panel). Their purpose: to make recommendations that strengthen good governance, ethical conduct and effective practice of public charities and private foundations. The invitation expressed concern about "transactions with and within charitable organizations that are inappropriately exploiting charities' tax-exempt status and that may be wrongly enriching individuals and corporations."

America's hospitals support key recommendations of the Panel that call for increased transparency and accountability of governance in hospitals and other not-for-profit organizations. We believe that many of the Panel's recommendations are a thoughtful and meaningful response to the concerns that have been raised, and provide a roadmap to improved transparency and accountability. We are particularly pleased that the report calls for improvement within the not-for-profit sector itself through the adoption of best practices and self-regulation, as well as more effective oversight and changes in law and regulatory requirements.

The AHA recently accepted Independent Sector's invitation to participate in a special Advisory Committee on Self-Regulation of the Charitable Sector. The goal of the committee is to help the Panel make recommendations for strengthening the not-for-profit sector's efforts to regulate itself. When the work of the special Advisory Committee and the Panel is complete, we anticipate endorsing additional recommendations for self-regulation.

Support for Recommendations that Strengthen Transparency, Governance and Accountability
AHA calls upon all (private) not-for-profit hospitals to adopt the following policies going forward:

- Have the CEO, CFO or highest ranking officer sign-off on Form 990.
- Attach audited financial statements for the Form 990 for hospitals with $1 million or more in annual revenues; for hospitals with revenues of $250,000 to $1 million, a required review of submitted financial statements by an independent public accountant. For health systems, allows for a single, system-wide audit to be performed.
- Prohibit loans to board members or executives.
- Disclose on the Form 990 whether a hospital has a travel policy.
- Disclose on the Form 990 whether a hospital has a conflict of interest policy.

Recommendations Pose Particular Difficulties for Hospitals
We do not support several of the Panel's recommendations because they would have unintended negative consequences for some hospital systems.

While the AHA strongly supports calls for stronger oversight and greater independence of the governance of not-for-profit hospitals and organizations, the recommendations requiring at least one-third of board members to be independent could, for example, hurt the leadership of religiously sponsored hospitals and health systems. Many of these organizations are sponsored by a governing board or council of a single or multiple religious congregations, which appoint a governing board of lay and religious leaders who work in partnership with the sponsoring council to provide effective oversight. Based on a review of the recommendations and summary information, it appears that the sponsoring boards of these organizations would not meet this independence requirement.

The AHA also is concerned about recommendations that would require Type III supporting organizations to distribute a specified percentage of their income or assets each year and limit the number of organizations that could be supported. Those recommendations pose particular difficulties for hospital systems that aggregate assets and capital in a Type III supporting organization in an effort to improve efficiency and organize purchases. In addition, several hospital systems that are organized as a Type III support more than five charitable organizations. The new limit would thus disrupt important work being done by these charities. Since the Panel's recommendations were aimed at donor-supported Type III organizations, applying these new restrictions to hospital systems is not only unnecessary, but also disruptive.

Practices in Other Areas

You asked us to comment on hospital practices in a number of areas, some of which are rather broadly defined. We believe we can most usefully contribute to furthering the Committee's knowledge by responding on these areas:

- Joint ventures and other financial arrangements – In questions that you directed to various hospital systems, the concern raised about joint ventures pertained to those between hospitals and physicians. The AHA believes that some joint ventures are defensive measures taken in response to a reimbursement system that encourages the development of specialty or limited-service hospitals. These specialty hospitals siphon off resources that community hospitals must have in order to provide a broad range of services that include emergency care and burn units that rarely if ever pay for themselves. They also deprive community hospitals of the services of physicians needed to provide on-call emergency care to meet instant, 24-hour demand.

  We applaud your leadership on the specialty hospital issue and encourage you to continue your investigation of these hospitals, including their investment structures, whether physician investors are truly at risk, and the proportionality of investment related to financial return.

- Executive compensation – We believe that the Internal Revenue Service's (IRS) current approach under its intermediate sanctions rules – which create a "rebuttable presumption of reasonableness" if hospitals take certain procedural precautions in determining executive compensation – is the correct approach. Those precautions include advance approval by an authorized body composed entirely of individuals without a conflict of interest, a determination by this body that the entire compensation arrangement is reasonable based on comparability data and contemporaneous documentation.

- Travel and expense reimbursement – The AHA endorses the Independent Sector proposal that charitable organizations should be required to disclose on their Form 990 whether they have a travel policy.

- Billing and debt collection practices – The AHA is a partner with other leading health groups in the Patient Friendly Billing Project®. That project is a national effort to make financial communications to patients – including hospital bills – clear, concise and correct. More information is available on this important project at www.patientfriendlybilling.org.

On the topic of debt collection, AHA calls upon all hospitals to adopt the following policies going forward:

- Maintain written policies about when and under whose authority patient debt is advanced for collection and liens are placed on a primary residence.

- Obtain written assurances that any outside organization used to assist with debt collection complies with The Fair Debt Collection Practices Act and the ACA International Code of Ethics and Professional Responsibility.

- Conflicts of interest – The AHA endorses the Independent Sector proposal that the IRS should require every charitable organization to disclose on its Form 990 whether it has a conflict of interest policy.

- Accounting, reporting, public disclosure, and general transparency – These issues are addressed throughout this letter.

We also note that the CHA provided additional useful information on these and other topics in its April 13, 2006 response to your inquiry.

AHA Governance Structure and Policies

You have asked several questions about the AHA's governance and membership structure, our policies, and our plans to work with outside and federal agencies to address some of the issues identified in the letter. In addition to the following response, we attach the AHA Guide, which addresses some of the same issues in greater detail.

AHA Governance and Board Structure

The AHA governance structure consists of a Board of Trustees that serves as the decision-making body of the association and is responsible for the approval of all major policy and governance activities. The Board includes a chair, chair-elect, immediate past chair, the AHA president, representatives (chairs) of the nine Regional Policy Boards (RPBs), 12 at-large trustees who represent a cross-section of the association's institutional membership (based on type of hospital or health system, geographic location, ownership, profession), and state hospital associations. In addition, up to two independent members (typically not affiliated with a member hospital) may serve.

Several committees report directly to the Board. Several are focused on external policy matters, while others focus internally on such matters as operations, audit, investments and executive compensation. The Operations Committee is responsible for monitoring the association's overall financial performance, as well as directly managing the relationship with our independent, external auditors.

The AHA's RPBs assist in the development of AHA policy by providing input on issues to be considered by the Board of Trustees. The RPBs include the RPB chair, representatives from each state in the region, constituency and membership section representatives, and regional physician and trustee delegates.

Other committees reporting to the Board include: an Executive Committee, a Long-Range Policy Committee, a Nominating Committee, several Constituency Sections representing various segments of the hospital field (e.g. small or rural hospitals, metropolitan hospitals, and long-term care and rehabilitation facilities), and several specialty committees (e.g. hospital trustees and volunteers).

The Committee on Nominations, which consists of the four most recent Board chairs and four at-large association members, annually recommends a slate of candidates for AHA chairman-elect, open Board seats, and most RPB positions. These are subsequently elected by the Board. Any member may nominate someone for a seat on the Board.

Benefits of AHA Membership

AHA is a voluntary, not-for-profit association of health care provider organizations that are committed to health improvement in their communities. The AHA is the national advocate for its members, which include 4,800 hospitals, health care systems and other health care organizations and 35,000 individual members. We represent their interests before the Congress, federal agencies, the judiciary and the media.

In addition to our advocacy and representation initiatives in Washington, the association addresses a wide range of issues and emerging trends that affect our member hospitals and the patients and communities they serve through research, education and policy development activities in areas such as quality and patient safety, hospital and health care governance and community health improvement.

AHA members have access to a wide range of information and resources on important issues and trends. In addition, AHA members receive continuous communications to help them implement new federal regulations or better serve patients and communities.

Institutional membership dues are based on a formula correlated with hospital expenses as reported on the AHA Annual Survey of Hospitals. If expenses were not submitted, dues are estimated based on the number of hospital-staffed beds multiplied by the national average expense per bed. Based on updated expenses, dues increases from one year to the next are capped at a percentage rate increase that is established annually by the Board of Trustees. Dues for non-hospital providers, provisional members, government groups, and associate members are billed at a flat rate.

The AHA attempts to help all hospitals improve performance by highlighting outstanding accomplishments in the field. In a variety of ways, including highlighting best practices in AHA publications or shining a spotlight on the exemplary performance through an

AHA-sponsored leadership award, we help hospital members better serve their patients and communities. For instance, AHA-sponsored leadership awards in quality, community health improvement and end-of-life care provide a roadmap for others to follow.

With regard to your question about AHA's interaction with the IRS, the AHA has been in regular contact and consultation with IRS officials regarding standards and rules governing tax-exempt hospitals. Most recently, AHA provided written comments on proposed regulations on tax-exempt financing, written comments on proposed changes to the Form 990, and advised our members, after consultation with IRS officials, on IRS examinations of how hospitals should determine executive compensation and how they should meet the community benefit standard. In December 2005, Lawrence Brauer, Acting Manager, Technical Group 1, Exempt Organizations, Internal Revenue Service, addressed AHA members on the IRS 2006 not-for-profit hospital agenda. A dialogue between AHA and key IRS officials on matters of concern to tax-exempt hospitals continues.

Conclusion

Senator Grassley, the AHA looks forward to working with you to address in a comprehensive manner the problems that confront the more than 46 million Americans who lack health insurance coverage. Hospitals will continue to care for all Americans, regardless of their ability to pay. However, more must be done by all with a stake in the problem, including physicians, commercial insurers, industry and policymakers.

Please contact Tom Nickels, our senior vice president of federal relations at (202) 626-2314 or tnickels@aha.org if we can provide additional information.

Sincerely,

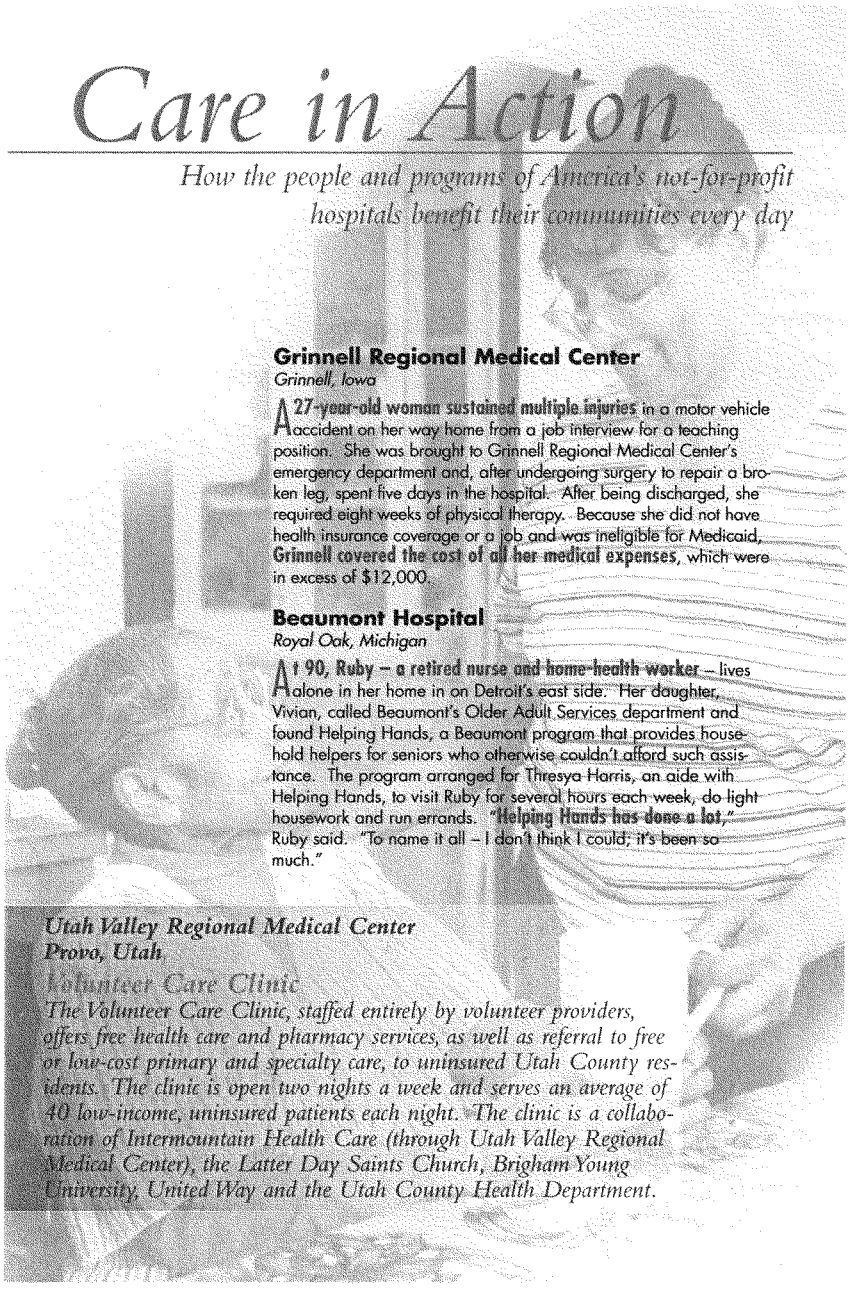
Dick Davidson
President

Courtesy Copy:
Senator Max Baucus (w/attachments)
Senator Ron Wyden (w/attachments)

Attachments:
AHA Principles and Guidelines
Guide to AHA Governance and Policy Development

Care in Action

How the people and programs of America's not-for-profit hospitals benefit their communities every day



Grinnell Regional Medical Center
Grinnell, Iowa

A 27-year-old woman sustained multiple injuries in a motor vehicle accident on her way home from a job interview for a teaching position. She was brought to Grinnell Regional Medical Center's emergency department and, after undergoing surgery to repair a broken leg, spent five days in the hospital. After being discharged, she required eight weeks of physical therapy. Because she did not have health insurance coverage or a job and was ineligible for Medicaid, **Grinnell covered the cost of all her medical expenses**, which were in excess of $12,000.

Beaumont Hospital
Royal Oak, Michigan

At 90, Ruby – a retired nurse and home-health worker – lives alone in her home in on Detroit's east side. Her daughter, Vivian, called Beaumont's Older Adult Services department and found Helping Hands, a Beaumont program that provides household helpers for seniors who otherwise couldn't afford such assistance. The program arranged for Thresya Harris, an aide with Helping Hands, to visit Ruby for several hours each week, do light housework and run errands. **"Helping Hands has done a lot,"** Ruby said. "To name it all – I don't think I could; it's been so much."

Utah Valley Regional Medical Center
Provo, Utah

Volunteer Care Clinic

The Volunteer Care Clinic, staffed entirely by volunteer providers, offers free health care and pharmacy services, as well as referral to free or low-cost primary and specialty care, to uninsured Utah County residents. The clinic is open two nights a week and serves an average of 40 low-income, uninsured patients each night. The clinic is a collaboration of Intermountain Health Care (through Utah Valley Regional Medical Center), the Latter Day Saints Church, Brigham Young University, United Way and the Utah County Health Department.

Saint Francis Medical Center

Grand Island, Nebraska

Raymond started using drugs when he was 12 years old. He got help for his addiction through Saint Francis Medical Center, which created the Student Wellness Center to provide general health care services, as well as mental health counseling ... including assistance for students with drug and alcohol problems. Since getting help from the Center, Raymond has consistently achieved A's and B's in class work and has participated in many school and community activities. **Saint Francis is making a difference** in the lives of vulnerable children and teens through the Student Wellness Center; Raymond Ramirez is living proof.

The Mercy Hospital of Pittsburgh
Pittsburgh, Pennsylvania

Operation Safety Net®

An innovative street outreach program for the unsheltered and transient homeless population, Operation Safety Net (OSN) consists of 14 teams that perform medical rounds by walking the city's streets, alleys and riverbanks providing prenatal care, health counseling, TB and HIV testing, and protection from severe weather conditions through an organized shelter. The program trains approximately 100 residents and medical and nursing students annually in street medicine.

