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September 27, 2007

VIA ELECTRONIC MAIL
Mr. Dean Zerbe
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Community Catalyst's comments on "Tax-Exempt Hospitals: Discussion Draft"

Dear Mr. Zerbe:

We write to you to express our strong, general support for your office's Discussion Draft proposals regarding free care and community benefits for hospitals.

Community Catalyst is a national nonprofit advocacy organization that builds consumer and community participation in the United States health care system to secure, quality, affordable health care for all. Since its establishment in 1997, Community Catalyst has worked with community organizations and other system stakeholders in promoting free care and community benefit standards across the United States. These standards can be found in several resources and publications developed by Community Catalyst, including the Patient Financial Assistance Act and the Health Care Institution Responsibility Model Act.[1]

Although some details of our positions may differ with the proposals expressed in your office's Discussion Draft, as we will note below, we wholeheartedly endorse your approach to tackling this important issue. We thank you for allowing us the opportunity to comment and look forward to continuing to work with you to translate your office's important proposals into clear, firm, legal requirements to be met by all tax-exempt hospitals.

It is clear that the system needs changing. The legal obligations that hospitals must meet to obtain federal tax exemption have no connection to the reality of today's health care system. Revenue Ruling 69-545, which describes the "community benefit" standard for nonprofit hospitals, is vague and, as your office's Discussion Draft notes, was written in 1969 based on faulty assumptions about the then-future scope of Medicaid and Medicare.[2] Overall, this federal hospital community benefit requirement does practically nothing to address the crisis facing the uninsured and underinsured in the American health care system.

In 38 years, no meaningful action at the federal level has been taken to address this problem. The IRS has fine-tuned, but has never fundamentally changed, the 1969 community benefit standard. Meanwhile, other requirements regarding free care in the hospital sector, such as Hill-Burton, have largely expired.[3] As a result of this lack of oversight, too many hospitals are allowed to do little or nothing to address the needs of the uninsured and underinsured in the communities they serve. The recent IRS Hospital Compliance Project Interim Report illustrates the problem by

showing that more than 20% of tax-exempt hospitals have provided less than 1% of their total revenue in uncompensated care.[4]

In addition to organizations like ours, we believe that you will find many allies in your efforts to improve the system. To their great credit, a significant number of tax-exempt hospitals have stepped up to the plate by providing meaningful amounts of free care, and by implementing a community benefits policy sensitive to the needs of the people they serve. At the state level, many regulators and legislators have acted upon concerns about the lack of hospital community benefits. Some states, using their own taxation or other regulatory authority, have stepped in to require tax-exempt hospitals to provide a certain level of free care and community benefits.[5] The IRS itself has recently taken the lead in promoting greater transparency in nonprofit hospital free care and community benefit reporting.[6]

It is clear that this is a bipartisan issue. Over the years, key players in the federal government, from both parties and from both the executive and legislative branches, have decried this state of affairs and discussed the need for reform. Despite this outcry, little has been accomplished at the federal level. We hope that your office's Discussion Draft, together with the IRS's recent Hospital Compliance and Form 990 Redesign projects, represent a promising move toward the imposition of meaningful, federal standards on all hospitals that seek tax-exempt status.

Our comments below are not meant to be comprehensive. There are certain areas of the Discussion Draft, such as in the sections related to conversions and joint ventures, where we would only strongly encourage you to adopt the approach contained in many state laws,[7] and in our own Conversion Model Act.[8] Our comments in this letter are focused on the Discussion Draft provisions related to free care and community benefits.

Minimum Free Care Requirements

We support your office's proposal of a requirement that all tax-exempt hospitals[9] provide a minimum of 5% of revenues or operating expenses, whichever is greater, in free care. In doing so, we also recommend that any federal legislation or regulation in this area allow states to retain the option to set additional, higher standards, so that 5% does not become a ceiling.

