U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

M E M O R A N D U M

To: Reporters and Editors
Re: Non-profit hospital responses to Finance Committee
Da: Tuesday, Sept. 12, 2006

In May 2005, Sen. Chuck Grassley, chairman of the Committee on Finance, wrote to 10 major non-profit hospitals, asking a series of questions about their care to the poor and service to the community. Grassley is convening a committee hearing tomorrow, Wednesday, Sept. 13, at 10 a.m., in 215 Dirksen Senate Office Building, to hear testimony on "Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals." He is releasing a summary of the hospitals' responses today and made the following comment on them.

"Today the Finance Committee is releasing the answers it received to its questions to 10 major non-profit hospitals. As the committee holds a hearing tomorrow on non-profit hospitals, I want my colleagues and the public to benefit from seeing the answers provided. Based on my review of these responses, and correspondence with for-profit and non-profit hospital organizations, I've reached preliminary conclusions.

"Non-profit doesn't necessarily mean pro-poor patient. Non-profit hospitals may provide less care to the poor than their for-profit counterparts. They may charge poor, uninsured patients more for the same services than they charge insured patients. They sometimes give their executives gold-plated compensation packages and generous perks such as country club memberships. All of this calls into question whether non-profit hospitals deserve the billions of dollars in tax breaks they receive from federal, state, and local governments.

"Unfortunately, it's almost impossible to get an exact measurement of how much charity care and community benefit, such as vaccination clinics or cancer screenings, that non-profit hospitals offer to earn their special tax status. That's because non-profit hospitals don't have to report any kind of information about those activities to the IRS. And there are no uniform standards or definitions for charity care and community benefit. The IRS, and Congress, have allowed non-profit hospitals to use their own definitions.

"In the responses from the 10 non-profit hospitals, it was surprising to get such enormous differences in answers to the same questions. It was rare to get the same answer from even two hospitals. These differences in responses were at the core of many questions, including: how charity care is determined and valued, who is eligible for charity care, and what constitutes community benefit and how that's measured.

"The different yardsticks used makes weighing and considering the charity care and

community benefit of different non-profit hospitals less like comparing apples to oranges as comparing apples to farm tractors. The Catholic Health Association (CHA) recently established common rules and guidance for reporting and measuring key parts of community benefit for its member hospitals. I appreciate this effort and am pleased that hundreds of hospitals already have agreed to comply with CHA guidelines. I'm sure many non-profit hospitals are well-intended and do outstanding work on behalf of their communities and the poor. But I'm concerned that the best practices of non-profit hospitals are not common practices for all.

"The IRS is creating a supplemental report to the Form 990 to include additional information from non-profit hospitals and their charity care and community benefit. I hope the IRS will give strong consideration to having that new information requirement conform with CHA guidelines. IRS Commissioner Mark Everson committed last year in hearings before the House Ways and Means Committee to having this new information reporting for hospitals in place. We need to see IRS action on this front. We also need to see all non-profit hospitals agree to common reporting. I'll listen closely at tomorrow's hearing to see to what extent congressional action may be necessary, and to what extent the IRS and the non-profit hospitals can achieve much more meaningful, uniform disclosure about hospital activities without additional legislation.

"The committee also is releasing today two letters from the Federation of American Hospitals (FAH), which represents investor-owned hospitals. The FAH information is very eye-opening. It highlights several for-profit hospitals that are providing as much if not more charity care than some non-profit hospitals. The Government Accountability Office (GAO) and the Commissioner Everson have both commented that there is often little to no difference between for-profit hospitals and non-profit hospitals when it comes to charity care and community benefits provided. Non-profit hospitals receive billions in tax breaks at the federal, state and local level. The public has a right to expect significant, measurable benefits in return. I hope the hearing will help the Finance Committee decide how we can best ensure that non-profit hospitals provide appropriate levels of benefit to the communities they serve.

"Not only is there often very little difference between for-profit and non-profit hospitals when it comes to serving the community, but also the release of the answers today shows that there appears to be very little difference on executive compensation. Some non-profit hospital executives enjoy the best hotels and great meals, all subsidized by the taxpayer. I find it especially troubling that executive after executive is having country club dues paid for by non-profit hospitals. While one hospital ended this policy after I inquired, far too many non-profit hospitals still think paying for country clubs should be business as usual. I'm afraid that if non-profit hospital boards are focusing so little attention on what they're paying executives, they're giving even less attention to how the hospitals are helping the community and the poor. I intend to look at legislative reforms that will make sure the boards are more focused on ensuring fair, just executive compensation at all non-profits, including hospitals."

Following is the May 25, 2005, news release describing Grassley's letter to the 10 non-profit hospitals. Attached are (1) a summary of the 10 non-profit hospitals' responses to Grassley and (2) two letters from the Federation of American Hospitals.

For Immediate Release
Wednesday, May 25, 2005

Grassley Asks Non-profit Hospitals to Account for Activities Related to Their Tax-exempt Status

WASHINGTON — Sen. Chuck Grassley today asked some of the nation's largest non-profit hospitals to account for their charitable activities, given the tax-exempt status they receive. The designation results in tax benefits totaling tens of billions of dollars every year.