Advocate Lutheran General Hospital

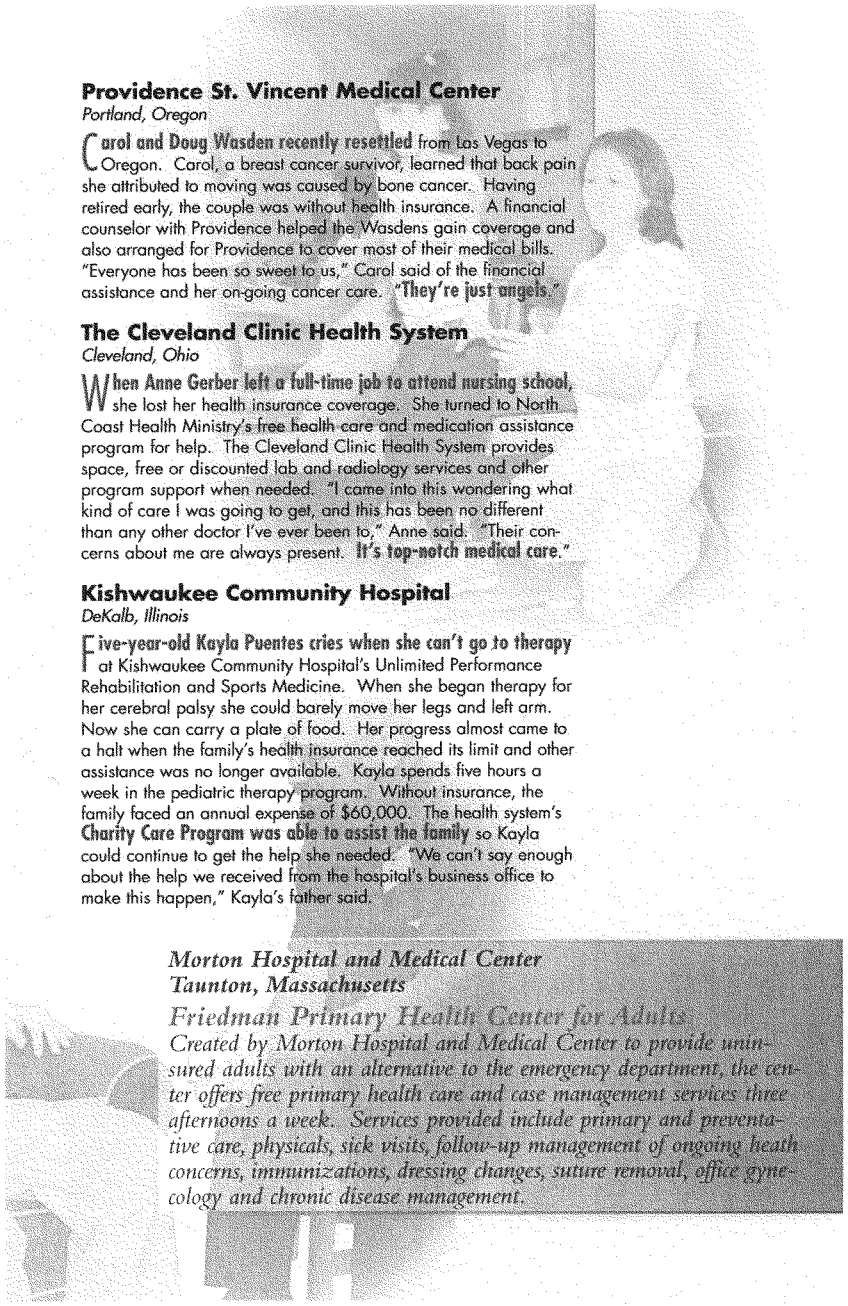
Park Ridge, Illinois

Lewis Wilker tried to ignore the sores on his legs because he didn't have health insurance. Lewis' legs were infected and a chest X-ray showed his lungs also were infected. Doctors realized Lewis had suffered a heart attack and needed a defibrillator implanted in his heart. Without insurance, Lewis and his wife feared he wouldn't receive care. That's when an Advocate hospital stepped in. "They told me not to worry – that the hospital would work it out. I received the implant – **the hospital covered the expense**," Lewis said. Lewis has since started cardiac rehabilitation, and his legs are finally healing with the help of physical therapy and wound care.

Sauk Prairie Memorial Hospital & Clinics

Prairie du Sac, Wisconsin

A 64-year-old Wisconsin woman with aggressive uterine cancer quickly accumulated $156,000 in hospital bills. She couldn't afford health insurance, was denied disability because her limited income was just over the qualifying threshold and was just shy of qualifying for Medicare. With limited financial resources and no health insurance, she found hope in her birthday horoscope – "You're in line for a miracle, so you can take on the impossible." That day she got a call from Sauk Prairie Memorial Hospital & Clinics' Community Care program that **her medical bills would be covered.** This program helps 300-500 patients every year.



Providence St. Vincent Medical Center

Portland, Oregon

Carol and Doug Wasden recently resettled from Las Vegas to Oregon. Carol, a breast cancer survivor, learned that back pain she attributed to moving was caused by bone cancer. Having retired early, the couple was without health insurance. A financial counselor with Providence helped the Wasdens gain coverage and also arranged for Providence to cover most of their medical bills. "Everyone has been so sweet to us," Carol said of the financial assistance and her on-going cancer care. **"They're just angels."**

The Cleveland Clinic Health System

Cleveland, Ohio

When Anne Gerber left a full-time job to attend nursing school, she lost her health insurance coverage. She turned to North Coast Health Ministry's free health care and medication assistance program for help. The Cleveland Clinic Health System provides space, free or discounted lab and radiology services and other program support when needed. "I came into this wondering what kind of care I was going to get, and this has been no different than any other doctor I've ever been to," Anne said. "Their concerns about me are always present. **It's top-notch medical care."**

Kishwaukee Community Hospital

DeKalb, Illinois

Five-year-old Kayla Puentes cries when she can't go to therapy at Kishwaukee Community Hospital's Unlimited Performance Rehabilitation and Sports Medicine. When she began therapy for her cerebral palsy she could barely move her legs and left arm. Now she can carry a plate of food. Her progress almost came to a halt when the family's health insurance reached its limit and other assistance was no longer available. Kayla spends five hours a week in the pediatric therapy program. Without insurance, the family faced an annual expense of $60,000. The health system's **Charity Care Program was able to assist the family** so Kayla could continue to get the help she needed. "We can't say enough about the help we received from the hospital's business office to make this happen," Kayla's father said.

Morton Hospital and Medical Center
Taunton, Massachusetts

Friedman Primary Health Center for Adults

Created by Morton Hospital and Medical Center to provide uninsured adults with an alternative to the emergency department, the center offers free primary health care and case management services three afternoons a week. Services provided include primary and preventative care, physicals, sick visits, follow-up management of ongoing heath concerns, immunizations, dressing changes, suture removal, office gynecology and chronic disease management.

Saint Joseph HealthCare
Lexington, Kentucky

Mobile Health Services

Mobile Health Services, which consists of two buses, provides needed care to the medically underserved, most of whom are uninsured. Serving several surrounding rural counties, including some in Appalachia, Saint Joseph HealthCare brings care to those most in need using telemedicine and a network of community leaders, volunteers and public-private partnerships. This free clinic helps individuals move from crisis management of illness to preventative care and wellness.

Memorial Medical Center

Neillsville, Wisconsin

Like many farmers, Ronald was accustomed to working with aches and pains. But one pain in particular brought him to Memorial Medical Center's emergency department. From the ED, Ronald was admitted to the hospital for several days. After consulting with physicians and running tests, he was finally discharged. Ronald and his wife lived primarily on his Social Security. When Ronald received his bill in the mail, he made an appointment to speak with Amanda in Financial Services. "I just told her the truth … that I was going to need help paying the bill. And Amanda couldn't have been nicer. **Two days later, Amanda called to say it was taken care of,**" Ronald said. "We can't thank them enough."

Mercy Hospital

Port Huron, Michigan

Sue Dawson, a financial counselor at Mercy Hospital, reflects on the notes of thanks written to her by patients and family members. Through Mercy Care, the hospital's financial assistance program for those in need, she was able to help a man in desperate need of eye surgery. Previously unemployable and uninsured, the man now has a much brighter future and wrote, "You are the best. **Now I can see life as it is. Sue, thanks for everything.**"

For more information on how hospitals are helping their communities, visit *www.caringforcommunities.org*

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October 30, 2006

By e-mail and U.S. Post
The Honorable Charles E. Grassley, Chairman
Committee on Finance
United States Senate
Washington, DC 21510-6200

Dear Chairman Grassley:

On behalf of our nearly 5,000 member hospitals, health care systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide written responses to Senators' questions regarding the testimony we presented on September 13, 2006 at the Committee on Finance hearing on charity care and community benefit.

QUESTIONS FROM SENATOR SANTORUM

1. *I have talked with many of the hospitals in PA and a number have charity care policies in place that provide free care to our most needy (under 200% of the federal poverty line), reduced care for those who have some ability to pay (above 200% but less than 400% of the poverty line), and even work with patients to qualify them for programs that will cover their medical expenses retroactively. However, to remain fiscally viable – even as a nonprofit – a medical facility has to make ends meet. The question then is how to balance the charitable mission of an organization with the need to remain financially stable to continue to serve your communities. How has your organization struck that balance? Is there a difference in how you reach that balance based on whether the nonprofit is a faith-based organization or a secular one? What is done with "margins"?*

We do not believe that there is a difference between how faith-based and secular hospitals should meet their charitable mission. With respect to "margins," that amount stays in the community and is used to continue to provide and expand services to the community.

In April, the AHA's Board of Trustees (Board) adopted a set of financial assistance and tax-exempt policies designed to help not-for-profit hospitals achieve the proper balance between financial stability and community service. In these policies, the Board addressed four areas: increased financial assistance for uninsured patients of limited means; ensuring fair debt collection practices; reporting community benefit; and increasing financial accountability. A copy of the document is attached. In addition, the Board adopted a "Statement of Principles and Guidelines on Hospital Billing and Collection Practices" (Principles and Guidelines) in 2003. That document was intended to assist hospitals in balancing the need to be profitable with service to their patients and communities. A copy of the Principles and Guidelines also is attached.

The financial assistance and tax-exempt policies adopted in April attempted to achieve the proper balance by calling upon hospitals to:

- provide services to uninsured patients below 100 percent of the federal poverty level at no charge; and
- provide financial assistance to all uninsured patients between 100 percent and 200 percent of the federal poverty level (based on a hospital's choice), asking them to pay *no more than:* a price paid to the hospital under contract by a public or private insurer *or* 125 percent of the Medicare rate for applicable services.

Hospitals can choose to charge on a sliding scale up to those limits or provide greater assistance if they are able to do so.

2. *We have heard some contend that while a nonprofit hospital's charity care policy may be sound, that patients are not aware of this policy and thus it is ineffective. At least in my state, the policies are required to be posted in key public areas, and generally a copy is given to the patient and conversations can be initiated by the patient or the hospital to determine if a patient is eligible any time in the payment or collections process. In addition the Hospital and Healthsystem Association of Pennsylvania put out guidelines on charity care and financial aid in July 2004 that includes a section on implementation such as communicating the availability of the policy, training staff on the policy and administering the policy fairly, respectfully and consistently. Without requiring every patient to be pre-screened for eligibility, what other specific points do you think should be added?*

We commend the Hospital and Healthsystem Association of Pennsylvania – and many other state hospital associations – for adopting charity care and financial aid guidelines that address many of the issues that hospitals across the country struggle with every day.

In our Principles and Guidelines, we listed specific actions that hospitals should take to ensure that they are helping patients qualify for coverage and communicating effectively with patients about the availability of charity care and financial assistance. For example:

- Hospitals should provide financial counseling to patients about their hospital bills and should make the availability of such counseling widely known.

- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Hospitals should have understandable, written policies to determine if they [patients] qualify for public assistance programs or hospital-based assistance programs.

The complete text of those recommendations is attached. To date, over 4,000 hospitals have signed a "Confirmation of Commitment" to adhere to the Principles and Guidelines.

The Board reaffirmed its commitment to the Principles and Guidelines in the financial assistance and tax-exempt policies adopted in April. That document called upon hospitals to provide financial assistance counseling for uninsured patients of limited means and make information about their financial assistance policies easily available to the public.

3. *How do you balance the desire to get patients enrolled in plans or qualified for the charity care policies without forcing patients to provide personal and financial information that they may not want to provide?*

The financial assistance and tax-exempt policies adopted by the Board in April recognized explicitly that:

> Hospital financial assistance is contingent upon the cooperation of a patient in providing the information necessary for a hospital to qualify that patient for its program of assistance or for public or other coverage or assistance that may be available.

Federal and some state regulations require that hospitals obtain certain information from patients in order to qualify them for charity care or financial assistance. While we understand and respect the personal nature of some of this information, hospitals are bound to comply with these requirements.

4. *In the Commonwealth there is a requirement that nonprofit hospitals certify annually to the Department of Public Welfare that they have a charity care program, their efforts to seek collection of all claims and attempts to obtain health coverage for patients. If we continue to provide charity care above a certain level – such as 400% of the poverty line – does that not discourage the purchase and maintenance of health insurance?*

The financial assistance and tax-exempt policies adopted by the AHA Board in April attempted to achieve the proper balance by calling upon hospitals to:

- provide services to uninsured patients below 100 percent of the federal poverty line at no charge; and
- provide financial assistance to all uninsured patients between 100 percent and 200 percent of the federal poverty line (based on a hospital's choice), asking them to pay *no more than:* a price paid to the hospital under contract by a public or private insurer *or* 125 percent of the Medicare rate for applicable services.

Hospitals can choose to charge on a sliding scale up to those limits or provide greater assistance if they are able to do so. However, it must remain the goal of Congress and the hospital field to encourage all individuals to have health insurance coverage and do nothing that would discourage such coverage. The issues being debated by the Senate Committee on Finance would best be addressed by encouraging health care coverage for all Americans.

5. *Community benefit is a concept that will vary greatly from hospital to hospital and area to area. I understand that some have argued that all community benefit should be limited to charity care or specific standardized items. In my experience the community benefit of the Children's Hospital of Pennsylvania offering training for parents on how to properly use child safety seats in cars and the low-income health clinics by our research hospitals both serve their community. How do we continue to ensure that there is community benefit but take into consideration the difference between types of hospitals, charitable missions, size and location?*

In our testimony on September 13, we continued to support the existing community benefit standard for many of the reasons Senator Santorum describes above. In our written testimony, we stated that the current community benefit standard "permits hospitals to satisfy their community obligations by providing the right mix of programs and services" so that hospitals can respond to the needs of their communities. For example, Pittsburgh's Mercy Hospital assembles teams of health professionals to locate and provide care for the homeless because that is a service needed in that community.

Community benefit should not be a one-size-fits-all standard. Retaining the current community benefit standard will ensure that hospitals are able to provide the programs and service needed in their communities. Ultimately, it is the community that decides whether the institution is meeting its responsibilities.

QUESTIONS FROM SENATOR ROCKEFELLER

Question 1 for Sister Carol Keehan, Kevin E. Lofton, and Scott A. Duke
Topic: Uninsured

I think the real issue facing all hospitals, but primarily nonprofit hospitals, is the problem of the uninsured. The Census Bureau just reported last month that, in 2005, the number of uninsured adults rose to 46.6 million. And, the number of uninsured children rose for the first time since 1998 to 8.3 million.

As I understand it, nonprofit hospitals have a hard time trying to shoulder the uncompensated health care burden caused by lack of health insurance. In West Virginia, nonprofit hospitals had $442 million in uncompensated health care in 2005. By comparison, the uncompensated health care burden of WV's for-profit hospitals was only $54 million.

With the added costs of Medicare and Medicaid cuts as well as cuts to health professions training programs, many nonprofit hospitals struggle to keep their doors open. And, their tax exempt status is the only thing that allows them to stay afloat.

Sister Keehan, Mr. Duke and Mr. Lofton, can you talk a little bit about the challenges faced by your hospitals because of the lack of health insurance? You can't just move costs around, can you?

Hospitals do more to assist the poor, sick, elderly and infirm than any other member of the health care sector. In 2004 alone, hospitals delivered more than $27 billion (in costs) in uncompensated care to patients, and uncounted billions more in value to their communities through services, programs and other activities designed to promote and protect health and well-being.

The growing number of uninsured Americans – 46.6 million according to current estimates – puts enormous strain on our nation's hospitals. A 2005 report from a major accounting firm stated that the availability of charity care at U.S. hospitals is all that stands "between a thorny policy dilemma and an access crisis for millions of Americans." Moreover, neither Medicare nor Medicaid pays hospitals the full costs of the care they provide to beneficiaries.

The AHA consistently has supported legislative and private efforts to expand insurance coverage for all Americans. And, hospitals will continue to serve all patients, regardless of their ability to pay, until a solution to the coverage crisis is found. However, as you state, hospitals cannot simply move costs around. As the cost of providing care for uninsured patients continues to grow, other hospital priorities will have to be postponed or sacrificed to meet this challenge.

Question 2 for All Panelists
Topic: IRS Determination of Tax Exempt Status

It has been suggested by some that the 1969 IRS Community Benefit standard for determining tax exempt status is too broad and was wrongly decided. However, it is true that nonprofit hospitals contribute to their communities in a variety of ways. Some nonprofit hospitals focus almost exclusively on providing charity care.

Others, such as teaching hospitals, focus more on scientific research that will lead to treatments and cures for diseases. Other nonprofit hospitals provide invaluable education services to their communities.

We have a Children's Health Van at Marshall University in West Virginia, which I helped create, that provides vital health education services to children and their families. Most of these families would have no contact with the health care system otherwise. I think that is a huge community benefit.

Don't you agree that nonprofit hospitals benefit communities in a variety of ways – from charity care to scientific research to capital investment and infrastructure development?

Who else is going to make the investment in health care that we are going to need as our population ages?

We agree entirely that not-for-profit hospitals benefit communities in a variety of ways – from charity care to scientific research, from capital investment to infrastructure development – and that, absent that investment by hospitals, such programs and services would languish. Hospitals are able to provide a variety of programs and services to their communities thanks in large measure to the 1969 Revenue Ruling 69-545, which established the current "community benefit" standard. That ruling established that "promotion of health in a manner beneficial to the community and free of any private benefits or profits is a charitable purpose."

The community benefit standard continues to work well for not-for-profit hospitals and, more importantly, the communities they serve. The standard permits hospitals to satisfy their community benefit obligations by providing the right mix of programs and services to their communities, so that:

- A hospital in Clarksburg, West Virginia, along with other not-for-profit hospitals in the state, can sponsor an asthma camp to help low-income children learn how to control their asthma – a service very much needed in a state that ranks fifth in the nation in asthma prevalence.
- A hospital in Ogden, Utah, can supply its community with a health fair that provides all local children and their families with medical, dental and vision screening as well as necessary follow-up care for low-income families.
- A hospital in Helena, Montana, can offer local residents the opportunity to visit a cardiologist and be tested for heart disease and related conditions.
- A hospital in Phoenix, Arizona, can provide an as-needed day care center for sick children staffed by pediatric caregivers.
- A hospital in rural South Dakota can fund a volunteer ambulance service to help residents get to the hospital in time.

These programs and services represent just a few examples of the thousands of ways hospitals across the country determine a community need and then act to address it.

Question 3 for Dr. Kane (with Follow-up from Mr. Duke and Mr. Lofton)
Topic: Nonprofit Hospital Tax Exemption Recommendation

In your testimony this morning you make a number of recommendations for a higher standard for a federal tax exemption. Your first suggestion is that nonprofit hospitals be required to provide charity or discounted care equal to the value of their tax exemption. I am concerned about what such a strict standard would mean for other public benefits that hospitals currently provide. Let me list just a sample of the other community benefits that members of West Virginia's Hospital Association provide:

i. free health screenings;
ii. cancer education programs;
iii. wellness classes and support groups;

iv. *scientific research;*
v. *in-kind donations of equipment, pharmaceuticals, and medical supplies;*
vi. *workforce development.*

It seems to me that a "community benefit" standard that considers only charity care disregards many of the other extremely valuable functions that nonprofit hospitals provide our communities. Why shouldn't those other contributions be considered in determining tax exempt status? And how accurately can we possibly quantify the value of those services to the community?