Fairness in Charging for Hospital Services

We share your office's concern about the vast gap between high hospital charges to self-payers and discounted charges to those who have insurance. We would support your office's proposal that charges to self-payers should not exceed the lower of the unreimbursed cost of the service provided, or the lowest rate paid by Medicaid or Medicare. On a related note, we recommend that hospitals value and report all services provided, including all free care provided, using an appropriate cost-to-charge ratio.[10]

Publicizing Free Care

We support your proposal that all hospitals thoroughly publicize their free care policies, and that these policies should be clearly written and available in appropriate languages. Through our free

care monitoring project, which looked at more than 60 nonprofit hospitals, we learned that some tax-exempt hospitals make little or no attempt to publicize their free care policies, and even deny that they offer free care.[11] As we note in our Patient Financial Assistance Act, in order to effectively publicize their free care policies, hospitals should ensure that clear, detailed, written notice of these policies are conspicuously posted throughout public areas of the hospital, in a prominent place on the hospital's website, and in a newspaper of general circulation in the hospital's service area on a quarterly basis.[12]

Eligibility for Free Care

We support full free care for all patients at up to 200% of the Federal Poverty Level (FPL), and partial free care for all persons at between 200% and 400% of the FPL.[13] We also support the provision of medical hardship assistance for those who would not qualify for free care, and whose hospital debts equal or exceed 25% of family annual income. If an asset test is used in determining medical hardship, we would encourage a broad exclusion of essential assets, such as the family's primary home and motor vehicle.[14]

The Discussion Draft correctly notes that bad debt does not constitute free care and is not a community benefit.[15] As the Discussion Draft adds, many hospitals that acknowledge this have developed intake systems that make free care eligibility determinations easier, thus minimizing the risk of charging people who should be receiving free care. We believe that it is essential that all hospitals do as thorough a job as possible of determining early in the intake process whether patients are eligible for full or partial free care. Too many hospitals have adopted a "bill first, ask questions later (if at all)" approach that can wreak havoc on the economic and emotional security of a patient and his or her family.

Additionally, in determining free care eligibility, an absence of documentation should not be a barrier to access. In these instances, hospitals should be required to accept affidavits. Finally, it is important that free care policies cover all medically necessary services, not only emergency services or certain outpatient services.

Collection Practices

We appreciate your office's interest in attempting to rein in unfair billing and collection practices. Placing internal hospital billing and collection practices under the Fair Debt Collection Practices Act (FDCPA) is a good starting place. However we believe there are additional, specific collection practices that hospitals should be required to adopt, and others that should be forbidden. For instance, it is our position that all hospitals, and their designated collection agents, must

+ Develop and make publicly available a written debt collection policy;
+ Forgo any action to garnish wages, attach liens on real or personal property, foreclose upon personal property, or attempt to attach or seize a bank account or any personal property without the express approval of the hospital's governing board;
+ Ensure that the hospital board must, on an annual basis, approve any designated collection agent;

+ Provide communications on collection actions in all of the significant languages within the community's population area; and
+ Exempt all patients enrolled in Medicaid, SCHIP, or who are subject to full free care, from collection actions. Partial free care recipients should be exempt above the level of their designated contribution.

We want to stress that hospitals should be required to halt collection actions while free care determinations are underway, and to suspend collection actions on persons who have applied for free care after a collection action has started, until a free care determination has been made.[16] Finally, we recommend that hospitals be banned from the practice of selling accounts to third parties, who then charge patients exorbitant interest rates on outstanding debt.

Community Needs Assessment

We strongly support the need for all hospitals to conduct a periodic community needs assessment. A community health needs assessment should be inclusive. Hospitals should solicit input from community groups, local government officials, health related organizations, and health care providers in making their assessments. In doing so, particular attention should be given to those individuals or groups that are underserved or that work on behalf of the underserved. Because needs in hospital service areas change, a hospital should conduct an assessment at least once every three years. [17]

Transparency

We support greater transparency and better reporting by hospitals in the areas described in your office's Discussion Draft. Overall, we would note that, although it is important that hospitals report the numbers of people served, and dollar amounts provided, regarding free care and other community benefits, it is also vital that hospitals report a detailed description of their free care policies and community benefit plans, a description of their free care application processes, and the identities of the person or persons responsible for making free care determinations.[18]

We would add that we believe that the proposed Schedule H to the redesigned IRS Form 990, with some modifications, will become an excellent resource for legislators, regulators, and the public who wish to learn more about how their community hospitals are doing.[19]

Sanctions

We support your office's proposed set of sanctions for hospitals that fail to meet their obligations. In the past, however, we have been concerned about the failure of regulators at the state or federal levels to impose sanctions, even in clear cases of violation. We strongly urge you to ensure that any regulation or legislation regarding sanctions have clear, bright-line standards that, if violated, will result automatically in an appropriate penalty.

