United States Senate Committee on Finance
Minority Staff Discussion Draft – Tax-Exempt Hospitals
October 30, 2007 Roundtable

Written Comments of Nancy M. Kane, DBA

My name is Nancy Kane, and I am Professor of Management at the Harvard School of Public Health. Thank you for the opportunity to speak at this roundtable on strengthening the federal standard for hospital tax-exemption, a topic about which I have testified on several occasions in the last 4 years. I am delighted to see many of the provisions I have argued for show up in recommendations of the minority staff's Discussion Draft, including the development and publicizing of hospital charity care policies, prioritizing the provision of charity care over other forms of community benefit as the fundamental basis for hospital charitable exemption, defining charity care as services provided to patients who are financially unable to pay for it, providing detailed guidance on what should "count" as charity care for purposes of tax-exemption, the extension of charity policy to hospital joint ventures, the requirement for hospitals to work with their local communities to define other community benefits, and enhancing transparency. The minority staff have been very thorough in their identification of the problems with the current standard and thoughtful in their recommendations of what should be done to strengthen the federal standard for hospital tax exemption.

I will restrict my comments to how to further strengthen the specific recommendations, reflecting my understanding of the state of charity care in the United States today.

Setting a Quantified Charity Care Standard of 5%

1. From what I have seen nationally, most nonprofit hospitals do not come close to providing charity care worth 5% of operating expenses, at least in terms of what hospitals define as charity care now. A 5% standard could be a significant increase in resources to support the needs of under- and un-insured Americans at a time when their ranks are growing. I would add a provision to insure that the 5% standard does not force some hospitals to convert to for-profit status or have to close their doors and adversely affect access. One possible provision would be to re-instate the pre-1969 IRS standard which required hospitals to provide charity care "to the extent of their financial ability"; the IRS would then have to develop guidelines for determining when the 5% standard is beyond a hospital's financial ability. Hospitals that are on the verge of closing or defaulting on their debts, for instance, might be temporarily exempt.

   A second modification would be to include as "charity care" amounts that hospitals provide to independent physicians who treat hospital charity patients, and who in return for such hospital payment agree to not bill the patient. While this could be seen to fall within your charity care definition (c) (providing medical care through free clinics, etc), it may need to be spelled out separately for physicians who are not hospital or community clinic employees.

2. I do not support the exempting of any class of nonprofit hospital from the charity care standard or minimum requirement. Some 1300 hospitals are now "critical access hospitals" (CAH). As the only provider of hospital services within a large geographic area, CAH's should be expected to provide care to anyone residing in the area who needs the level of services provided. Many are located in low-income rural areas and should have no trouble meeting the standard. Some are located close enough to non-critical access hospitals that exempting them from a charitable standard could give them an unfair competitive advantage over the non-CAH hospital. I see no reason to exempt any class of 501 (c) 3 hospital from the charitable standard, particularly if there is a provision for exemption from the standard based on financial distress as suggested in my earlier remarks.

Sanctions For Failure to Meet Requirements:

3. It is hard to envision that any hospital cannot find a medically indigent population in its service area or a nearby one for which charity care is not needed, given the 47 million uninsured people in this country, who are present in every state. The "lack of demand" proposed exemption from sanctions should be very stringently defined, and be based on "demand" at the community level, not in terms of demand for the specific service mix of the hospital. Changes in hospital service mix could have the effect of reducing medically indigent "demand", such as the closure of a mental or dental health clinic. However the need for subsidized mental or dental health would remain extant in the community.

Transparency and Reporting Requirements:

4. With regard to annual reporting on the composition of board of directors, it would be helpful to be more specific as to the nature of what is reported. For instance, policy-relevant characteristics might include whether or not the director lives in the hospital's primary service area, the director's occupation, whether or not the director/family or his/her employer does any business with the hospital; and the primary reason the director was recruited to the board (eg donor, health expert, community advocate, etc).

5. With respect to disclosure of executive compensation, there should be disclosure to the full hospital board of the amount as well as the process by which executive compensation is determined. The requirement should be met regardless of whether the executives are employees of the hospital/health system or with an unaffiliated or affiliated taxable or other type of management company with a contract to manage the hospital.

Specific Requests for Comments:

6. With regard to whether the charity and community benefit standards should be aggregated to a hospital system or be enforced on a hospital-specific basis, it would be most relevant to the affected communities to know what their local hospital's charity care and community benefit activities are. To the extent that the standard applies to every hospital, the information/transparency would need to be available at the hospital level.

Every hospital has a primary service area which is providing it with local tax exemptions and donations; and many if not most hospitals within systems maintain a local 'advisory" board that is expected to "represent" the community. Local community "oversight", however it is achieved, will be more effective if the information about what a local hospital is providing is available.

If a hospital in a system is below the standard on charity care but is transferring resources to subsidize a hospital that is well over the standard, that subsidy or transfer should "count" toward the donor hospital's required charity care.

7. With respect to medical education as a community benefit, it would be helpful for Congress to determine from time to time what types of medical education should "count" toward a federal standard of community benefit. For instance, over the next 5 – 10 years, we are likely to experience a growing shortage of primary care physicians, particularly gerontologists, as well as RN's. Rather than allowing the cost of training additional dermatologists and plastic surgeons to count toward "community benefit" for tax-exempt purposes, it might be worth exploring the feasibility of including only those educational programs deemed to meet a national priority with respect to manpower training. The process by which those determinations are made should be ongoing, as the needs change.

8. Netting the provision of charity care and community benefit against the resources (DSH, Medicare Direct Med Ed and Indirect Med Ed, patient revenues that partially offset services, dedicated philanthropy) that are used to pay for them: If these resources are not used to offset the costs of providing charity care and community benefit, some other resources will be used. The only "other" resource that is generally available to offset the cost of charity care and other community benefits is increased payment from privately insured patients. Tax-exemption does provide value, but it does not provide cash to meet real cash expenses. The goal of requiring hospitals to provide a certain amount of charity care is to get them to improve access to those most in need in our society. It is not to weaken the financial condition of hospitals. In particular, in setting the 5% charity care requirement, it should be determined before offsets (DSH, etc) are applied. Certainly the availability of such offsets should be reported and made transparent; but the key is to encourage more provision of services to people who need them but cannot pay for them. It is not to keep the hospital from finding a way to pay for them from other sources. In particular one does not want to see hospitals billing insured patients to make up for uncompensated care losses.