Mr. Duke and Mr. Lofton, what are your thoughts on this?

Again, we agree entirely that a community benefit standard that considers only charity care, and disregards many of the other extremely valuable services and programs that not-for-profit hospitals provide, would be wrong and have a negative impact on the communities now served by not-for-profit hospitals.

As described above, hospitals provide an impressive array of services and programs designed to respond to the needs of the communities they serve – not those of a community in another part of town, or the state, or another state entirely. This flexibility is invaluable.

At the same time, we recognize that the full value of many of these community benefit programs and services may be difficult or even impossible to quantify. This concern was reinforced in a recent *Health Affairs* article, where the authors (both prominent health researchers) concluded that "**[a]ssessing the full impact that health care organizations have on communities is difficult, because not all community-benefit activities are readily measurable.**"

The researchers also cautioned against the imposition of standard criteria against which not-for-profit entities' performance would be measured, concluding that such criteria would be "**excessively inflexible, substituting decisions by state and federal policymakers or regulators for choices better made in communities.**" Instead, the authors argue for an approach that fosters community involvement. We agree.

Question 4 for Sister Carol Keehan and Mr. Lofton
Topic: Medicare and Medicaid Shortfalls

It is my understanding that nonprofit hospitals are required to participate in Medicare as a condition of retaining tax status. However, from year-to-year, nonprofit hospitals experience shortfalls in Medicare reimbursements as well as Medicaid reimbursements. In West Virginia, the underpayments by state and federal governments for treating Medicaid patients cost hospitals an additional $100 million annually.

My question, Sister Keehan and Mr. Lofton, is why shouldn't shortfalls in Medicare and Medicaid reimbursement – assuming they can be accurately calculated – be included in a nonprofit hospital's community benefit calculation?

It is the position of the AHA Board that both Medicaid and Medicare underpayments should be included, along with the cost of bad debt, in a not-for-profit hospital's community benefit calculation.

After months of consultation with our members and a review of the ways in which many states handle community benefit, the Board in May 2006 unanimously passed a resolution calling on hospitals to take steps to foster additional community involvement and increase transparency in the service of that benefit. Specifically, the Board called for **standardized public reporting of community benefit (as an attachment to Form 990) using the model developed by the Catholic Health Association of the U.S. in cooperation with VHA, Inc.** The Board determined that the calculation of community benefit should fully reflect the benefits hospitals provide, and thus include: the direct and indirect costs of subsidized health care services; charity care; bad debt; and the unpaid costs of government-sponsored health care, including Medicaid, Medicare and public and/or indigent care programs. The Board stated:

> We believe there is general agreement, albeit not consensus, among the not-for-profit hospital field that the Community Benefit Guidelines [CHA/VHA], with the accommodations reflected above, is an appropriate model for achieving standardized community benefit reporting at the federal level.

This approach is consistent with that of many states, including California, Idaho, Illinois, Indiana, Nevada, North Carolina, Pennsylvania, Rhode Island, Texas and Utah.

We appreciate that there can be intellectually honest differences within the hospital field regarding reporting that includes or excludes Medicare underpayment or bad debt. But those differences should not and are not preventing not-for-profit hospitals from reporting the value of their community benefit in a way that reflects the cost to those hospitals of shouldering the burden of bad debt and coping with the gaps created by Medicare and Medicaid underpayments.

QUESTIONS FROM SENATOR BINGAMAN

1. *Over the past several years, attention on the issue of how hospitals handle charitable care and community benefits has clearly had a positive impact, as hospitals across this country have revised their policies and made those very policies more transparent to the public.*

   This hearing was rightly focused largely on issues around "charitable care" and "community benefits" and the "tax-exempt status" of certain hospitals in the country.

   I would like to bring to the table another issue that is of importance to my state and those of the Chairman and Ranking Member and that has to do with the Medicaid and Medicare disproportionate share hospital (DSH) programs. These programs are also under the jurisdiction of the Senate Finance Committee, and I think that we should also think carefully about the billions of dollars spent on those programs and the impact they have on charitable care and community benefit.

First, due to historical nature of the DSH program, there are profound differences in the amount of federal Medicaid DSH dollars that go to provide assistance to hospitals that care for a disproportionate share of low-income Medicaid and uninsured patients based on state boundaries. States such as New Mexico, Iowa, Montana, Arkansas, Oregon, North Dakota, Idaho, Utah, and Wyoming receive less than an estimated $82 per uninsured individual in DSH funding compared to over $650 per uninsured individual in New Hampshire, Louisiana, Rhode Island, Maine, and Missouri. In other words, federal Medicaid DSH dollars are flowing to certain states to help hospitals deal with the uninsured at more than eight times the level than nine states represented on the Senate Finance Committee.

For the information of Mr. Hartz, Virginia also receives less than $100 per uninsured individual from the federal Medicaid DSH program.

What should the Senate Finance Committee do to improve the fairness within the Medicaid DSH program and the equity in funding that goes to help hospitals address uncompensated care in their communities and states?

Should DSH funds follow the uninsured patient so that hospitals are not, what some might call "double-dipping," by both collecting DSH funding and then billing the uninsured patient separately?

The Medicaid program continues to serve as the nation's health care safety net for low-income and vulnerable populations. Hospitals always have played an important role in ensuring access to care for the Medicaid population, and, for the last 25 of its 40 year existence, the Medicaid program has recognized the importance of providing hospitals with additional financial assistance when serving large populations of Medicaid and uninsured patients. These Medicaid disproportionate share payments have allowed safety-net hospitals across the country to continue their mission.

Over the last 15 years, Congress has addressed several issues with regard to the states' operation of their Medicaid DSH payment programs, and the Centers for Medicare & Medicaid Services (CMS) has continued its vigorous oversight of the program. It is important to note that despite the additional funds provided to hospitals through Medicaid DSH, the overall Medicaid program continues to pay hospitals well below the cost of providing care to the Medicaid population. In 2005, Medicaid paid only 88 cents on every dollar of care provided, resulting in nearly $10 billion in underpayments to hospitals. As the Committee on Finance examines the Medicaid DSH program, it must look at the chronic underfunding of Medicaid that has plagued the program for years. The questions of equity and balance in the Medicaid DSH program can be addressed only when the overall program is adequately funded and pays for the full cost of the care its beneficiaries receive. Anything less is tinkering at the margins.

2. *On a related matter, the Medicare DSH program has a formula that has the paradoxical effect of, while intended to target money to safety net and charitable hospitals, of actually reducing funding to hospitals as they provide more and more uncompensated care. The formula is flawed in that uncompensated care is not reflected in the numerator but only in the*

denominator. Thus, for every increase in uncompensated care at a hospital, the formula has the perverse effect of actually reducing DSH dollars to that hospital.

"The DSH payment formula rewards hospitals that treat poor patients who have health insurance but penalizes hospitals for treating patients who do not have health insurance," says Sean Nicholson at AEI in a report entitled Medicare Hospital Subsidies. "Ironically, the structure of the DSH payment formula may...reduce the supply of hospital care to the (low-income) uninsured, the group that arguably faces the greatest barriers to medical care." Mr. Samuelson estimated that, in addition to losing revenue through uncompensated care on uninsured patients, hospitals lose an additional $171 per uninsured admission, on average, due to reductions in Medicare DSH payments.

In recognition of this problem, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations in the past regarding revising the Medicare DSH formula, including:

- *The low-income share measure should reflect the cost of services provided to low-income patients in both inpatient and outpatient settings. This, of course, would help rural hospitals greatly, as they provide a larger volume of their care in such settings.*
- *In addition to Medicare SSI and Medicaid patients, the low-income share measure should include uninsured and underinsured patients represented by uncompensated care and also other patients sponsored by other state and local indigent care programs. This would help eliminate disparities in Medicare DSH payments caused by differences in Medicaid eligibility rules across states.*
- *Medicare DSH should be concentrated among hospitals with the highest shares of low-income patients. A minimum threshold should be established below which a hospital receives no DSH payment but there should be no "notch" that would provide substantially different payments to hospitals just above and below the minimum threshold.*

Mr. Nicholson argued that the MedPAC proposals "correct most of the problems with the structure of the DSH program. The more inclusive measure of care provided to the poor would direct more DSH funds to hospitals that provide a substantial amount of uncompensated care but have a relatively low volume of Medicaid and Medicare/SSI patients...The proposed index would also eliminate the perverse incentive that currently exists of penalizing hospitals that increase the number of uninsured patients they treat. Under the recommended formula, admitting more uninsured patients would increase rather than decrease DSH payments."

As such, when the federal government is investigating the issue of charitable care and community benefit provided by hospitals, should the federal government also reassess a funding formula in the Medicare program that actually has the perverse incentive of penalizing hospitals for caring for uninsured and underinsured patients?

In addition, what do the witnesses think about the recommendations made by MedPAC in 1998, 1999, and 2001 and summarized in the bullets above to revise the Medicare DSH

formula and do they agree with Mr. Nicholson that they would improve the Medicare DSH formula?

And finally, to what extend should DSH funds be targeted on core safety net providers that are financially vulnerable?

The AHA supports the inclusion of uncompensated care in the Medicare DSH formula. Toward that end, the AHA, along with MedPAC and others, has worked with CMS to develop a reliable data collection instrument, as was instructed by the *Balanced Budget Refinement Act of 1999*. That work continues today. While the Medicare DSH program has provided financial assistance to hospitals to ensure access to care to Medicare beneficiaries, it is important to note that overall Medicare payments to hospitals remain well below the cost of providing care to the Medicare population. In 2005, hospitals received 92 cents on every dollar of care provided to Medicare beneficiaries, and Medicare underpaid hospitals by $15 billion overall. We look forward to working with the Committee, MedPAC and others to re-examine the Medicare DSH formula once we have sufficient and reliable data. We also look forward to working with the Committee to address the program's hospital underpayment problems.

Thank you for the opportunity to respond to these questions. If you need further information, please contact Tom Nickels, AHA senior vice president for government relations, at (202) 626-2314 or tnickels@aha.org.

Sincerely,

Kevin E. Lofton

Kevin E. Lofton
Chair-Elect

cc: Senator Rick Santorum
Senator Jay Rockefeller
Senator Jeff Bingaman

AMERICAN HOSPITAL ASSOCIATION

Approved
Board of Trustees
April 29, 2006

BILLING, COLLECTION AND TAX-EXEMPT STATUS

Following are a set of hospital financial assistance and tax-exemption policies and procedures that build on AHA's existing *Hospital Billing and Collection Practices Statement of Principles and Guidelines*. Together, they represent AHA's strong statement of expectation – a more detailed direction in which the hospital and health system field can and should move on its own to address issues of billing, collection, increased accountability and tax-exempt status. Some of these elements may be appropriate for legislation. These policies and procedures outline what hospitals can and should do, from this day forward, to make sure we are doing everything we can to better serve patients and to treat them equitably, with dignity, compassion and respect.

INCREASED FINANCIAL ASSISTANCE FOR THE UNINSURED OF LIMITED MEANS
(Applies to all hospitals)

- Provide financial assistance and counseling for uninsured people of limited means, without regard to race, ethnicity, gender, religion or national origin.

- Financial assistance provided by hospitals to uninsured people of limited means should in no way substitute for state efforts to provide or expand coverage to the uninsured. State Medicaid programs should be required, at a minimum, to sustain a "maintenance of effort" keeping programs' eligibility at least at their current levels. Further, state Medicaid programs also should be required to expand coverage to *all* individuals at or below the poverty level. Until that time, hospitals should have policies to provide services to uninsured patients below 100% of the federal poverty level at no charge. Existing clinical and geographical criteria used by hospitals to determine eligibility for certain services would apply.

- Provide financial assistance to all uninsured patients between 100% and 200% of the federal poverty level by asking them (based on a hospital's choice) to pay *no more than*:
  - A price paid to the hospital under contract by a public or private insurer; *or*
  - 125% of the Medicare rate for applicable services, given that in the aggregate today, Medicare pays less than the cost of care.

  For these patients, hospitals may choose to charge on a sliding scale up to the stated limits. Hospitals also may choose to provide greater assistance.

- May offer financial assistance to uninsured patients with incomes in excess of 200% of the federal poverty level at the discretion of the hospital.

- Hospital financial assistance is contingent upon the cooperation of a patient in providing the information necessary for a hospital to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from hospitals shall have a responsibility to pay according to the terms of that policy.

- Cosmetic surgery and other non-medically necessary services are exempt.

- Make information about a hospital's financial assistance policy easily available to the public.

- Hospitals that have financial assistance policies that meet or exceed those above shall have immunity from related class action lawsuits.

ENSURING FAIR DEBT COLLECTION PRACTICES
(Applies to all hospitals)

- If using outside debt collection organizations, obtain written assurances that that organization complies with the Fair Debt Collection Practices Act and the ACA International's Code of Ethics and Professional Responsibility.

- Have written policies as to when and under whose authority a patient account is advanced for collection. If a patient has completed a hospital's application for financial assistance, that account should not be advanced for collection pending determination of eligibility.

- Have written policies as to when and under whose authority a lien can be placed on a patient's primary residence.

REPORTING COMMUNITY BENEFIT
(Applies to non-government, not-for-profit hospitals)

- Conduct a periodic community needs assessment, with a frequency to be determined by the hospital (can be done collaboratively with other community organizations).

- Assign responsibility for a community benefit plan to a hospital employee.

- Calculate community benefit for purposes of reporting using the Community Benefit Guidelines in CHA/VHA's *Community Benefit Reporting* document; when calculating community benefit for each category, however, hospitals should include direct and indirect costs of subsidized health care services, charity care, bad debt, and the unpaid costs of government-sponsored health care (including Medicaid, Medicare and public and/or indigent care programs).

- Report community benefit, as calculated above, as an attachment to the Form 990.

INCREASING FINANCIAL ACCOUNTABILITY
(Applies to non-government, not-for-profit hospitals)

- CEO, CFO or highest ranking officer sign-off on Form 990.
- Attach audited financial statements for the Form 990 for hospitals with $1 million or more in annual revenues; for hospitals with revenues of $250,000 to $1 million, a required review of submitted financial statements by an independent public accountant. For health systems, allows for a single, system-wide audit to be performed.
- Prohibit loans to board members or executives.
- Disclosure on the Form 990 as to whether a hospital has a travel policy.
- Disclosure on the Form 990 as to whether a hospital has a conflict of interest policy.

American Hospital Association

Hospital Billing and Collection Practices

Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association

The mission of each and every hospital in America is to serve the health care needs of people in their communities 24 hours a day, seven days a week. Their task, and the task of their medical staffs, is to care and to cure. America's hospitals are united in providing care based on the following principles:

- Treat all patients equitably, with dignity, with respect and with compassion.
- Serve the emergency health care needs of everyone, regardless of a patient's ability to pay for care.
- Assist patients who cannot pay for part or all of the care they receive.
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals' doors open for all who may need care in a community.

Hospitals' work is made more difficult by America's fragmented health care system ... a system that leaves *millions* of people unable to afford the health care services they need ... a system in which federal and state governments and some private insurers do not meet their responsibilities to cover the costs of caring for Medicare, Medicaid or privately insured patients ... a system in which payments do not recognize the unreimbursed services provided by hospitals ... a system in which a complex web of regulations prevents hospitals from doing even more to make care affordable for their patients. Today's fragmented health care system does not serve Americans well in many ways. It is in need of significant change as each day leaves more and more hospitals unable to make ends meet.

While most Americans have insurance coverage for their unexpected health care needs, more than 43 million people do not. Some of these people can pay for the health care they

may need, but America's hospitals treat millions of patients each year who can make only minimal payment, or no payment at all. In the absence of adequate insurance coverage for all, America's hospitals must find ways to both serve and survive.

Unfortunately, a vast and confusing array of federal laws, rules and regulations make it much more difficult than it should be for hospitals to respond to the concerns of patients of limited means who are unable to pay their hospital bills. Government must commit to removing these regulatory barriers to allow hospitals to do even more to make care affordable for patients who cannot pay for part or all of the care they receive.

The following guidelines outline how hospitals can better serve their patients. Hospitals have been following some of these guidelines for years as they work each day to find new ways to best meet their patients' needs.

Guidelines

Helping Patients with Payment for Hospital Care

Communicating Effectively

- Hospitals should provide financial counseling to patients about their hospital bills and should make the availability of such counseling widely known.
- Hospitals should respond promptly to patients' questions about their bills and to requests for financial assistance.
- Hospitals should use a billing process that is clear, concise, correct and patient friendly.
- Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services.

Helping Patients Qualify for Coverage

- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.
- Hospitals should share these policies with appropriate community health and human services agencies and other organizations that assist people in need.

Ensuring Hospital Policies are Applied Accurately and Consistently

- Hospitals should ensure that all written policies for assisting low-income patients are applied consistently.
- Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

Making Care More Affordable for Patients with Limited Means

- Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community's health care needs, including providing the necessary subsidies to maintain essential public services.
- Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts (pending needed federal regulatory clarification). Policies should clearly state the eligibility criteria, amount of discount, and payment plan options.

Ensuring Fair Billing and Collection Practices

- Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.
- Hospitals should define the standards and scope of practices to be used by outside collection agencies acting on their behalf, and should obtain agreement to these standards in writing from such agencies.
- Hospitals should implement written policies about when and under whose authority patient debt is advanced for collection.

Hospitals in some states may need to modify the use of these guidelines to comply with state laws and regulations.

Hospitals exist to serve. Their ability to serve well requires a relationship with their communities built on trust and compassion. These guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of hospitals' commitment to caring.

