

**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.