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We commend you, Senator Grassley, for your draft proposal on the important issue of nonprofit hospitals' charitable obligations. Millions of Americans are faced with health care costs that they cannot afford. More than a third of non-elderly adults – 34 percent – have had trouble paying their health care bills, are paying off accrued medical debt, or both. Thirty-nine percent of adults with medical bill problems or medical debt have used up all of their savings to pay medical bills. When medical debt becomes too great to bear, the consequences can be catastrophic. In some instances, legal action – such as seizure of wages, assets, and property – may be taken against people with unpaid medical bills. Charitable hospital care is thus an essential community benefit, assisting people who are uninsured and underinsured, and we greatly appreciate your efforts to strengthen nonprofit hospitals' charitable obligations.

We believe that nonprofit hospitals can and do provide an essential role in protecting vulnerable consumers. America's health care consumers will be best served if nonprofit hospitals survive and remain financially viable so they can succeed in their charitable missions. Government can help the nonprofit hospitals remain viable, for example, by ensuring that they receive timely reimbursements from Medicare and Medicaid. At the same time, we believe that many nonprofit hospitals can strengthen their charity care programs to better serve the consumers that rely on them. Families USA, the national voice of health care consumers, is here today to share some of the experiences and recommendations of Americans who have not been able to surmount problems of medical debt.

We suggest the following seven additions to or modifications of the minority staff proposal:

1. further distinguish bad debt and charity care;
2. allow states to increase the income guidelines for charitable care;
3. ensure referrals of potentially eligible people to public coverage programs;
4. add protections for Medicaid and CHIP beneficiaries to the unfair billing practices section;
5. address the billing practices of contracted hospital units and of providers that the hospital assigns to consumers;
6. clarify the sources of nonprofits' charitable obligations; and
7. study the consequences of the proposed 501(c)(4) provision.

Each of these is discussed below.

1. **Definition of charity care:** We support the draft proposal's definition of charity care as care provided without expectation of payment and the value of discounts in care to people who apply for it and meet certain eligibility guidelines. We also support determining the value of charity care based on the hospitals' actual costs or Medicare/Medicaid reimbursement rates. In most cases, the hospital should inform people of charity care opportunities and accept applications in advance of service. However, people must also have a later opportunity to apply for charity care for emergency admissions or for other instances where they were unable to understand and negotiate their financial obligations in advance. Hospitals should *not* write off bad debt to charity care. Specifically, they should not be allowed to count debt as charity care in any of the following circumstances: (a) the person did not apply for charity care either at the time of service or at a later time; (b) the hospital or its collection agency continues to attempt to collect the debt; (c) the debt will continue to affect the consumer, such as by appearing on the consumer's credit rating; (d) the amount of the bill, or the amount that should be paid by an insurance carrier, is still in dispute; or (d) the person did not meet eligibility guidelines.

2. **Allow states to increase income guidelines for charitable care**: We agree that nonprofit hospitals should be required to provide uncompensated care to people who meet a specific income guideline and reduced-price care to people over that income guideline who face medical hardships. Your discussion draft suggests a minimum income threshold of 100 percent of the Federal Poverty Level for full charity care, and a threshold of 100 to 300 percent of the poverty level for discounted care. People will need very significant discounts with incomes in these ranges. Many people with income of 200 percent of poverty ($27,380 for a couple) will be unable to contribute anything towards their hospital bills. They already face out-of-pocket expenses for other medical care that are unaffordable – about 20 percent of families with incomes below 200 percent of poverty report difficulties paying medical bills. Earlier this year, Rhode Island passed new regulations that require all of the state's hospitals, which are not-for-profit institutions, to provide free care to uninsured individuals below 200 percent of poverty, and other states have similarly established laws or agreements with hospitals that reflect their communities' needs and resources.

   Though the federal law should set minimum guidelines for charity care policies, states or hospitals should be allowed to set higher standards. For example, if a state provides public coverage to the great majority of residents below the national income guideline but there are unmet needs for a different group of residents, the state or hospital might consider a higher income standard. If the hospital routinely has charitable funds remaining at the end of the year after providing broad outreach to the lowest income population about charity care policies, the hospital or state should raise income guidelines. Similarly, we want to guarantee that the lowest income people receive top priority for the receipt of any charitable benefits.

3. **Publicize free care and public coverage sources:** We support your proposal that all hospitals thoroughly publicize their free care policies and agree that these policies should be clearly written and available in appropriate languages. Nonprofit hospitals should also make a diligent effort to refer people to public coverage programs, when they exist, so that charitable care dollars will be saved for people who cannot get insurance or who are underinsured. Many hospitals already display literature about public coverage programs and use out-stationed Medicaid eligibility workers or have trained their own staffs to assist people who may be eligible for Medicaid or SCHIP. As part of their efforts to assist low-income individuals in the community and to bill appropriately for services rendered, all nonprofit hospitals should actively determine whether patients are enrolled in public coverage programs for which they are eligible and, for those who appear to be eligible but are not enrolled, provide appropriate information about how to apply.