Statement of Senator Charles Schumer
Finance Committee Hearing
"Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals"
September 13, 2006

Mr. Chairman, I am deeply concerned by what brings us here today.

We are a country with more than a few problems in our health care system. As you know, there are 46.6 million uninsured Americans. All Americans, insured and uninsured alike, are subject to skyrocketing health care costs. And, unfortunately, we as a nation will pay anything for expensive, heroic interventions once we're already sick or in danger, but do not value the cheap preventive care that can keep us from getting sick in the first place.

And yet, despite all of these problems, the subject of today's hearing is whether non-profit hospitals deserve their tax-exempt status or not.

New York State has 209 non-profit hospitals. They are often the only point of access to health care for 3 million uninsured New Yorkers. This service comes at an enormous cost, since New York hospitals have been in the red for the last seven consecutive years, but they continue to accept the patients that come to their doors.

And they have done a wonderful job, not only in providing charity care, but also in developing innovative ways to benefit the community.

Seton Health in Troy, for example, runs a "Mommy" program that teaches pregnant teenagers how to balance adolescence with parenthood. Participants in the program receive early training in how to be new mothers and responsible caregivers.

Another non-profit hospital, Strong Memorial at the University of Rochester, runs the SMILE program in which 12 full-time staff travel around the region in a mobile dentist's office. These dedicated workers provide dental care to 3,700 children and teens in 15 inner city schools, eight Head Start programs, and three remote rural locations.

These are only two examples of the wonderful things that non-profit hospitals do, yet these kinds of programs are not taken into account by the critics who claim that non-profit hospitals are not doing enough to justify their tax-exempt status.

I understand that there are bad actors. There are bad actors in every industry, and we should certainly hold hospitals accountable that are hounding uninsured patients who are poor and can't possibly pay bills for marked-up services.

But to claim, as some have, that non-profit hospitals are no different from for-profits is ludicrous. Many for-profit institutions will find any way they can to turn away poor people. But places like New York Presbyterian, which is a non-profit hospital that I pass

by all the time when I'm in Washington Heights, take in the poorest of the poor and turn no one away.

Mr. Chairman, I'm nervous about the desire expressed today to narrowly define what "community benefit" means. Great variation exists among hospitals and the needs of the communities they serve, both between states and within states. New York's hospitals do not make money and will be affected very differently by any new requirements we impose than hospitals in another state. And likewise, how can we define "community benefit" in a way that makes equal sense for rural, suburban, and urban hospitals?

To address the real health care issues in our country, we must ensure that Americans have health insurance so they can go to a regular doctor and stop overcrowding emergency rooms. We must also focus on preventive care so that Americans will use fewer, and less expensive, hospital-based treatments.

In the meantime, let's not rush to impose new requirements on the institutions that serve as a safety net for our sickest and weakest citizens. God knows we don't give them the resources they need, and yet they are there for us in our most terrifying moments.

They stitch the gashes on our children's heads, they treat the strokes and heart attacks of our parents, and they diagnose our cancers. They do this for the people sitting in this room, and they do it for the 46.6 million people that we have abandoned. Thank you.

Statement of the Honorable Olympia J. Snowe
Senate Committee on Finance
Hearing: Taking the Pulse of Charitable Care and
Community Benefits at Nonprofit Hospitals
September 13, 2006

Good morning. I would like to thank Chairman Grassley for holding this hearing so we can consider the critical issue of how our non-profit hospitals are serving their communities.

Today approximately 85 percent of the nearly 5000 hospitals in America are non-profit institutions. They enjoy tax exempt status - by the rationale that they utilize that advantage to contribute to their communities. In their beginning, some of these institutions functioned as the *only* means of accessing care for the indigent. Today charity care is but a part of their mission, as non-profit hospitals provide such services as education and training, disease screenings, wellness programs and much more. Yet we have heard of some hospitals where the original core mission - to treat all persons, regardless of circumstances - may have been compromised.

I do not see that in my state of Maine. In my state - where we are served *exclusively* by non-profit hospitals - nearly all have given free care to any patient below 150 percent of the federal poverty level (FPL). Today all are pledging to do so. And most do *far more*. Over half give free care for patients up to 200 percent of FPL, while two reach all the way to 250 percent. Many also utilize a sliding fee scale above these limits to discount charges. Indeed one - the Franklin Memorial Hospital - has been nationally recognized as it in fact does *both*.

There is little doubt that for-profit hospitals sometimes look similar to non-profits today. In part, that reflects the fact that all hospitals are struggling under a complex and strained health care finance system. Each struggles with the burden of the uninsured - a population now at a *record level of 46.6 million*. So we should not expect hospitals - whether for-profit or non-profit - to fill all the gaps in our system.

This hearing is largely about equity - and what special obligations we will expect of hospitals which enjoy a non-profit status. Today the IRS no longer requires charity care of non-profits, but uses a "facts and circumstances" test for determining tax status - and there is no *"bright line"* between for-profit and non-profit status. Indeed last year IRS Commissioner Everson indicated that it is becoming increasingly difficult to distinguish non-profit hospitals from their for-profit counterparts. He stated, "*We at IRS are now faced with a health care industry in which it is increasingly difficult to differentiate for-profit from non-profit health care providers.*"

Our attention has been drawn to this issue as the uninsured, with the least resources, pay the highest prices for their health care. When you have been severely ill - when you are facing bills four to five times what an insurance company would pay - and when collectors come hounding you to pay - and the non-profit hospital looks more to you like an organization with its focus only on the bottom line - that is most *certainly* a recipe for outrage. *But is that sort of behavior an aberration?*

We certainly must address the fact that some Americans are facing these circumstances. And we must look carefully here as we examine how non-profits serve their communities. It is entirely appropriate that we examine the standards for this privileged status. Today a number of factors are considered in determining whether an institution provides substantial community benefit, such as whether staff privileges are available to all qualified physicians in the community. I am quite confident that the vast majority of institutions would certainly pass muster when we examine their performance. *I know my own in Maine would.*

I look forward to hearing our witnesses today, and welcome a discussion, including the full scope of the community benefits of non-profit hospitals.

Thank you, Mr. Chairman.

Senate Finance Committee:
"Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals"

Senator Craig Thomas (R-WY) Statement for the Record

September 13, 2006

Thank you, Mr. Chairman, for holding what I hope will be the beginning of a series of Finance Committee hearings to discuss the special tax status America's non-profit hospitals enjoy. It is my understanding that there have been numerous lawsuits filed over the past year alleging that non-profit hospitals are intentionally inflating their costs and price-gouging folks who do not have any insurance. I have also seen several reports claiming non-profit hospitals not only engage in these types of unscrupulous billing practices, but also hire extremely aggressive collection agencies to prey on patients who cannot afford to pay their debts. Like the Chairman, I want to ensure that non-profit hospitals are treating folks fairly. Are uninsured patients across the country consistently charged outrageous prices for medications, medical equipment, and surgeries? Today's hearing will require non-profit hospitals that have long been seen as charitable organizations to answer some very serious questions about whether they deserve to keep their tax exempt status.

After reviewing the witnesses' testimony, however, I am concerned that we are jumping too quickly to label all non-profit hospitals as "bad actors". As Republican Co-Chair of the Senate Rural Health Caucus, you all know rural health care is near and dear to my heart. My hometown, Wapiti, Wyoming is a community that is rural beyond rural. So, I have some first-hand knowledge of the obstacles families face in obtaining medical care in rural America. I also understand the challenges our hospitals and providers face in delivering quality, affordable, accessible care to families in a remote environment with limited resources.

Wyoming communities face considerable challenges as they hold together fragile health care networks that deliver essential primary health care services. There are well over 20 non-profit hospitals in Wyoming, and while I know that not all health systems and providers are perfect, I have seen the work our rural hospitals and our Critical Access Hospitals (CAH) have each done to benefit their individual communities. Rural hospitals are a central hub of community service and economic development. Wyoming communities that can offer quality health care are better able to attract and retain residents, workers, and businesses. In fact, rural hospitals provide more than just inpatient and outpatient services. Rural and frontier hospitals offer home health, hospice, rehabilitation, skilled nursing, laboratory, and ambulance care – just to name a few. Rural hospitals and their hospital administrators shoulder significant community demands. The CEOs in my state work hard to keep their facilities operating in the black on limited budgets, to be good fiscal stewards of taxpayer dollars, and to meet local demands for services at affordable prices. This is no easy task, especially since the folks coming to the hospital for services are not simply admissions, but our families, friends, and neighbors. I say all this because I hope that when folks walk away from this hearing, they will keep in mind what non-profit hospitals mean to rural communities. Everyone must and should be accountable to play by the rules. However, I do not believe we should throw the baby out with the bathwater. If not for the presence of non-profit hospitals in rural Wyoming communities, I wonder whether there would be any for-profit hospitals willing to serve them?

There is no question that these non-profit institutions as well as the Internal Revenue Service must do a better job reporting, tracking, and monitoring their charity care and community benefit activities. At the same time, we cannot forget the implications any proposed tax policies may have on the overall health care system. I am pleased to see we have folks here to testify today on both sides of this complex issue. I look forward to hearing their testimony.

COMMUNICATIONS

Statement for the Record
of the
Alliance for Advancing Nonprofit Health Care
for the
United States Senate
Finance Committee

Hearing on Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals

September 13, 2006

Mr. Bruce McPherson
Executive Director
Alliance for Advancing Nonprofit Healthcare

Mr. Chairman, Ranking Member Baucus, and distinguished Members of the Committee, Started in mid-2003, the Alliance for Advancing Nonprofit Healthcare is dedicated to preserving and enhancing the abilities of nonprofit healthcare organizations to serve society and their individual communities. Through research, public education, and advocacy, the Alliance seeks to provide a strong, cohesive and persistent "voice" for a wide range of nonprofit healthcare organizations sharing many common goals and challenges--hospitals, health insurers, nursing homes, home care providers, community health centers, and others. In addition, through educational programs, guidelines and other tools, the Alliance seeks to enhance the performance of nonprofit healthcare organizations in carrying out their unique roles and responsibilities in their communities. For instance, the Alliance has developed guidance documents on community benefits and governance.

Mr. Chairman, in previous remarks you have said the nonprofit hospital community "should come forward with its own substantive proposals for common definitions and reforms in areas such as community benefit, charitable care, charges to the uninsured, debt collection and joint ventures." The board of the Alliance for Advancing Nonprofit Health Care takes this challenge very seriously. Accordingly, the Alliance for Advancing Nonprofit Healthcare has worked with its membership and other healthcare organizations to develop a constructive proposal for reforming the tax exemption requirements for nonprofit hospitals.

The Alliance commends the Committee for examining the issue of tax-exempt status in the health care community, and hopes that this examination will reaffirm the widespread commitment of nonprofit hospitals and other nonprofit health care organizations to serving their communities. In the face of some well publicized reports in the media that have highlighted some alleged inappropriate behaviors by a very small percentage of nonprofit heath care providers, we hope that these hearings will help publicize the much more prevalent story of the great benefits that the vast majority of nonprofit heath care organizations provide to the communities they serve, as well as to broader society, including charity and discounted care, innovative programs that lead to increased community health and wellness, as well as medical research and education. They strive to provide these services in close relation to the needs of their communities and within the boundaries of their financial abilities. Bad publicity over some nonprofit hospital billing and collection practices for low-income, uninsured patients has spurred some critics to call for a specific charity-care standard or other financial test for tax exemption. The Alliance believes that such "one-size-fits-all" regulatory approaches would only serve to undermine nonprofit hospitals' ability to respond to the special healthcare needs of the communities they serve within their unique financial circumstances.

The Alliance's reform proposal is consistent with the overall movement toward greater public accountability and transparency on the part of nonprofit health care organizations. The proposal would require all tax-exempt hospitals to:

- Report annually in a uniform manner on the community benefits they provide. Definitions of categories of community benefits and methods for estimating financial investments and results would be derived from the voluntary guidelines already developed by the Catholic Health Association and VHA. The report could be made publicly available via the organization's Form 990 filing and posting on its Web site.
- Adopt and broadly disseminate a clearly written policy for providing financial assistance to low-income uninsured and underinsured patients. Each hospital's policy would need to specify:
    - The annual income level and other criteria the hospital uses to determine which patients are eligible for financial assistance.
    - The amount of the discount, the discount rate or the method used to compute the discount or the discounted rate.
    - Whether and in what circumstances outsourcing of collections is used as well as various types of legal tools (e.g., garnishment of wages, lien on the primary residence) with respect to the collection of unpaid bills. Methods used to compute and report annually on the numbers of patients and dollar amounts associated with patient financial assistance.

Requirements for disseminating the policy would be derived from voluntary guidance already developed by a number of state hospital groups. Federal requirements would need to be compatible with existing state requirements, and phased in and tailored to the capabilities of different sized hospitals and systems.

The Alliance's proposal is intended to address concern about the vagueness of the current community-benefit definition and standard, while preserving the flexibility that the individual not-for-profit hospital must have to address the specific needs of the community it serves within its unique financial circumstances. The detailed proposal developed by the Alliance for its membership is attached for your reference and review, as well as the guidance documents that have been developed for our membership that address governance guidelines for nonprofit healthcare organizations, as well as our guidelines on community benefits practices.

Background on Tax-Exemption of Hospitals

Nonprofit hospitals have played a vital role throughout our nation's history in delivering health care services to their communities. According to the latest available data from the American Hospital Association (AHA), there are 2,984 private nonprofit hospitals in the U.S., representing 61% of all of the short-term acute care hospitals (4,895) in the U.S. Another 1,121 hospitals are owned by state or local government (23%), and 790 (16%) are for-profit/investor-owned. 787 (26%) of the private nonprofit hospitals are religiously sponsored.

In order to qualify for tax exemption as a charitable organization under the Internal Revenue Code, an organization must be organized and operated exclusively in furtherance of a charitable purpose, and must not be operated, directly or indirectly, for the benefit of private interests. However, the activities of organizations carrying on many vital charitable functions, notably education and the promotion of health, are at least superficially similar to the activities of commercial organizations, *i.e.*, for-profit schools and hospitals. In addition, educational organizations and hospitals both impose charges (with exceptions) for their services and may operate with an annual surplus of receipts over disbursements. While nonprofit health care organizations must operate under the adage, "No money, no mission", they do not face the demands of the equity markets to maximize earnings for investors. Nonprofit earnings need not be as high, or as constant, and all that they are able to earn is "plowed" back into facilities, programs and services benefiting the community in a variety of ways.

The IRS has appropriately recognized that a nonprofit hospital may qualify for exemption as a charitable organization even though it operates at an annual surplus of receipts over disbursements. Thus, in Revenue Ruling 69-545, the IRS concluded that the promotion of health, like the relief of poverty and the advancement of education and religion, was one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, so long as the class that is benefited is not so small that its relief is not of benefit to the community. In Revenue Ruling 69-545, the IRS approved the exemption of the hospital considered in that Ruling in large part because, by operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, that hospital was promoting the health of a broad class of persons and thus providing a benefit to the community. The favorable conclusion in Revenue Ruling 69-545 also reflected the fact that control of the

hospital rested with a board of trustees, which was composed of independent civic leaders; that the hospital maintained an open medical staff, with privileges available to all qualified physicians; and that all members of its active medical staff had the privilege of leasing available space in its medical building.

While the conclusion of Revenue Ruling 69-545 rested in part on the fact that the hospital considered in that Ruling operated an emergency room open to all persons, the IRS has characterized the presence of an "open" emergency room only as "strong evidence" of a charitable purpose, and has never made the operation of an "open" emergency room either a sufficient or a necessary condition to tax exemption. For example in Revenue Ruling 69-544 which was published concurrently with Revenue Ruling 69-545, the IRS denied tax exemption to the hospital considered in that Ruling even though that hospital also operated an emergency room open to all persons.

The basis for the denial of exemption in Revenue Ruling 69-544 was the conclusion of the IRS that the hospital considered in that Ruling, which had initially been established as a proprietary institution operated for the benefit of its owners and later transferred to a nonprofit organization, had continued to operate for the private benefit of its original owners who exercised control over the hospital through the board of trustees and the medical committee. Revenue Ruling 69-544 concluded that this group had used their control to restrict the number of doctors admitted to the medical staff, to enter into favorable rental agreements with the hospital, and to limit emergency room care and hospital admission substantially to their own patients.

More recently, the IRS has also concluded that, in appropriate cases, a nonprofit hospital could qualify for tax exemption even though it did not maintain an "open" emergency room. For example in Revenue Ruling 83-157, the IRS concluded that a nonprofit hospital that was not required to operate an emergency room where a state or local health planning agency had found that this would unnecessarily duplicate emergency services and facilities that were adequately provided by another medical institution in the community could still qualify for exemption as a charitable organization based on other significant factors, including a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research, indicate that the hospital is operating exclusively to benefit the community.

More generally, Revenue Ruling 83-157 also noted that certain specialized hospitals, such as eye hospitals and cancer hospitals, offer medical care limited to special conditions unlikely to necessitate emergency care and do not, as a practical matter, maintain emergency rooms. Revenue Ruling 83-157 stated that these organizations may also qualify for exemption as a charitable organizations based on other significant factors that demonstrate that the hospitals operate exclusively to benefit the community.

Tax-Exemption and Community Benefit

The fact that nonprofit hospitals typically find themselves in competitive markets does not mean that they are principally commercial enterprises like for-profit hospitals. To be

sure they are often competing for patients who are beneficiaries of large government financing programs like Medicare and Medicaid or who are members of private health plans. They also often face intense competition for private philanthropic support from a variety of other types of national, state and local nonprofit organizations. Despite competition, nonprofit hospitals continue to play a unique and critical role in our society.

The difference between nonprofit and for-profit hospitals has recently been called into question, but the difference is really quite simple: nonprofit hospitals exist to serve their communities, while for-profit ventures exist primarily to serve their investors. While it may seem elementary, this distinction is not a simple one that can be easily quantified through the cursory examination of charity care or other numbers. The community benefits provided by nonprofit hospitals extend far beyond the number of Medicaid patients they treat, their annual amount of charity and discounted care, and even the offering of typically unprofitable services like emergency care or burn care. The true community benefit of a nonprofit hospital is all of these things and more that come together to form a total composite of value for the community.

