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Statement of Community Catalyst at the Roundtable on the Senate Finance Committee Minority Staff Discussion Draft on Tax-Exempt Hospitals

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Introduction

Thank you to Senator Grassley and his staff members for the chance to participate in this roundtable. My name is Frank McLoughlin, and I am a Staff Attorney with Community Catalyst's Hospital Accountability Project. I'm joined today by my colleague Renée Markus Hodin, the Director of the Project.

We are here today to express our support for your general approach on the issue of developing free care and community benefit standards for tax-exempt hospitals. We have suggestions that we hope might strengthen some of your specific proposals. To many advocates here today, our concerns will sound familiar. We and others have expressed them many times before. This time, however, we expect results and call upon our legislators and regulators to work to achieve meaningful standards.

Our organization, 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, and in our report, *Not There When You Need It: The Search for Free Hospital Care*. We have provided these and other materials to the Committee staff and have brought them with us today. All of our materials can be found on our website: www.communitycatalyst.org. Our letter to this Committee responding to the Discussion Draft, which was signed by 25 organizations from across the United States, can also be found on our website.

Time is tight, so we will not be talking today about the significant issue of hospital conversions and joint ventures. We do have some hard-earned experience in this area, however, and would be pleased to follow up with you on this topic with our tools and resources.

Today, we would like to focus on hospital practices related to the provision of free care and other community benefits.

The Need for Standards, Transparency, and Accountability

As most in this room would acknowledge, hospital free care is the health safety net for millions in the United States. Yet, there has been an absence of federal free care standards since 1969. As

you noted in your Discussion Draft, the vague community benefit standard established by Revenue Ruling 69-545 became archaic from the moment it was written.

As a result, it's like the "Wild West" today in the nonprofit hospital sector. Some hospitals, to their great credit, shoulder much of the burden of providing free care and other community benefits for the uninsured and underinsured. Some hospitals do next to nothing. We believe that many tax-exempt hospitals could be doing more. We would refer everyone to the interim report issued by the IRS's Hospital Compliance Project, which shows that more than 20% of tax-exempt hospitals provide less than 1% of their revenues in uncompensated care. This is unacceptable.

We think that it is time to implement **real federal standards**. We support the "5% proposal" described in your draft, although we wish to emphasize that it must not become a *de facto* ceiling, or result in any pre-emption of a state's ability to go above 5%.

We support **minimum free care eligibility requirements,** and recommend that all patients at or below 200% of the federal poverty guidelines be entitled to full free care. At between 200% to 400%, patients should be entitled to partial free care at a sliding scale. Above that income level, we support the provision of medical hardship assistance to families who need it. Hospitals should only use asset tests in determining medical hardship, with appropriate exclusions of essential assets.

It is worth stopping here to state in the strongest possible terms that **bad debt should not be considered a community benefit**. Allowing hospitals to call bad debt a community benefit creates a disincentive for them to develop appropriate intake processes and procedures.

We support **fairness and clarity in charging all patients for services**. It is well-documented that self-payers, including the uninsured, are often billed at multiple times the discounted amount charged to insureds. We agree with your call for charges not to exceed cost, or the unreimbursed rate paid by Medicaid or Medicare, whichever is lower.

We are concerned about the **collection practices** of some hospitals. We refer you to our letter, where we spell out some of our proposals in detail in this area. Above all, a collection action should never be instituted against a person eligible for full free care or government-sponsored programs such as Medicaid or SCHIP, and the practice of pursuing collection actions while free care determinations are being made must end. Inappropriate collection practices can compound the already heavy physical and emotional toll on the patient and his or her family and create a disincentive to seek future medical services.

We support the requirement of **community needs assessments** and would refer you to our materials for much more on best practices in this area.

It's time for **accountability** at the federal level. We support your proposals regarding sanctions against hospitals that fail to live up to their obligations. In the past, we have been concerned about regulators failing to enforce sanctions, even in obvious cases of violation. Clear violations must trigger clear and certain sanctions by regulators.

One last point: **transparency underpins everything we have discussed today**. Hospitals must ensure that the communities they serve are aware of the existence of free care and other community benefit programs. There must be clear and uniform standards for valuing and reporting the services provided by hospitals, including the provision of free care and other community benefits, using an appropriate cost-to-charge ratio. On this point, we believe that the redesign of IRS Form 990 is a step in the right direction. Hospitals must also publicize collection policies.

Conclusion

We are eager to work with you further on these issues, and to help connect the many local and state health advocacy organizations with whom we collaborate with decision-makers here in Washington. We are always ready to work with hospitals and other institutional stakeholders on approaches to these vital issues.

As I indicated earlier, we've been here before. Advocates -- and leaders from both sides of the aisle -- have discussed reforms in this area for a long time. This time, we hope we can achieve results.

Thank you for your time and attention.