4. **Billing of Medicaid/CHIP beneficiaries:** We applaud you for addressing unfair billing and collection practices in the draft proposal. Similarly, we request that you address unfair billing of Medicaid and CHIP beneficiaries. In particular, we have worked with consumer assistance programs around the country that cite many instances in which Medicaid beneficiaries are wrongly billed, sometimes with very serious consequences, even though all of their providers had signed participation agreements with the Medicaid program. These agreements state that providers will accept Medicaid as payment in full.

   In some hospitals, patients are required to sign the financial responsibility statements saying that they agree to pay any bills not paid by their health insurer—even if they presented a Medicaid card at the time of admission. Then, if the Medicaid agency is slow to pay or if the clerk copied the person's Medicaid number wrong, this statement can come back to haunt the patient once collection actions begin.

   Medicaid patients also frequently encounter payment problems when they experience an emergency and seek care while traveling out of state. Although under federal law and regulations, state Medicaid agencies are supposed to have interstate agreements to coordinate payment of care (Section 1902(a)(16) of the Social Security Act and 42 Code of Federal Regulations §431.52), hospitals actually have to enroll in another state's Medicaid program to collect reimbursement. If a hospital does not do this, for whatever reason, the patient is left with the bill. In past correspondence with CMS, we have suggested ways that the federal government might address this problem by providing streamlined and standardized Medicaid provider enrollment procedures for out-of-state claims.

   While these problems need to be fixed for Medicaid beneficiaries in all contexts, we request that you address them now in the context of nonprofit hospitals' obligations in two ways: (1) Prohibit nonprofit hospitals from requiring Medicaid beneficiaries to sign general financial responsibility statements that say they will

be liable for any bills not paid by their insurer on a timely basis; (2) Prohibit nonprofit hospitals from instituting collection actions against people who received Medicaid either in their own or another state.

5. **Balance billing by non-participating providers within a hospital:** Your proposal mentions charitable responsibilities of joint ventures. We request that you also discuss contractual arrangements in which another entity (such as a pharmacy or lab) operates out of a nonprofit hospital. Hospitals frequently have units that are not under the direct control of the hospital, or give providers (such as anesthesiologists) privileges even though they do not participate in the same insurance plans as the remainder of the hospital. This causes severe problems for patients who are unaware that they are using out-of-network providers and who often do not have any choice in the matter. For example, we regularly hear of problems like the following:
   - patients who had non-elective surgery and were assigned an anesthesiologist, only to find out that this anesthesiologist did not accept their insurance;
   - couples who receive bills as large as $35,000 for neonatal care because the hospital's subcontracted neonatal unit does not participate in the same plans as the hospital;
   - billing by emergency room physician groups that are not in the same network as the hospital emergency room; and
   - a shock-trauma unit that did not participate in the same health insurance plans as the hospital's emergency room.

   In many of these cases, even when state consumer assistance programs negotiate with the insurer and provider, the patient is still left with large portions of the bill.

   Nonprofit hospitals should require that all hospital units and affiliates participate in the same insurance plans that the hospital itself accepts, and hospitals should be obligated to assign providers to patients who accept those patients' insurance coverage.

6. **Source of free care/community benefit obligations:** The draft proposal mentions obligations accepted by nonprofits in exchange for tax exemptions. When an entity converts to for-profit status, the draft suggests charging a termination tax. While we strongly agree with the need to reform the tax code to hold nonprofits that are receiving tax exemptions accountable, we want to be sure that the committee report clearly states that the obligation to act charitably goes beyond the tax exemption. Nonprofits are obligated by their articles of incorporation and by their missions to act for charitable purposes and in the public interest, rather than to act in the interests of owners or stockholders. These purposes supersede any tax exemption. If an entity changes its tax status, but there has not been formal action to change its corporate mission, it will still be bound to its charitable goals. Under some state conversion laws, for example, the nonprofit entity and state must determine whether the conversion is in the public interest at all, before determining the amount of money that should be devoted to

community benefits in the event of conversion.[1] This issue has arisen for us recently in the context of nonprofit insurers. Their federal tax status changed in 1986, but the insurers still have charitable missions and are not publicly traded. Some states and the District are currently considering the appropriate financial roles for these nonprofit entities in the communities they serve, and we imagine similar issues will arise for other institutions in the future.

7. **Proposed 501 (c) (4) requirements:** Finally, while we generally support the ideas in the discussion draft, we are concerned about the proposal that hospitals could obtain a 501(c)(4) status with reduced charitable care obligations. We suggest further study of the extent to which this would lessen the availability of desperately needed charitable care.

Thanks again for your work on this important issue.

[1] See, for example, the *Report of the Maryland Insurance Administration Regarding the Proposed Conversion of CareFirst, Inc. to For-Profit Status and Acquisition by Wellpoint, Inc, 2003* for a discussion of factors to be considered in valuing community obligations in Maryland.