Nonprofit hospitals also engage in community outreach activities and programs in a variety of ways to promote wellness and improve the health status and well-being of their communities. Community benefit outreach efforts are not sought out for marketing purposes, or increasing potential patient visits for profitable services. Nonprofit hospitals seek ways to address these needs as part of their essential mission to serve the community. These outreach efforts are not typically uniform to all parts of the nonprofit hospital's geographic service area, but instead are often specific to the mix of people in the communities they serve. Some hospitals provide culturally sensitive services targeted to underserved immigrant populations in their region, others provide preventive care services in their community such as childhood fitness and screening in conjunction with school districts, others provide free car seats and training on their use, day care services, and outreach and counseling to the elderly. While the costs of such activities in actual dollars may vary widely, the effects and benefits they have in their communities can be immense, albeit very difficult to measure.

An additional challenge to determining the true community benefit of a nonprofit hospital centers around defining exactly what is the community in question. While most people define a community solely by the geographic region or catchment of the hospital, that is an oversimplification of the larger roles that nonprofit hospitals play. Nonprofit hospitals are heavily engaged in medical and health professions education, which serve the entire health care sector, as well as their specific geographic regions. Nonprofit hospitals are often at the forefront of research, not just in the clinical applications of new techniques and technology, but also research into improving patient outcomes, creating new efficiencies, preventive medicine and wellness activities, innovative access demonstration projects, and reducing medical errors. Through the extensive and intensive research being performed everyday by nonprofit hospitals, the entire healthcare industry benefits from the sharing of this knowledge, and achieves even greater degrees of efficacy and efficiency.

Another important type of community benefit is where a nonprofit hospital can demonstrate superior operating performance compared to other hospitals operating in its

community with respect to one or more measures of cost, quality and/or patient satisfaction. Some nonprofit hospitals may also have, and be sharing with others, innovations in medical management or in other areas of operations. Excellent performance in various performance dimensions represents a benefit to current and potential future patients and can "raise the bar" for others, resulting in benefits for the broader community. The Alliance has conducted its own review of the research literature and has posted on its Web site, www.nonprofithealthcare.org, a summary of findings which strongly suggests overall superior performance by nonprofit hospitals on various cost, quality and service indicators that were studied.

In addition to this tapestry of community services, nonprofit hospitals also provide more intangible benefits. One essential assurance that for-profit enterprises can never guarantee with the same degree of certainty – nonprofit hospitals are typically permanent fixtures and health care providers in the community, and will not sell, close or move due to short-term fiscal pressures. One cannot put a price tag on community trust that the organization will stay to serve the community through thick or thin, that the organization's business practices will be ethical, and that energies will be expended on a sustained basis by the organization to advocate public policies to improve

One final point requires emphasis. Tax exemptions and other special tax treatments are essential for ensuring that nonprofit hospitals have reasonable access to capital so that they can compete on a fairly level playing field with for-profit hospitals having access to the equity markets.

Conclusion

The Alliance strongly believes that the current tax-exemption requirements for nonprofit hospitals are not fundamentally broken, but can and should be enhanced through annual uniform reporting requirements related to community benefits and through broad dissemination of hospital policies related to financial assistance to low-income uninsured and underinsured patients.

We commend the Committee for taking the time to examine this important sector of health care, and would be happy to work with the Committee throughout its deliberations, and to try and answer any questions it might have. The Alliance would also be pleased to discuss with you the voluntary guidance that we have already developed for our members on community benefits and governance, and any ways in which such guidance might be embellished.

Thank you.

Attachments (4)
--Alliance Membership List
--Proposal for Reform of the Federal Tax Exemption Requirements for Nonprofit Hospitals
--Guidelines on Community Benefit Practices
--Guidelines on Governance Practices

ALLIANCE MEMBER ORGANIZATIONS

Alabama Blue Cross Blue Shield
Alliance of Catholic Health Care
American Association of Homes and Services for the Aging
Cleveland Clinic Health System
East Alabama Medical Center
Excela Health
Florida Blue Cross Blue Shield
Geisinger Health System
Hospital Alliance of Tennessee
Health Care Service Corporation[1]
Henry Ford Health System
Jewish Guild for the Blind
Lifetime Healthcare Companies[2]
Massachusetts Blue Cross Blue Shield
Metropolitan Jewish Health System
Michigan Blue Cross Blue Shield
Michigan Health and Hospital Association
Minnesota Blue Cross Blue Shield
National Association of Community Health Centers
Provena Health
Rehabilitation Institute of Chicago
Rocky Mountain Health Plans
Sacred Heart Health System
UMass Memorial Health Care, Inc.

[1] Includes Blue Cross Blue Shield Plans in Illinois, New Mexico, Oklahoma and Texas
[2] Includes Excellus Blue Cross Blue Shield Plans in Upstate New York and Univera Healthcare HMO in Buffalo

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PROPOSAL FOR REFORM OF THE FEDERAL TAX EXEMPTION REQUIREMENTS FOR NONPROFIT HOSPITALS

Approved by the Alliance Board of Directors on February 14, 2006

Background

Over the past two years House Ways and Means Committee Chairman William Thomas has held hearings on nonprofit hospital tax-exemption, questioning whether the $66 billion federal tax-exemption for hospitals is justified. High on Chairman Thomas' list of concerns is the amount of financial assistance that nonprofit hospitals provide to their low-income uninsured patients, and the need for a clearer, more specific community benefit standard.

Within the past year Senate Finance Committee Chairman Charles Grassley began his own examination of the community benefit and related practices of selected hospitals and hospital systems, and recently has publicly challenged the nonprofit hospital sector to come forward with its own definitions and standards for reform of the federal tax-exemption requirements for nonprofit hospitals.

The Alliance for Advancing Nonprofit Health Care accepts this challenge. The Alliance proposes reforms that address policymakers' criticisms of the vagueness of the current community benefit definition and standard, while preserving the flexibility that the individual nonprofit hospital, whether independent or part of a system, must have to address the specific needs of the community it serves, within its unique financial circumstances.

This proposal is consistent with the overall movement toward greater public accountability and transparency on the part of all sectors of society.

The Alliance's Proposal

The Alliance proposes two major federal tax-exemption reforms for nonprofit hospitals:

1. Require all tax-exempt hospitals to report annually in a uniform manner on the community benefits they provide
    a. The requirements should include:
        i. Definitions of categories of community benefit and methods of estimating costs, revenues and results where feasible, adapted from the voluntary

guidelines already well developed by the Catholic Health Association and VHA, Inc.

ii. Methods for making these reports publicly available, including Form 990 filing and posting on the organization's web site

b. The requirements should complement existing state requirements for hospital community benefit reporting

c. The requirements should be phased in and tailored to the capabilities of different sized hospitals and systems

2. Require all tax-exempt hospitals to adopt and broadly disseminate clear written policy for providing financial assistance to low-income uninsured and underinsured patients. Hospital policies should embody fair, dignified, compassionate and respectful treatment of patients, while recognizing that each hospital must balance the needs of patients for financial assistance with other community needs and with the hospital's larger responsibility to be able to serve its community over the long run.

   a. The tax-exempt hospital's policy should include at least the following information:

      i. The annual income level[3] and other criteria the hospital uses for determining which patients are eligible for financial assistance

      ii. The amount of the discount, the discounted rate, or the method used to compute the discount or the discounted rate for eligible patients

      iii. The hospital's policy on outsourcing collections, and on various legal tools[4] to be used or not used, under specified circumstances with respect to collection of unpaid bills

      iv. The methods by which the hospital computes and reports at least annually the number of patients and dollar amounts associated with financial assistance

   b. The requirements for dissemination of the hospital's policy within the organization and in the community should be adapted from guidance developed by state hospital groups, such as those in California, Illinois, Minnesota, New York, Oregon and Pennsylvania

   c. The requirements should be phased in and tailored to the capabilities of different sized hospitals and systems

The Alliance is eager to work with interested Congressional leaders, the IRS and major hospital groups on the details of these proposed reforms and to explore any other reasonable reform measures they may suggest.

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[3] To be expressed in relation to the federal poverty level using the most current data

[4] For, example, wage garnishments, liens on a primary residence, or body attachments

Advancing the public accountability of nonprofit health plans:

GUIDELINES ON COMMUNITY BENEFIT PRACTICES

ALLIANCE FOR ADVANCING NONPROFIT HEALTH CARE
WWW.NONPROFITHEALTHCARE.ORG

INTRODUCTION

Nonprofit health plans[1], many created by nonprofit hospitals during the Depression, have histories rich in the tradition of providing social benefits to their communities. Over the past three decades, however, with increased competition from for-profit health insurers, conversions of some nonprofit health plans to for-profit, and movements from community rating to experience rating of health risks in many parts of the U.S., the community benefits being provided by nonprofit health plans have become less apparent to government, subscribers, other stakeholders, and the general public.

At the same time, with rising health care costs, shifting of those costs by business to employees, cutbacks in government financing and delivery of health care, and growing numbers of uninsured and underinsured individuals and families, unmet community needs are increasing, resulting in greater public scrutiny of and demands for demonstrated community benefits from nonprofit health plans as well as nonprofit health care providers.

Researchers Schlesinger, Gray, and Gusmano recently reported on the results of their research on the nature, scope, and depth of HMO community benefit activities in 1999.[2] While they found that nonprofit health plans were providing broader community benefits, they also

noted wide ranges in the degree of sophistication with which individual organizations approach the community benefit component of their missions.

Purpose of This Report

The Alliance intends that the ideas and concepts presented in this document be used as a tool to motivate and enable nonprofit health plans to improve their community benefit practices. The guidelines are based on the recommendations of Alliance members, taking into consideration the excellent guidance developed over the past decade for nonprofit health care providers by the Catholic Health Association and VHA, Inc.[3]

Special Notes

- Since the bylaws, organization structures, and other circumstances of individual nonprofit health care organizations vary from one community to the next, the guidelines will not be a perfect fit in each instance and must not be construed as prescriptive standards. Rather, they provide a pathway to examining and continuously improving governance.

- Each organization will need to adapt them to its own needs and situation, and should consult legal counsel before and during their implementation regarding federal, state, and local laws defining community benefit standards and reporting requirements.

- The nature and extent of the specific community benefit programs or activities provided or supported by nonprofit health plans will vary based on community needs and the organization's resource capabilities at any given time.

- Substantial and sustained success in carrying out the community benefit component of the organization's mission hinges on ongoing commitment from the top, including both governance and executive management, creating and maintaining a culture of supportive values, policies, structures, and processes that ensure that delivering community benefits becomes an integral part of planning, operations, performance assessment, incentives, and recognition.

- Some nonprofit health plans conduct many or all of their community benefit efforts through their parent organization, while others do so through one or more subsidiaries, such as a nonprofit health care foundation. Regardless of the locus, the planning, implementation, assessment, and reporting of community benefits needs to be coordinated across the entire organization. This suggests the need for a community benefit "infrastructure," consisting at a minimum of a designated lead executive for organization-wide coordination of effort.

- By the very nature of their enterprises, an essential component of the community benefit focus of nonprofit health plans is and must be improving access to care for at-risk or underserved population groups. At the same time, there are likely to be significant needs and opportunities related to health status improvement or quality of life of the broader community, as well as for quality improvement or cost reduction in the health care system. Consequently, setting priorities can be extremely challenging. At the same time, the organization is likely to have a much greater impact if it focuses its resources in a few areas at a time, rather than spreading them thinly across a wide variety of needs and initiatives.

- Ongoing dialogue and collaboration with community leaders, whether through informal contacts or formal channels, is also essential to success in planning and implementing community benefit programs—to better understand community needs and priorities; to understand existing assets or capabilities in the community; to identify areas where individuals and organizations can work together synergistically; to communicate how and why the health plan has chosen to target its community benefit efforts and the resources involved; and more fundamentally, to establish and maintain trust and effective working relationships. The nature and extent of the collaboration will be impacted by the size and capabilities of the health plan. Collaboration with nonprofit hospitals and other nonprofit health care organizations in the community may be particularly valuable, given their special missions and capacities.

1 This guidance is also intended for the financing component of integrated health care systems.
2 "A Broader View of Managed Care, Part 3: The Scope and Determinants of Community Benefits," *Health Affairs*, May/June 2004: 210–221
3 "Community Benefit Program: A Revised Resource for Social Accountability," CHA, 2002, available for purchase on its web site, www.chausa.org.

- Health plans should encourage their employees at all levels of the organization to voluntarily participate in community organizations and projects, should celebrate their contributions, and should explore whether there are important needs and opportunities to link the organization's community benefit efforts with those of individual volunteers. In assessing and reporting on community benefit programs involving donations of employee time, the organization should distinguish between the paid time that employees devote and the time they volunteer outside work.

- In planning, assessing and reporting on community benefit programs and activities, the organization should strive to measure their costs and benefits, with certain caveats in mind:

  — Some community benefits may be qualitatively important and should not be discounted just because their results are difficult if not impossible to quantify over a given period of time. For instance, some public advocacy efforts on behalf of the disadvantaged may not bear fruit for an extended period, but require persistence. Nor can one put a value on such intangibles as active participation by community leaders in the organization's governance, or the organization's long-standing commitment to the community "through thick or thin."

  — Some community benefit programs and activities may involve significant resource investments on the part of the organization, the measurement of which should be based on clear and consistent accounting practices throughout the organization.

  — Some community benefit efforts may have significant payoffs for the community and should not be discounted just because they do not require significant resources or subsidies from the plan, such as writing a grant application for another organization in the community.

Before presenting specific principles for planning, implementing, assessing, and reporting on community benefits, it is useful to describe the potential range of community benefits that a nonprofit health plan might conceivably provide or support. This description is intended to promote a common understanding and "language" of community benefits among nonprofit health plans, and may suggest additional avenues to some.

THE POTENTIAL RANGE OF COMMUNITY BENEFITS OF NONPROFIT HEALTH PLANS

Nonprofit health plans are essentially "community investment organizations," serving their patients or members and the broader community, not stockholders. As noted earlier, the nature and extent of the community benefits reflect the needs and priorities of the community and the capabilities of the organization, and may be affected by government requirements as well as local market conditions.

There are two very broad categories of community benefits, summarized as follows:

Specific Community Investments

This is the conventional conceptualization of community benefits: special community programs, activities or donations—outside of the plan's regular business operations—intended to:

- Help at-risk or underserved population groups[4]—by increasing their access to care, increasing their access to health insurance, or improving their health status, functional status, or quality of life;[5]

- Help the broader community, rather than a specifically targeted group—by increasing their health status or quality of life; and/or

- Improve quality of care and/or reduce costs/waste through specially targeted efforts within the health care system itself, rather than through its standard provider relationships and regular business operations.

All nonprofit health plans can be expected to provide specific community investments. Appendix A illustrates one approach to categorizing these types of investments.

It should be noted that Appendix A includes the provision of safety net insurance products and participation in government programs. Some health plans may consider these as community benefits within their regular business operations, described in the second category to follow, rather than as special community investments.

4 For example, the poor, the working poor, the uninsured, the underinsured, individuals, small groups, undocumented aliens, the physically disabled, the chronically mentally ill, specific ethnic or racial groups.

5 Quality of life improvements are "community-building" initiatives such as workforce enhancements, housing improvements, and economic development.

Benefits to the Community Derived from Regular Business Operations

Some nonprofit health plans may be able to demonstrate superior operating performance compared to other plans in its community along one or more dimensions, such as the portion of the premium dollar devoted to health care services to members, HEDIS quality indicators, member satisfaction, extensiveness of benefits, accessibility of benefits,[6] or premium levels. Nonprofit health plans that consider provision of safety net insurance products and/or participation in government programs as part of their regular operations may be able to demonstrate that they are experiencing higher enrollment levels in these areas than other health plans in their communities. Some nonprofit health plans may also have, and be sharing with others, innovations in medical management or in other areas of operations. Excellent performance represents a benefit to current and potential future subscribers and may "raise the bar" for others, resulting in benefits for the broader community.

Some nonprofit health plans, however, may not be able to demonstrate performance excellence in their regular operations, lacking valid comparable data or being precluded from differentiation due to state regulatory requirements or market conditions. For example, data on premium levels of competing health plans for comparable insurance products may be unavailable, or intense competition may preclude the health plan from making benefits more accessible in terms of certain underwriting practices.

It is recommended that all nonprofit health plans at least investigate whether it is feasible to achieve and report on particular areas of performance excellence in their regular business operations.

SPECIFIC GUIDELINES

To follow are basic principles recommended as best practice guidelines for nonprofit health plans in planning, implementing, assessing, and reporting on their community benefits.

I. Board and Executive Roles and Commitments:

A. The Board has adopted, regularly reviews, and ensures the broad dissemination both internally and externally of a statement[7] that includes its definition of community benefits and describes the organization's commitment to a formal community benefit program, integrated with other aspects of operations, as an essential component of its mission and as an essential dimension of performance. The organization's community benefit definition encompasses some or all of the elements presented the previous section.

B. The Board approves on a regular basis the organization's multiyear strategic plan as well as the annual operating plan and budgets developed by executive management, with review of the strategic plan at least once a year for any needed major adjustments. Community benefit programs and services are explicitly described in plans and budgets.

C. Board meetings are primarily devoted to important strategic and policy matters, including community benefit goals, progress, and results.

D. An important criterion for selecting individual Board members and the Chief Executive Officer (CEO) is their community benefit orientation, and an important criterion for the Board's overall self-assessment and assessment of the CEO is community benefit performance.

E. Compensation for the Chief Executive Officer, as well as other executives, managers, and staff as appropriate, is linked in part to community benefit performance.

F. The orientation programs for new Board members and new employees include a summary of the organization's community-benefit-related policies and the most current plan and results.