Grassley said the inquiry is a continuation of his effort to review the non-profit sector in advance of legislation he will introduce to prevent abuse of the federal tax laws that created non-profit organizations and encourage charitable donations. Grassley is chairman of the Senate Committee on Finance, which is responsible for tax legislation and oversight.

"It's my duty to make sure charitable donations actually help those in need," Grassley said. "It's also my job to make sure charities are earning their generous tax breaks. Tax-exempt status is a privilege. Unfortunately some charities abuse that privilege. By gathering information from non-profit hospitals, I hope to learn whether the benefits they provide to the needy justify the tax breaks they receive."

In a letter today to 10 hospitals and hospital systems, Grassley asks for information about issues including charitable activities, patient billing, and ventures with for-profit companies and hospitals. Grassley sent his letter was sent to the following hospitals:

--The Cleveland Clinic, Cleveland, Ohio;
--New York Presbyterian Hospital System, New York, N.Y.;
--Advocate Health Care Network and Advocate Health and Hospitals Corporation, Oak Brook, Ill.;
--Resurrection Medical Center and Resurrection Health Care, Chicago, Ill.;
--Phoebe Putney Health Systems, Inc., Phoebe Putney Memorial Hospital, Inc., Albany, Ga.;
--William Beaumont Hospital and Beaumont Properties, Royal Oak, Mich.;
--North Mississippi Health Services, Inc., North Mississippi Medical Center, Tupelo, Miss.;
--Sutter Health, Sacramento, Calif.;
--Fairview Health Systems, Minneapolis, Minn.; and
--Banner Health, Phoenix, Ariz.

Grassley began his oversight of the non-profit sector several years ago when problems emerged with the United Way and the American Red Cross. Grassley conducted his first hearing to examine the ways some tax-exempt organizations game the tax system in June 2004. In April 2005, he held a second hearing. That hearing examined schemes to take inflated deductions for non-cash donations, such as those involving taxidermy, and the broad scope of charitable sector enforcement problems, according to the Internal Revenue Service commissioner. The Minnesota attorney general testified about highly questionable activities by non-profit health care operations in that state.

Earlier this month, Grassley introduced legislation to crack down on abuses in certain life insurance contracts involving tax-exempt organizations. He is working on a series of legislative reforms to curb various other abuses and improve charities' accountability to taxpayers and potential donors. He continues to consult with the non-profit sector to ensure that his reforms are effective yet not unduly onerous for charities, especially small charities.

Here is the text of today's letter.

May 25, 2005

The Congress is considering the issues of tax-exempt organizations and particularly the duties and requirements of public charities in relation to the billions of dollars in tax benefits that tax-exempt organizations receive at the federal, state and local level. To assist the Congress in this review and determination of actual practices in the field for tax exempt hospitals, I request the following information:

Charity Care and Community Benefit

1. How does your organization define charity care? What types of activities or programs does your organization include in its definition or determination of charity care? Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital? Does your organization maintain a charity policy? If so, please describe the policy or provide a copy of such policy. Does this policy require that certain types and amounts of charity care be provided?

2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years? How does this differ from 10 years ago? 25 years ago?

3. What percentage of your patients for your most recent fiscal year were: (a) uninsured, (b) covered by Medicare, (c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals, or (d) otherwise covered by private insurance?

4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?

5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt writeoffs of your hospital over the past five years?

6. Has your hospital or other members of your hospital system group entered into joint ventures with other nonprofit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.

7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.

8. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures.

9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy. Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced. If your organization does not track charity care expense by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant.

10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons.

11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture?

12. Please provide a charity care breakdown for each entity that is a member of your hospital system group. In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis?

13. In your judgment, should the Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement? If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?

14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides $100 of charity care, do you count $0, $50, $100, or some other amount, as charity care provided directly by your hospital?

15. What types of research and teaching are performed by your hospital as a charitable or educational activity?

16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital. Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families?

17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture?

18. Do your compensation arrangements with physicians and other professionals in any way

encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?

19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.

20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?

21. Please explain how the amount of charity care you provide differs in magnitude and kind from that provided by your for-profit competitors?

22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?

23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?

24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards? Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences.

25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.

Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues

1. Please explain what is the average mark-up of charges over costs? What is the average private pay contractual allowance (charges to payments) weighted by payer?

2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status.

3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the

already high chargemaster rate? What is your discount policy? What is the collection rate for self-pay?

4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate?

5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status?

6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject.

7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff.

8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay."

   In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule? Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured?

9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002?

10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals $22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government. Please list your payments under disproportionate share for the past three years as compared to uncompenstated care, separating out bad debt.

11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed."

12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice.

13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients.

14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured.

15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment.

16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals. Please identify the amount of debt that was at issue in each suit. Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection. Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales

were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts. Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not "double dipping.".

Please provide copies of your contracts, if any, with collection agencies. Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization. Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt. Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt. If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt.

17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action.

18 Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.).

19. Some hospitals have taken the position that the provision of healthcare, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain.

20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well. Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over $1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip. Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18. Finally, please detail any payments or reimbursements made to employees for country clubs.

Thank you for your time and assistance on this matter. I would ask for a complete response by July 11, 2005.

Sincerely,

Charles E. Grassley
Chairman

cc: Senator Baucus
Chairman Thomas

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