

Statement to the United States Senate Committee on Finance
“Taking the Pulse of Charitable Care and Community Benefit at Nonprofit Hospitals.”
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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.

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 hospitals⁴. Add to that roughly \$22

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 authorities 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)

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. "Strengthening Transparency, Governance, and Accountability of Charitable 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 hospitals⁹, 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 practices¹¹, 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 990s 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.

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,prcat 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.