6 Absence of preexisting condition clauses, waiting periods, or other underwriting-base restrictions
7 The statement may be part of the organization's statement of purpose, mission, vision, or values, or it may be a separate policy statement.

G. A lead executive, or a manager reporting to an executive, is assigned the responsibility of coordinating community benefit planning, implementation, assessment, and reporting. This individual is provided with sufficient core resources to effectively carry out this responsibility. While responsibilities for implementation of specific programs, practices, activities, or contributions are assigned as appropriate (e.g., executive management, individual departments, corporate foundation), community benefit is broadly owned throughout the organization.

H. The Board and executives ensure that regular reports are made to key stakeholders, the general public, managers, and staff about the organization's community benefit plan and performance.

II. Collaboration:

A. The organization's members and key stakeholders are involved as appropriate in planning, implementing, and/or assessing the community benefit program. Collaborative relationships are developed and maintained with hospitals, physicians and other health care providers, public health agencies, other public agencies, businesses, church organizations, organizations for specific population groups (e.g., the elderly, children, the disabled, AIDS), civic groups, consumer advocates, and others as appropriate.

B. The organization is actively involved in developing and implementing a broadly supported community-wide plan addressing high priority needs for specific underserved or at-risk population groups within the organization's defined community and/or for its broader community.

III. Planning and Budgeting:

A. Community benefit goals and resource commitments reflect a definition of community, community needs/problems, priorities, community assets, and organizational capabilities, and are appropriately balanced with other dimensions of organizational performance.

B. Community is defined and analyzed geographically and demographically, with particular attention to underserved or at-risk populations.

C. Needs are identified by collecting and analyzing information, including morbidity and mortality, from a variety of existing and/or new sources. New information may need to be collected through written surveys, personal interviews or focus groups, community forums, or other means. Whenever feasible, information collection and analysis involves coordination with and support from other key stakeholders. Healthy People 2010 may be used as a framework to collect and organize information on the health of people in the community.

D. Priorities are set taking into account the scope of the problem (numbers of people affected), the seriousness of the problem (consequences to individuals if not addressed), expected impacts if addressed (improved access, health status, quality of life, short-term versus longer-term effects), and the organization's strengths (tradition, expertise, synergies, available resources).

- The organization compares identified needs to the organization's current community benefit investments.
- Care is taken by the organization to focus on the highest priority need(s) and a limited set of goals, in coordination with key stakeholders in order to create synergies, avoid unnecessary duplication or confusion, and maximize results.
- Given the organization's role and expertise in financing health care services, special attention is given to recognized needs related to:
  - Improving financial access for the poor and uninsured. Examples include: provision of safety net health insurance coverage for individuals and/or small groups; making special payments, grants, or donations to selected individual health care providers with limited means providing free or discounted services to the poor and uninsured; or developing and advocating public policy positions intended to provide more permanent solutions to the financial access problems of the poor and uninsured.
  - Addressing known deficiencies in the quality of health care services that contribute to system waste or increased mortality or morbidity. Examples include community reporting of provider quality performance data, broad-based stakeholder agreement on evidence-based care guidelines, and clinical outcome performance metrics for key conditions and procedures.

E. Specific community investments to meet priority needs are identified, with action plans developed for each, including purpose and description, target group, any community partners/collaborators and the roles of each, timelines, expected outcomes, means of measuring progress and results, staffing and/or other resource requirements, any expected revenues, and person(s) accountable.

F. As part of its community benefit plan, the organization encourages staff to volunteer time for community service, with or without pay, particularly in support of the priority areas identified in the plan. The plan also includes organizational recognition and celebration of staff contributions to community service.

G. Based on the forgoing, an overall community benefit plan and budget are established as part of the organization's overall plan and budget.

IV. Monitoring and Evaluation:

A. The organization evaluates on a periodic, regular basis the structure of its community benefit program, including the nature and extent of support from its leadership; resource commitments; relationships/partnerships with community organizations and other stakeholders; updated information about community needs, assets, and problems; the organization's overall priorities and goals for community benefits; and its reporting strategies.

B. The organization regularly monitors and evaluates how well each key component of its community benefit program is being carried out, in terms of: meeting milestones; the overall adequacy as well as efficient use of staff or other resources; the quality and effectiveness of its partnerships in community benefit efforts, including ways in which the organization might be a better partner; and any unanticipated negative consequences of the organization's efforts.

C. Consistent with its mission and fiduciary responsibilities, the organization regularly evaluates where feasible the costs and results of each major component of its community benefits:

- Is the organization able to achieve and demonstrate areas of performance excellence in its regular business operations that benefit current and potential members or the broader community (e.g., medical loss ratios, selected quality indicators, innovative medical management practices, extensiveness of benefit coverage, accessibility of coverage, premium levels)?

- For each of the organization's specific community investments:

— Does it support the organization's mission?

— Does it address an identified, priority unmet community need?

— Does it explicitly and directly benefit community residents beyond the plan's membership?

— Is it focused on a specific at-risk or underserved population group, intended to increase access to care, increased access to health benefit coverage, improve health status, improved functional status, or improved quality of life? Or is it intended to improve the health status of the broader community or to improve the quality of care or reduce the costs of a targeted provider(s)?

— Does it involve coordination with and support for other community-based organizations that are addressing the same unmet community need or goal?

— Does it focus on the causes of the problem rather than symptoms?

— Does it have an explicit budget in the upcoming fiscal period?

— Does it produce a measurable result, and has it achieved the expected measurable result?

— Even if the costs or subsidies are negligible or the results are intangible, is it nonetheless important from qualitative and commonsense perspectives?

— Would it likely be discontinued if the decision were made on a purely financial basis (i.e., intentionally does not cover its full costs or yield a normal contribution margin)?

— Is it the best approach to addressing the problem?

— Is it credible from the perspectives of members and various stakeholders, so that it is viewed as primarily done in the community's interest rather than in self-interest?

The more the answers to these questions are in the affirmative, the more confident the organization, members, key stakeholders and the general public can be that it is a worthy community investment.

V. Reporting:

A. The organization recognizes multiple reasons for reporting its community benefits both externally and internally: being accountable, demonstrating to all that its actions are consistent with its mission; improving staff morale and commitment; stimulating suggestions for improvements; providing a better understanding of the organization and community needs; informing the general public and targeted groups about available services; and fostering collaboration and participation by others in advocating for and meeting community needs.

B. Through surveys, interviews, focus groups, advisory committees, or other means, the organization regularly gathers and analyzes information about how it is perceived by various stakeholders in order to help determine the most effective means of telling its community benefit story.

C. Specific accounting and other policies guide the organization's categorization, measurement, and reporting of community benefit resource investments and outcomes/results.

D. In its community benefit reporting, the organization includes its mission and core values; its history of commitment to the community and to identifying and acting on its needs; a description of the current priority problems in the community being addressed; a description of the nature and extent of the community benefits it is providing, including as much information as possible about resource commitments and outcomes/results; and human-interest stories.

E. The organization employs a variety of communication vehicles for reporting community benefit information matched to specific internal and external audiences, including making such information broadly and easily accessible to the general public. Examples of such vehicles are printed annual reports distributed by mail or available on the organization's web site, newsletters, verbal presentations with PowerPoint in a variety of forums (Board meetings, managers' meetings, staff meetings, orientation programs for new staff and new Board members, community health fairs and screenings, meetings with reporters or editorial board members, meetings of local organizations, donor events), lobby exhibits, and membership materials.

F. The organization is prepared to respond to questions on why net earnings and reserves not devoted to community benefits are necessary to meet other capital and operating needs and any externally mandated requirements.

APPENDIX A

A SUGGESTED APPROACH TO CATEGORIZATION OF THE POTENTIAL RANGE OF A NONPROFIT HEALTH PLAN'S SPECIFIC COMMUNITY INVESTMENTS (PROGRAMS, ACTIVITIES, DONATIONS)

Provision of Safety Net Insurance Products, e.g.:

- Interim coverage for individuals between jobs
- Children of uninsured individuals or families
- Individuals with high health risks
- Any uninsured individuals or families
- Small groups

Participation in Government Programs, e.g.:

- Medicaid
- Children's health insurance program (CHIP)
- Medicare
- Statewide charity care financing pool

Special Support for Health care Providers Related to Patient Care or Other Operations, e.g.:

- Free or discounted services to the poor or uninsured
- Services or health care personnel that would not otherwise be available in the community if the decision were made purely on a financial basis
- Information technology to improve quality and/or reduce costs
- Diversity of health care practitioners

Support for Health Professions Education, e.g.:

- Medical students, interns, residents, or fellows
- Nursing students
- Specific types of allied health profession students
- Diversity of health care students

Provision of or Support for Research, e.g.:

- Community health research
- Clinical research
- Health services research

Provision of or Support for Community Health Promotion and Related Services, e.g.:

- Community health education[8]
  - Preventive
  - Curative
  - Palliative
- Health screening
- Support groups

Support for Community Development/Building, e.g.:

- Housing improvement
- Economic development
- Environmental improvement
- Cultural improvements
- Workforce enhancement
- Infrastructure enhancement

Public Advocacy, e.g.:

- Support of laws and regulations intended to improve access to care for the poor or uninsured

The Plan's Internal Community Benefit Infrastructure/Operations, e.g.:

- Dedicated staff, office, equipment, and supplies
- Assessment of community needs and currents assets in the community to meet those needs
- Promotion of employee volunteerism in community programs

8 May include education on the individual's responsibilities.

Advancing the public accountability of nonprofit health care organizations

GUIDELINES ON GOVERNANCE PRACTICES

The Environment

There has been significant scrutiny recently of for-profit corporate directors, emphasizing their duties of care and loyalty, culminating in the Sarbanes-Oxley Act, SEC recommendations, NYSE rulings, and many blue-ribbon pronouncements. There also have been a few recent scandals involving failure of governance by nonprofit health care organizations that have resulted in state regulatory interventions.

The Challenge

While nonprofit health care organizations have different missions than their for-profit counterparts, serving in addition to their patients or members the broader community rather than stockholders, it would be a mistake to ignore the new governance requirements and recommendations for for-profit companies. Many of these reforms are becoming increasingly viewed in both the public and private sectors as relevent to many nonprofit organizations. Pressures for their adoption or adaption by nonprofit healthcare organizations will increase from a variety of sources—state attorneys general and insurance commissioners, the IRS, federal and state legislators, donors, business partners, companies providing board liability insurance, voluntary accreditation organizations, institutional associations and professional societies, the media, and current and prospective board members themselves.

Because of their unique missions, however, nonprofit[1] health care organizations must do more than just meet these demands for greater governance oversight, board independence, and transparency. Their boards also have the fiduciary responsibility to approve plans and budgets for community benefit programs,[2] monitor their progress, and assess and report to the public on their costs and results. Excellence in other performance dimensions, especially in patient safety and quality with proven linkages to cost savings, can augment the resources available for the provision of other social benefits to the community, including but not necessarily limited to improvements in health care access for at-risk and underserved population groups.

Purpose of This Report

The Alliance intends that the ideas and concepts presented in this document be used as a tool to motivate and enable nonprofit health care delivery and financing organizations to improve their governance practices. The guidelines are based on the recommendations of Alliance members, numerous professionals and panels in the public and private sectors, and the highly regarded Boardroom Consultants.

Special Notes

Since the bylaws, organization structures and other circumstances of individual nonprofit health care organizations vary from one community to the next, the guidelines will not be a perfect fit in each instance and must not be construed as prescriptive standards. Rather, they provide a pathway to examining and continuously improving governance. Each organization will need to adapt them to its own needs and situation, and should consult legal counsel before and during their implementation.

In this document the term "Director" is used to refer to Board members, in order to help set the tone that they must be fully engaged, assertive and accountable in carrying out their fiduciary responsibilities. For simplicity's sake, these guidelines assume one 'tier" of governance. Organizations with more than one tier, with differing roles, responsibilities and authority at each level, will need to interpret and apply these guidelines accordingly. Similarly, these guidelines assume ultimate authority residing in the Board for decisions such as selection of its members, whereas for some nonprofit healthcare organizations a corporation membership, policyholders, consumer group or other legally constituted body has such authority.

GUIDELINES

I. Mission:

A. The Board strives to meet the short and longer term needs of its community as defined in statements of purpose, mission, vision and values, and in organizational plans, recognizing that without continuity of the organization there is no mission.

B. The Board aspires, for itself and the organization, to the highest standards of ethical conduct; doing what it says; and maintaining full compliance with the laws, rules and regulations that govern its services and business.

C. The Board reviews its statements of purpose, mission, vision and values, as well as by-laws, at regular intervals, reaffirming or modifying them as appropriate.

D. The Board ensures that regular reports are made to the public with accuracy and transparency on the organization's mission, programs and services, goals and performance (including community benefits, safety and quality, customer service, and audited financial statements), as well as executive and any Board compensation.

II. Corporate Governance:

A. The Board ensures that the services, property and affairs are well managed.

B. The Board ensures that it is well informed through discussions in Board meetings with the Chief Executive Officer (CEO) and other officers, by requesting and reviewing needed materials, by visiting facilities, through discussions in meetings of Board committees, and by other activities and interactions between meetings.

C. The Board ensures that the information brought to it is relevant, clear, concise, and accurate, and is provided sufficiently in advance of meetings to allow for meaningful Board understanding, analysis and decision-making.

D. The Board ensures that minutes are recorded and approved of all discussions and actions in all meetings of the Board and Board committees.

[1] For simplicity's sake the term "nonprofit" is used in this document; however, the guidelines are intended to also encompass non-investor-owned health care organizations that operate as nonprofits.

[2] Community benefits are business operational results or specific programs, activities and/or financial or in- kind contributions designed to: promote or provide needed services, improved access to needed services, improved quality and/or reduced costs, and/or improved health status, functional status or quality of life for at-risk or underserved population groups or for the broader community.

III. Overall Role, Responsibilities and Composition of the Board of Directors:

A. The special mission of the organization requires active and effective Directors. Above all else, the Board provides for the perpetuity of the organization while benefiting the community as defined in the organization's mission statement. In all actions taken by the Board, the Directors are expected to exercise their reasonable business judgment in what they believe to be in the best interests of the organization and the community served.

B. The Board of Directors, each of whom is elected by the full Board , is the ultimate decision-making body, responsible for the organization's direction and performance. It establishes the organization's mission, vision, values and fundamental policies.

C. The Board selects the CEO with the necessary leadership, managerial and personal attributes, including honesty, integrity and community-benefits orientation, to conduct the organization's operations consistent with the Board's directives.

D. Unless provisions have been made to eliminate any potential conflicts of interest, such as the appointment of an independent Lead or Convenor Director, the positions of Chair of the Board and CEO are separate.

E. The Board acts as a coach and mentor for the CEO and executive management more generally while holding them accountable, overseeing and supporting performance through approval of and monitoring progress and results on goals, plans and budgets. The ability of the Board to effectively monitor the performance of management is achieved by the presence of outside Directors of stature, who understand sound management practices and who are knowledgeable about or have the ability to learn the facets of healthcare in which the organization is engaged.

F. The Board plans for succession to the position of Chair of the Board, other Board positions, and the position of Chief Executive Officer.

IV. Independence and Qualification of Directors:

A. The Board of Directors adopts a formal set of Director Qualification Standards with respect to the determination of Director independence. To be considered independent, a Director must be determined, by resolution of the Board as a whole, after due deliberation, to have no material relationship, as defined in its Director Qualification Standards, with the organization other than as a Director. For instance, executive officers of the organization are not permitted to serve as Directors of a company that concurrently employs a Director of the organization. In each case, the Board broadly considers all relevant facts and circumstances. (Note: For those who may be interested, see the Appendix for examples of ways in which some organizations have defined "material relationships.")

B. A clear majority of the members of the Board meet its criteria for independence and any other applicable laws, rules and regulations regarding independence in effect from time to time.

C. Candidates are selected for their character, community benefits-orientation, judgment, diversity of experience, overall competence and acumen, and their ability to exercise due care and loyalty to the organization and its mission. Experience and acumen may include scientific, financial, managerial or other technical expertise, prior government service and familiarity with national issues affecting healthcare.

D. The number of other public or private company boards on which a Director may serve is subject to a case-by-case review by the committee responsible for governance performance and nominations, in order to ensure that each Director is able to devote sufficient time to perform his or her duties as a Director and to ensure lack of conflict.

E. Except in unusual circumstances, the CEO is a voting member of the Board in order to help foster a teamwork relationship.

[3] For some nonprofit health care organizations a corporation membership, policyholders, consumer group or other legally constituted body makes the final selection of Board members.

V. Numbers and Selection of Board Members:

A. The full Board has final approval of the policy on Board size and on the selection of specific Board members.

B. As a matter of policy, the numbers of Directors do not exceed a size that can function efficiently as a body and are not less than the numbers needed to effectively conduct the business of the Board's committees.

C. Current Directors are evaluated, nominated and re-elected, or not re-nominated, at the discretion of the Board of Directors.

D. The Board has policies and procedures for removal of non-performing Board members.

E. The committee responsible for governance performance and nominations assists the full Board by considering and making recommendations to the Board concerning the appropriate size and composition of the Board, the overall number and length of Board meetings needed to function efficiently and effectively, the best candidates to fill new positions created by expansion or vacancies that occur due to resignation, retirement or other reasons, and any major performance deficiencies of current Board members. In identifying candidates to fill new or vacant positions on the Board, the committee takes into consideration the current composition of the Board and its diversity (culture, expertise, experience and perspective), unmet needs, and candidates' relative abilities to meet those needs. Depending on need and the availability of resources, a board search firm may be engaged to assist the committee in such areas as defining qualifications, finding potential candidates and objectively screening them. The committee interviews face-to-face those candidates whom it intends to recommend to the full Board for approval.

VI. Term Limits or Renewable Terms:

A. In order to help ensure effective Director participation and contribution, the organization has either term limits for Directors (for example, a maximum of three consecutive three-year terms) or terms that are renewable subject to an affirmative finding regarding the individual Director's performance.