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Finally, we would like to emphasize that the crisis in health care access is so great, and so grave, that even perfect laws in the nonprofit hospital sector cannot resolve it. Other system stakeholders, such as for-profit health care providers and private insurers, who have benefited so much under our current system, must do much more to address our nation's widening gap in health care. It is our hope that addressing the failure of many nonprofit hospitals to serve the un- and underinsured will help shine a brighter light on other players in the system that should be doing more.

We are committed to working with you on improving the accountability of our nation's hospitals to the communities they serve. Thank you,

Frank McLoughlin

Staff Attorney
Community Catalyst

Renée Markus Hodin

Project Director
Community Catalyst

Also on behalf of:

Oregon Health Action Campaign
Salem, Oregon

Families USA
Washington, District of Columbia

ACORN – Association of Community Organizations for Reform Now
New Orleans, Louisiana

Northwest Federation of Community Organizations
Seattle, Washington

West Virginians for Affordable Health Care
Charleston, West Virginia

West Virginia Citizen Action Group
Charleston, West Virginia

New York Immigration Coalition
New York, New York

Community Service Society
New York, New York

Empire Justice Center
Rochester, New York

The Artists Foundation
Boston, Massachusetts

Covering Kentucky Kids and Families Coalition
Lexington, Kentucky

Mississippi ACORN
Jackson, Mississippi

Long Island Health Access Monitoring Project
Long Island, New York

TakeAction Minnesota
St. Paul, Minnesota

Mississippi Coalition for Citizens with Disabilities
Jackson, Mississippi

Virginia Poverty Law Center
Richmond, Virginia

Washington Community Action Network
Seattle, Washington

Idaho Community Action Network
Boise, Idaho

Consumers for Affordable Health Care
Augusta, Maine

Health Care for All
Boston, Massachusetts

Florida PIRG
Tallahassee, Florida

Florida CHAIN
Plantation, Florida

Michigan Legal Services
Detroit, Michigan

Health Law Advocates
Boston, Massachusetts

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[1] All Community Catalyst tools, resources, and publications mentioned in this letter can be located on our website: www.communitycatalyst.org.
[2] Discussion Draft, p. 5.
[3] U.S. Department of Health and Human Services, Health Resources and Services Administration http://www.hrsa.gov/hillburton/default.htm.
[4] Internal Revenue Service, Hospital Compliance Report, Interim Report, p. 24.
[5] See Community Catalyst, Health Care Community Benefits: A Compendium of State Laws.
[6] Details on the Form 990 redesign process can be found at http://www.irs.gov/charities/article/0,,id=171216,00.html.
[7] See Community Catalyst, Conversions: A Compendium of State Laws.
[8] For example, we strongly recommend that 100% of the fair market value of any converting nonprofit healthcare institution be preserved.in the nonprofit sector and that those assets be dedicated to a health-related mission similar to that of the converting nonprofit institution. See Community Catalyst's Conversion Model Act for more information.
[9] We would caution against setting different standards between 501(c)(3) and 501(c)(4) hospitals. We are concerned that this presents a potential "loophole" for 501(c)(3) institutions seeking to evade their full obligations to their communities.
[10] See Community Catalyst's September 13, 2007 Comments to the Internal Revenue Service on Nonprofit Hospital Reporting Requirements, p. 3 and fn. 9. These comments were also submitted on behalf of twenty other organizations from across the United States.
[11] Community Catalyst, Not There When You Need It: The Search for Free Hospital Care.
[12] See Community Catalyst, Patient Financial Assistance Act, Section IX "Notification."
[13] *Id.*, pp. 10-11 and Section IV, "Free Care Eligibility Categories."
[14] *Id.*, p. 11.
[15] The Catholic Health Association of the United States (CHA), for example, has stated that bad debt should not be considered a community benefit. See A Guide for Reporting and Planning Community Benefit, 2006. See also Community Catalyst, Patient Financial Assistance Act, pp. 7-8.
[16] For more detailed information, see Patient Financial Assistance Act, Section VI, "Collection Action."
[17] See Health Care Institution Responsibility Model Act, Section 103; See also the Commentary to the Health Care Institution Responsibility Model Act, pp. 8-9. To prevent duplication and unnecessary expenditure, we encourage health care institutions to collaborate wherever possible in conducting community needs assessments. *Id.*, p. 9.
[18] See Patient Financial Assistance Act, Section X., "Reporting."
[19] See Community Catalyst's September 13, 2007 Comments to the Internal Revenue Service on Nonprofit Hospital Reporting Requirements.