VII. Board Committees:

A. It is the general policy of the organization that all major decisions be considered by the Board as a whole. The organization has standing committees responsible for audit, compensation (or human resources), and governance performance and nominations, with additional committees limited to only those considered to be essential to, or required for, the effective operation of the organization (e.g., community benefits, planning, finance, quality, corporate compliance).

B. Except in unusual circumstances, all members of the standing committees (other than the executive committee if one exists), meet the Board's standards for independence, as well as any other applicable laws, rules or regulations regarding independence.

C. The standing committee chairs and other members are appointed by the Board or Board Chair, taking into consideration the recommendations of the standing committee responsible for governance performance and nominations, after consultation with the individual Directors. Standing committee chairs and memberships are rotated periodically.

D. Each standing committee has its own written charter that complies with general standards and with applicable laws, rules and regulations. The charter sets forth the mission, goals and responsibilities of the committee as well as qualifications for committee membership, procedures for committee member appointment and removal, committee structure and operations, and reporting to the Board.

E. The chair of each standing committee, in consultation with executive management and the committee members, determines the frequency, length and agendas of the committee's meetings consistent with any requirements set forth in the committee's charter. At the beginning of the year each committee establishes a schedule of agenda subjects to be discussed during the year, to the degree these can be foreseen. The agenda and other relevant information for each committee meeting are furnished to all members in advance of the meeting. Each independent Director may attend any meeting of any standing committee, whether or not he or she is a member of that committee, except in the case of the executive committee if one exists, where permission to attend is requested in advance.

F. All Board standing committees have the power to hire and fire needed independent advisors (e.g., legal, financial, compensation). Except in unusual circumstances, these decisions are reached jointly with executive management in the spirit of teamwork.

VIII. Board Meetings:

A. Directors are expected to regularly attend Board meetings and meetings of committees and subcommittees on which they serve, and to spend the time needed and meet as frequently as necessary to properly discharge their responsibilities.

B. The Chair (or Lead/Convenor Director) and the CEO establish a calendar of standard agenda items to be discussed at each Board meeting scheduled to be held over the course of the ensuing year, and also establish the agenda for each Board meeting, with the understanding that certain items pertinent to the policy-making, advisory and monitoring functions of the Board be brought to it at appropriate intervals by the Chair and the CEO for review and/or decision. Agenda items that fall within the scope of responsibilities of a Board committee are reviewed with the chair of that committee.

C. For purposes of preserving the Board's independence as well as ensuring clear and candid communication among the Board members and with executive management, at least several times a year on a pre-scheduled basis, the independent Directors meet in executive session without the presence of Management. The Board Chair or a designated Lead/Covenor Director presides at the executive sessions.

IX. Strategic Planning:

A. The Board approves on regular bases the organization's multiyear strategic plan as well as the annual operating plan and budgets developed by executive management, with review of the strategic plan at least once a year for any needed major adjustments. Community benefits programs and services are explicitly described in plans and budgets.

B. Board meetings are primarily devoted to important strategic and policy matters, including community benefits priorities.

X. Communications:

A. The Board Chair (or Lead/Convenor Director) and/or the CEO are responsible for ensuring the establishment and maintenance of effective communications with the media and with the organization's key stakeholder groups, e.g., patients and other customers, employees, community leaders or groups, suppliers, creditors, governmental entities, organizational partners.

B. The CEO and/or other designated executives are the primary spokespersons for the organization. In exceptional cases, individual Board members meet or otherwise communicate with various stakeholders that are involved with the organization, subject to prior consultation with executive management.

XI. Code of Conduct and Corporate Responsibility:

A. A code of conduct and corporate responsibility program are developed by executive management and approved by the Board to support the organization's purpose, mission, vision and values, providing ethical standards and a comprehensive process that are intended to ensure: compliance with all governance policies and procedures; compliance with all areas of professional conduct, including employment policies; an open relationship among colleagues that contributes to good business conduct, including protecting individuals against recrimination for reporting potential violations in the code of conduct or of the law; avoidance of conflicts of interest (with zero tolerance for self-dealing); protection of intellectual property and confidential information; and an abiding belief in the integrity of individuals.

B. Where separate codes of conduct are established for Directors, employees, temporary workers and other independent contractors or consultants to enhance their relevance, such codes are consistent in all important respects.

C. The Board reviews a report by management at least annually on the performance of the organization's code of conduct/corporate responsibility program.

XII. Auditing:

A. The committee responsible for audit has the sole authority to select, direct, retain and terminate independent auditors.

B. This committee reviews at least annually an independent audit report, and periodically meets separately and jointly with management, internal auditors and the independent auditor.

C. This committee establishes policies for: pre-approval of any non-audit services to be provided by the independent auditor; rotation of the lead auditor, or the partner responsible for reviewing the audit, at least every five years; rotation of the audit firm, at least every 10 years; establishment and maintenance of an internal audit function; and CEO and principal financial officer certification of financial reports presented to the Board, the public, and governmental bodies.

XIII. Director Access to Executive Management and Other Employees:

A. Directors have full and free access to executive management and other employees to become more knowledgeable about the organization and its people. Except in unusual circumstances where a sensitive issue needs to bypass normal channels or where particular managers or staff have Board or Board committee liaison roles, contacts by Board members are arranged through the CEO's office or other staff assigned to support the Board.

B. The Board welcomes regular attendance at each Board meeting by selected members of executive management. If the CEO wishes to have additional personnel attendees on a regular basis, this suggestion is brought to the Board for approval.

XIV. Director Orientation and Development:

A. The Board, taking into consideration the recommendations of the committee responsible for governance performance and nominations, provides for an orientation program for new Directors and a development program for all Directors. These programs include presentations by executive management on the organization's mission, structure, significant challenges and opportunities and strategic plans related thereto, code of conduct and corporate responsibility program, and internal and external auditing processes.

B. The orientation program includes visits to significant facilities, to the extent practical.

C. All Directors are expected to participate in their orientation and development programs.

XV. Succession Planning:

A. The Board plans for succession to the position of Chair (or Lead/Convenor Director) of the Board, other Board positions, and the position of the Chief Executive Officer.

B. The committee responsible for governance performance and nominations makes a report at designated intervals to the Board on succession planning for the Board Chair (or Lead/Convenor Director), taking into account that individual's assessment of potential successors, and for other Board positions.

C. The committee responsible for compensation (or human resources) makes a report at designated intervals to the Board on succession planning for the CEO position, taking into consideration the CEO's assessment of potential successors. The CEO meets periodically with this committee in order to make available his or her recommendations and evaluations of potential successors, along with a review of any development plans recommended for such individuals. It is fully understood that it is ultimately the responsibility of the Board to make these succession decisions, not the CEO.

XVI. Board Chair and CEO Goals, Performance Assessment, and Compensation:

A. The Board sets annual performance goals for the Board Chair (or Lead/Convenor Director) and evaluates his or her performance against such goals.

B. The Board may provide an appropriate stipend to the Board Chair (or Lead/Convenor Director), one or more standing committee chairs, and/or other members of the Board in order to attract the best possible individuals and compensate them for their time and efforts in an era of heightened public accountability.

C. The Board sets annual and long-range performance goals for the CEO, evaluates his or her performance against such goals, and determines appropriate compensation, consistent with the organization's needs, expectations, and market conditions.

D. The committee responsible for governance performance and nominations makes an annual report to the Board on goals and performance of the Board Chair (or Lead/Convenor Director), taking into consideration that individual's self-assessment and recommendations.

E. The committee responsible for compensation (or human resources) makes an annual report to the Board on goals, performance and compensation for the CEO, taking into consideration the CEO's self-assessment and recommendations. The CEO's goals, assessment and compensation reflect and balance all key dimensions of performance, including community benefits.

F. These annual reports are reviewed for approval or modification by the independent Directors of the Board at a meeting or executive session of that group.

G. The Board ensures the full public disclosure of all compensation of top executives and any Board member compensation.

XVII. Evaluation of Board Performance:

A. The committee responsible for governance performance and nominations conducts an annual review of Board performance, in accordance with guidelines recommended by the committee and approved by the Board.

B. The annual review includes: an overview of the role of the Board and its performance; the role of the Board's committees and their performance; the current talent base of the Board and its committees and competencies needed in the future; and an individual assessment of each Director's skills, areas of expertise, other competencies; qualification as independent under its standards and any other applicable laws, rules and regulations, consideration of any changes in a Director's responsibilities that may have occurred since the Director was first elected to the Board, and such other factors as may be determined by the committee to be appropriate for review.

C. The results of the committee's annual review of Board performance, and any recommended actions to improve performance of the Board as a whole, individual Board committees, or individual members, are summarized and presented to the Board for review and approval.

APPENDIX

EXAMPLES OF SPECIFIC CRITERIA BEING USED BY SOME ORGANIZATIONS FOR DETERMINING THAT A CURRENT OR POTENTIAL BOARD MEMBER HAS A MATERIAL RELATIONSHIP AND IS NOT INDEPENDENT

Recentness of Relationship (Look-Back Period)

Within previous three years (NYSE and NASDAQ)

Within previous five years (GE, Richard Kusserow)

Within previous two years (American Law Institute)

Employment or Other Direct Compensation Relationship

The Director has been an employee of the organization[1]. (NYSE, NASDAQ, and American Law Institute)

An immediate family member[2] is an executive officer of the organization. (NYSE and NASDAQ)

The Director or immediate family member has received more than $100,000 in compensation during the year, other than any Director fees, pensions or other deferred compensation from prior service. (NYSE)

The Director or family member has received during the year more than $60,000 in direct compensation, excluding any Director fees, deferred compensation, and in the case of a family member, compensation as a non-executive employee. (NASDAQ)

The Director has been an employee of another company or an immediate family member has been an officer of another company on whose board of directors an executive of the organization serves. (GE)

The Director or family member has been employed as an executive officer of another company on whose board compensation committee an executive of the organization serves. (NYSE and NASDAQ)

Auditing Services Relationship

The Director a family member is affiliated with or employed in a professional capacity by a present or former auditor of the organization. (NYSE)

The Director or a family member is a current partner of the organization's outside auditor (or who was a partner or employee of the organization's outside auditor), and worked on the organization's audit. (NASDAQ)

Legal and/or Investment Services Relationship

The Director is affiliated in a professional capacity with a law firm that has been the primary legal advisor to the organization with respect to general corporate law matters or with an investment firm that has been retained by the organization in an advisory capacity or that has acted as a managing investor of the organization's funds or as a managing underwriter of an issue of the organization's bonds or other securities. (American Law Institute)

Other Financial Relationships

The Director has been an executive officer or an employee, or a family member has been an executive officer, of a company that receives payments from, or makes payments to, the organization for properties or services in an amount which in any single year exceeds the greater of $1,000,000 or 2 % of the company's consolidated gross revenues. Any charitable contributions are excluded but must be disclosed if they exceed this threshold. (NYSE)

The Director or a family member has been a partner, controlling stockholder or executive officer of a company that receives payments from, or makes payments to, the organization for properties or services in an amount which in any single year exceeds the greater of $200,000 or 5 % of the recipient's consolidated gross revenues. Payments arising solely from investments in the organization's securities are excluded as well as non-discretionary charitable contribution matching programs. (NYSE)

The Director, or a company that he/she owns or has an equity interest in, receives from or makes commercial payments to the organization that exceed $200,000, when multiplied by the Director's percentage equity interest). Or, the Director is the principal manager of a company that receives from or makes commercial payments to the organization that exceed the greater of $200,000 or 5% of the organization's consolidated gross revenues. (American Law Institute)

The Director is an executive officer of a company that does business with the organization, and the annual sales to, or purchases from, the organization are 1% or more of the annual revenues of the other company. (GE)

The Director is an executive officer of a company that is indebted to the organization, or to which the organization is indebted, and the amount of either company's indebtedness to the other is greater than of the total consolidated assets of the company where he/she serves as an executive officer. (GE)

The Director serves as an officer, director or trustee of a charitable body where the organization's discretionary charitable contributions are 1% or more of that body's charitable receipts. (GE)

[1] The organization includes its parent and any subsidiaries.
[2] NYSE defines immediate family member to include spouse, parents, children, siblings, in-laws (mother, father, sons, daughters, brothers, sisters) and any one else sharing the Director's home other than an employed domestic. The SEC defines immediate family to include only spouse, minor children or step-children, or children or stepchildren sharing the Director's home.

United States Senate Committee on Finance

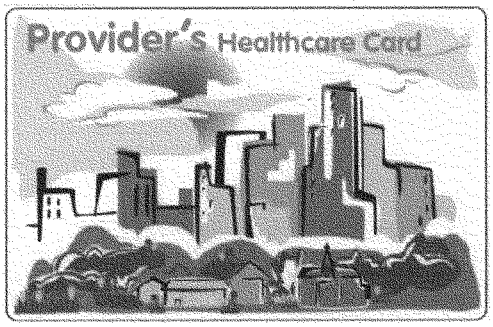
Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals

September 13, 2006, at 10:00 a.m., in 215 Dirksen Senate Office Building

STATEMENT OF ALLIANCE NATIONAL, INC.

1063 Snowdon Court, Asheboro, NC 27203-4055

VIEWS OF ROGER BERLINER, CEO



Healthcare's Path to the 21st Century

United States Senate Committee on Finance

Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals

September 13, 2006, at 10:00 a.m., in 215 Dirksen Senate Office Building

STATEMENT OF ALLIANCE NATIONAL, INC.

1063 Snowdon Court, Asheboro, NC 27203-4055

VIEWS OF ROGER BERLINER, CEO

Thank you for the opportunity to provide testimony for the record of the Senate Finance Committee's September 13, 2006 hearing on charitable care and community benefits at non-profit hospitals.

Alliance National, Inc. (ANI) is a financial services company that is engaged in the development of proprietary products to manage, service and fund the out-of-pocket portion of health care. We apply contemporary risk management techniques and operating systems to create products that allow providers to make objective, replicable decisions as to which accounts are payable, in whole or part, and which should be expensed as charitable care, courtesy allowances or bad debt. The techniques utilized are a patent-pending intellectual property that is available for licensing.

Among other things, our approach creates an auditable record of why an allocation was made to a specific category. This would allow IRS, Medicare, state Medicaid agencies and payers to determine whether applicable federal, state and community standards were consistently achieved. In particular, as it relates to the Senate Finance Committee's concerns, IRS would be able to determine in an efficient manner whether a charge is being improperly categorized.

While not the topic of the committee's hearing, we note that this capacity to manage the out-of-pocket portion of health care costs using objective standards also has applicability in reducing the number of uninsured individuals in the United States. We are preparing for field testing of the Provider's Healthcare Card[SM] program with BlueCross & BlueShield of Florida. One goal of our joint effort is the development of cost-effective insurance products for employers that currently do not provide health insurance for their employees and for individuals of limited means without health insurance. To make these products work, payers and providers need a system that tracks deductibles and co-payments in real-time.

ANI's Objective Response to Medicare's Subjective Standards on Ability to Pay

As the Finance Committee is discovering, properly accounting for charitable care, courtesy allowances and bad debt is close to impossible under the current system.

Even providers with the purest of motives cannot be sure that they have fulfilled the requirements of law.

Providers have been held to standards that have no objective basis. Every non-paying patient forces decisions that cannot be assured in advance to be correct nor with any certainty determined to be correct afterward (audit trail). In contrast, providers using ANI programs are able to assure themselves that they have met all applicable rules and requirements and know that they will have a clean audit as it relates to allocation of expenses to charitable care, courtesy allowances or bad debt.

ANI's system of objective, replicable standards for ability to pay, directly responds to the lack of usable guidance provided by CMS. In a 2004 exchange of letters between the American Hospital Association and the US Department of Health and Human Services, the Secretary stated "Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a hospital from waiving collection of charges to any patient, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy."

In the six page Q&A, the Secretary provided extensive detail on various nuances of the Department's position, particularly that income thresholds and collections procedures must be the same for Medicare and non-Medicare patients. Waiving collection of charges is clearly permitted in the Secretary's six page Q&A. However, as the AHA pointed out, there is no guidance as to what basis should be used in developing a policy to determine a patient's financial ability to pay for services and when and how it should be applied.

This is not quite true. The Provider Reimbursement Manual and Program Instructions that were put in place in 1974 sets standards by use of terms such as "best business judgment" and others. This effectively established subjective analysis as guidance and standard.

From a provider's standpoint, the goal is to have a set of objective standards on ability to pay that can be replicated in consistent fashion regardless of the patient's financial situation or insurance coverage. It is this capability that ANI brings to the marketplace. With its use, providers can know in advance that they are treating all patients fairly with regard to ability to pay and that, in doing so, they are also producing auditable protocols that assure them of legal compliance with regard to charitable care, courtesy allowances and bad debt.

Conclusion: Problems with Charity Care and Bad Debt are Solvable

Providers, as well as any debt collection agency that they hire, lack an objective measure of ability to pay that can be fairly applied to all patients. Regulations lead providers astray by telling them to use their "best business judgment," as if credit assessment is or should be a core competency of providers.

ANI would be pleased to have the opportunity to provide the Finance Committee with additional information on solutions that provide objective standards and auditable results.

Statement of the
American Federation of State, County and Municipal Employees (AFSCME)
for the
Senate Finance Committee Hearing
on
Charitable Care and Community Benefits at Nonprofit Hospitals
September 13, 2006

A Failing Mission: The Corporatization of Resurrection Health Care

Nonprofit health care institutions are a vital component of our health care system. The public is best served by policies that foster a strong public and nonprofit health care sector. However in some instances, we know that there are nonprofit institutions that behave more like profit-maximizing corporations rather than entities centered on a mission to serve their communities. One such example is Resurrection Health Care.

Resurrection Health Care (RHC), now the second-largest health care corporation in the Chicago region, began as a single community Catholic hospital on Chicago's Northwest Side. But what began as a caring hospital for those in need has been transformed into a corporate entity increasingly driven by the bottom line.

In recent years, RHC has rapidly expanded into a chain of eight hospitals that produces more than $1.4 billion dollars in annual revenue. In this process, RHC hospitals have lost their non-profit mission focus and community-based orientation as they have been melded into the larger corporate organization. RHC patients, especially the poor and the uninsured, have paid a high price for the corporatization of this health care network.

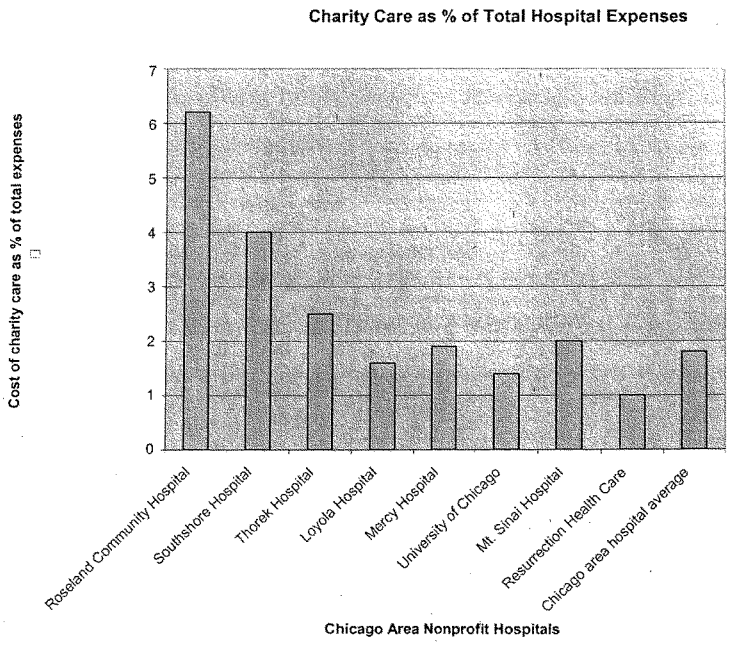
Abandoning Those In Need

As RHC expanded, it drastically cut the amount of charity care (free or discounted care to those who cannot afford to pay) it provided. In 2002, despite several years of record profits, RHC implemented new, restrictive corporate policies on charity care. As a result, undocumented immigrants, patients with existing medical debts, and all those living outside arbitrarily defined "service areas," were ineligible for charity care. The impact was a dramatic drop in charity care at Resurrection hospitals.

According to reports filed with the Illinois Department of Public Aid, Resurrection hospitals provided 15 million dollars in charity care in 2003; only 0.6 percent of total gross charges. This was a dramatic drop from charity care at Resurrection hospitals in 2001, which was 1.9 percent of total gross charges. It was also less than half the average of charity care provided by private, nonprofit hospitals reporting in Cook County in 2003.

These findings were published in, *A Failing Mission: The Decline of Charity Care at Resurrection Hospitals*, a report issued by Illinois AFSCME Council 31 in 2004, prompting both public outcry and an investigation by the Illinois Attorney General (AG). However, it did not prompt significant changes in charity care levels at RHC hospitals.

In compliance with a recently implemented reporting requirement, RHC submitted a community benefits report to the AG indicating that the cost of charity care provided in 2005 was $13 million, less than 1 percent of total expenses. And RHC continues to lag behind other non-profit hospitals in the region, which averaged charity care levels of 1.8 percent of expenses according to research conducted by the Center for Tax and Budget Accountability.



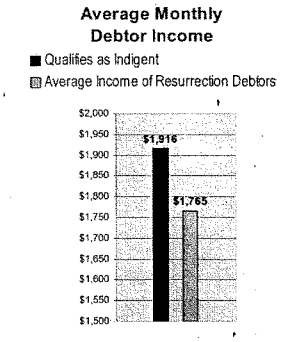
Growing public pressure did spur RHC to launch an unprecedented advertising campaign that included mailings to over 1 million Chicago area households trumpeting RHC's generous "free care," reported as $147 million in a recent brochure. However, this number is inaccurate and misleading because it includes the corporation's bad debt. RHC includes bad debt despite the fact that Illinois state law defines charity care as care that is provided without expectation of payment. The Catholic Health Association recommends a similar definition and specifically states that bad debt should not be considered charity care.

HARASSING DEBTORS

According to Idida Perez, Executive Director of the community organization West Town Leadership United in Chicago, *"By cutting back charity care and going after patients to pay their bills – turning them over to collections or suing them, Resurrection is sending a message to the residents in our community: If you're poor and especially if you're an undocumented immigrant, go somewhere else for your care."*

Resurrection Health Care has aggressively pursued those who are unable to pay their medical bills. It has filed collection lawsuits against more than 2,300 individuals over the past five years.

Between 1998 and 2003, the court granted indigent status to 105 debtors being sued by Resurrection, yet RHC continued to pursue their collection case against them. The average annual income for these debtors was $9,994 – 40 percent of them were unemployed.



The average gross monthly income for non-indigent debtors, where income levels were available either through interviews or wage garnishment records, is $1,765. Resurrection's debt collection practices, discriminatory pricing policies and failures to provide adequate levels of charity care have led debtors to file four separate lawsuits against the company in recent years.

Suzanne Gibbons was sued by RHC and eventually forced to declare bankruptcy, resulting in the loss of her home and retirement savings. She described her experience with Resurrection by stating that, *"If you don't have insurance and you go to Resurrection -- you are in trouble. I had nothing by the time I got to bankruptcy. I had a little bit of money and not enough to pay the hospital bills so it still didn't get paid, but in the meantime they wrecked another life."*

According to its public statements, Resurrection's standard practice is to bill patients first, and begin the financial aid application process when a patient contacts the hospital to ask for help. In 2003, of the more than 98,000 inpatients, only 217 were identified as charity recipients prior to discharge. Other hospitals have a much higher rate of determining charity care eligibility prior to discharge. In 2003, the average percentage of hospital inpatients who were determined to meet charity care criteria prior to discharge was 1.1 percent in Cook County, while RHC's was just 0.2 percent system-wide.

Unfortunately, unless charity status is determined prior to the collections process, eligible patients who cannot pay are subjected to frightening collections tactics and others make enormous sacrifices to pay their bills because they do not know that help is available.

DISCRIMINATING AGAINST THE UNINSURED

In a six-year period, the number of uninsured inpatients admitted to Resurrection hospitals dropped 28 percent. By 2003, despite the growing number of uninsured, only 3.4 percent of inpatients admitted at Resurrection's eight hospitals were uninsured – a rate 37 percent below the average for private Cook County hospitals.

As with many nonprofit hospitals, the corporation charges the uninsured the full list price for medical services. RHC's overall price markup of 315 percent of cost is the highest of any Illinois health care system. *Modern Healthcare* magazine's *2005 Year in Review* reported that RHC settled a suit brought on the basis that Resurrection wrongly overcharged its patients.

In addition, research based on 2003 hospital data indicates that uninsured patients do not receive the same level of care and access as patients with insurance. According to Illinois Department of Public Health inpatient data, on average, uninsured patients at Resurrection hospitals had 35 percent shorter stays than insured patients with the same condition. In addition, Resurrection employees reported that uninsured patients seeking counseling were required to pay upfront, and patients enrolled in substance abuse programs were denied charity care.

PRIORITY ON MARKET SHARE NOT PATIENT CARE

RHC has a history of acquiring community health facilities, and then discontinuing services or closing facilities that are not profitable. In many cases, RHC has indicated in its permit application for acquisition its commitment to continue services and within a few years has moved to close services. When Resurrection applied for a permit to acquire Holy Family Medical Center, it assured state officials that its acquisition of Holy Family would, "increase patient access to a full continuum of health care services." Several years later, RHC closed the hospital's emergency room and discontinued other services, as the corporation elected to convert the hospital into a long-term acute care facility.

Not three years after acquiring St. Mary of Nazareth and St. Elizabeth Hospitals, the corporation applied for the closure of 168 beds and the discontinuation of most inpatient services provided at St. Elizabeth Hospital. Local residents protested the closures and were particularly concerned that they would have a disproportionate impact on Latinos, who made up 52 percent of St. Elizabeth inpatients in 2003, one of the highest in the state.

At the same time, RHC has moved forward with renovations and expansions of more highly profitable services, and even acquiring additional facilities. This behavior is questionable for a nonprofit community health care system benefiting from millions of dollars in tax exemptions.

HIGHLY PAID CORPORATE INSIDERS DOMINATE

RHC is increasingly governed by corporate insiders who do not reflect the Catholic values of the founding sponsors.

- Resurrection's chief executive officer (CEO) received $2.4 million in 2003 and $1.4 million in 2004, exceeding the national averages for those years by 164 percent and 52 percent respectively.

- Additionally, CEOs of the individual RHC hospitals continue to be compensated at levels far above national averages. While RHC hospital CEOs were compensated, on average, 36 percent above national averages in 2004, they were compensated 56 percent above national averages in 2005.

- There are few independent voices on the Resurrection Board of Directors to question these excessive compensation practices and the relentless corporatization. Of the 62 board members serving on the governing boards of the Resurrection hospitals, more than two-thirds are RHC employees.

- Only six board members can be considered independent.

While the insiders are minding the business, who is minding the mission? The RHC board of directors' lack of accountability and its control by insiders is both unethical and bad business. Resurrection's mission and its long-term interests are being compromised.

CONCLUDING REMARKS

We commend the Committee for holding this hearing and for investigating abuses by nonprofit hospitals and hospital systems. While it is important to address the failures of some nonprofit hospitals, it is also important to note that their failures are not the cause of the health care crisis. No matter how strong and properly operated public and nonprofit health care institutions are, they cannot make up for the fact that 47 million people have no health care coverage and that the rising cost of coverage threatens the economic security of working families.

Only comprehensive, systemic reform will fix our broken system. AFSCME calls upon the Congress to enact health care reform legislation that provides for universal and affordable coverage, fair financing of our health care system, and improved quality of care.

VHA Inc.
Statement for the Record

Hearing on
Taking the Pulse of Charitable Care and Community Benefits
at Nonprofit Hospitals
in the
Committee on Finance
of the
United States Senate

September 13, 2006

VHA Inc. appreciates this opportunity to submit views related to the issue of not-for-profit hospitals' reporting of community benefits.

VHA has a long history of working with its own members and in partnership with other not-for-profit hospital alliances to help health care providers conduct and report their community benefit services. Our experience has taught us many things, including:

1. Voluntary community benefit reporting guidelines are working and are the best way to achieve consistency, lasting commitment and transparency;
2. The not-for-profit hospital community has embraced and is in agreement with the basics of the reporting methodology outlined in guidelines created by VHA and the Catholic Health Association; and
3. Additional regulation will further burden community-owned hospitals already feeling intense pressures to provide what seems to be unlimited care on limited budgets.

About VHA
VHA is the nation's largest alliance of not-for-profit, community-based health care organizations with a mission to help each member improve clinical quality and economic performance. Nearly 1,200 hospitals across the country have elected to be a part of the VHA network – roughly 25 percent of the nation's not-for-profit hospital community. These include small, rural; large, urban; and everything in between. Along with such prestigious organizations as The Mayo Clinic, Massachusetts General and New York-Presbyterian, the VHA network also includes many outstanding community hospitals, including 46-bed Glendive Medical Center in Glendive, Montana, and 44-bed Floyd Valley Hospital in Le Mars, Iowa, which are well-respected and relied upon in their communities.

VHA Inc. 901 New York Ave., NW, Suite 510 Washington, DC 20001
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Not-for-Profit Hospitals Represent Highest Quality of Health Care in America
This summer, *U.S. News and World Report* released its annual ranking of America's best hospitals. The magazine has been conducting the survey since 1990 highlighting the hospitals that rank at the top because of their work to pioneer new treatment guidelines; conduct bench-to-bedside research; and leverage the latest advances in imaging, surgical devices, and other technologies.

Of the 14 hospitals on the magazine's 2006 Honor Roll, all are not-for-profit; five are members of the VHA alliance. The recognition demonstrates that there is much our health care provider system can learn from how these hospitals advance care – inside and outside of the hospital.

At a time when not-for-profit hospitals are leading the way in providing care for all Americans, they also welcome the examination of their efforts to uphold their community benefit responsibilities and the consideration of improvements in the reporting of those benefits.

There is little doubt that these hospitals' community benefit programs – their commitment to outreach, the reinvestment in local services, research and treatment – is a major factor of their success, clinical or otherwise. There also is little doubt that we must work harder to create greater understanding among more Americans about the definition and differentiation of not-for-profit care. It's a challenge we readily accept as we strive to improve service and accountability.

What Americans do understand is what they feel when they walk through the doors – anytime, day or night, for minor maladies to major emergencies. Without knowing what to call it, Americans rely on their community and academic hospitals to provide the kind of care and programs that are needed to serve many of the most vulnerable in our communities.

Vital Role of Not-for-Profit Hospitals
Across the country, health care providers are advancing the treatment they offer to patients. Amidst this innovation, however, there are still community needs that are not met through the regular course of care.

We regularly hear from VHA members about the increased pressures they face. In fact, hospitals have never been under so much pressure to provide unlimited care on a limited budget. They face uninsured patients, an aging population, staff shortages and a list of problems that all require significant resources.

In addition to these issues, there are the needs hospitals identify in their communities that are addressed through a series of innovative and essential community benefit services. From transportation to new parent education classes to nutrition programs, VHA member hospitals are helping people where they live with the services they need the most.

Filling these gaps in the local health care delivery system is what these hospitals do. If they didn't, someone else would have to pick up the tab. Taxpayers would feel the brunt of the burden, having to foot the bill for services they have come to expect from community-owned hospitals. And while an exact estimate of this national amount does not yet exist, based on what we know about charity care services, it ranges in the billions each year.

VHA/CHA Community Benefit Reporting Services
The value VHA and other not-for-profit hospitals provide to their communities is clear – the question is how they are reporting these benefits to others. Our experience tells us that voluntary community benefit reporting guidelines are the best way to achieve consistency, lasting commitment and transparency.

Consistent, voluntary guidelines allow community-based hospitals to continue offering the kinds of programs community members have come to expect rather than succumbing to lowest-common denominator programs that allow them to meet the letter of the law, but nothing more.

VHA knows that high-caliber programs must continue and has a long history of helping its members communicate their good work. Since Congress last examined the issue in the early 1990s, VHA has worked in collaboration with the Catholic Health Association of the United States to develop resources and tools to assist not-for-profit hospitals in documenting the benefits they provide to the community. This close partnership has helped to establish and communicate best practices and a methodology for reporting community benefits.

The results of this partnership are many:

- More than 800 not-for-profit hospitals today are using software developed by VHA and the Catholic Health Association (CHA) to track and communicate information on community benefit. The software, called the Lyon Community Benefit Inventory for Social Accountability has set the standard in consistent and transparent reporting.
- A series of guides now exist to help not-for-profit hospitals provide more clarity on "Community Benefit." These include the *Community Benefit Planning: A Resource for Nonprofit Social Accountability* (2002); and the *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability* (2004).
- A bi-annual national conference on the community benefit process is hosted by VHA and CHA. The conference is open to all not-for-profit hospitals and is intended to assist them in fulfilling their charitable missions. The first conference was held in 2002.

The New Reporting Guidelines
Just in the last six months, VHA and CHA have taken our work in this area to the next level with the development a new tool, "A Guide for Planning and Reporting Community Benefit."

This guide, distributed to all VHA members this summer, consists of clear standard definitions of community benefit and an industry-wide method of reporting that is both consistent and transparent. The not-for-profit hospital community is in broad agreement with the guidelines. Even in states with their own reporting requirements, many of the state regulations were developed with the VHA/CHA guidelines as the foundation.

The guide provides a systematic, consistent method of planning, evaluating and reporting community benefit, and is designed to help VHA hospitals to:

- Identify community needs and effectively allocate scarce resources to best help those in need;
- Proactively plan and budget for community benefit programs;
- Standardize criteria used to determine what constitutes community benefit;
- Standardize accounting practices to help make financing of community benefit programs more predictable, sustainable, comparable and credible;
- Facilitate building important community relationships to improve access to services; and
- Communicate the ways not-for-profit health care organizations meet and exceed legal requirements for tax exemption.

Importantly, the guidelines help further define what constitutes community benefit. Generally speaking, these programs and services are ones that provide treatment or promote health and healing. Community benefit programs are provided to address specific community needs and meet at least one of the following criteria:

- Generates low or negative margin;
- Responds to needs of vulnerable and medically underserved persons;
- Provides a service or program that would likely be discontinued if the decision were made on a purely financial basis;
- Involves education or research; and/or
- Responds to public health needs.

Results So Far
After being out in the field for about three months, we can report that the not-for-profit hospital community has embraced and is in agreement with the basics of the reporting methodology outlined in the VHA and Catholic Health Association guidelines. This is good news. Layering additional regulation onto our already stressed community health care providers will only serve to further burden hospitals already feeling intense pressures to care for the mounting needs disadvantaged populations.

VHA has asked each of our 1,200 members to sign a pledge agreeing to use the standard guidelines when creating next fiscal year's community benefit report. VHA is pleased to report today that more than one-third of our members -- 400 hospitals in 36 states -- have signed on to this pledge.

Our goal, of course, is 100 percent commitment. To achieve this, we have asked the leaders of each of our 18 regional offices to hold briefings and information sessions with members across the country as a way to raise awareness about the new guide and to secure additional pledges.

In Summary
The needs of America's not-for-profit hospital community are great, as are the needs of our citizens. As a matter of public policy, we need to be doing all we can to encourage the best ways of providing the best services our communities need without layering in additional costs.

Voluntary community benefit reporting guidelines are the best way to achieve consistency, lasting commitment and transparency. We must support the work of our community-owned hospitals to ensure they remain in place serving the needs of the community.

The voluntary guidelines are working. There is agreement across the not-for-profit hospital community on the basics of the reporting methodology outlined in the VHA and Catholic Health Association guidelines.

VHA looks forward to working with Chairman Grassley and other members of the Senate Finance Committee to review this important issue and consider the best ways to achieve consistent, transparent reporting as well as to maintain the necessary community services America's not-for-profit hospitals provide.