

Holding Nonprofit Hospitals Accountable
A Report on the Effectiveness of the Texas Charity Care Law in
Meeting the Needs of the Low Income Uninsured and Underinsured

A Report Prepared for the
Hospital Accountability Project
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EXECUTIVE SUMMARY

WHAT THIS REPORT IS ABOUT (Introduction)

Almost 25% of Texans do not have health insurance of any kind. Another large and growing percentage of Texans who do have some health insurance are seriously underinsured. That is, because of their limited income and/or assets, their insurance does not provide them with adequate protection in the event of serious medical expenses (a result of deductibles, co-pays, limits on coverage and exclusions in the policy).

This report has been prepared at a time of economic hardship for many Texans and relentless cost increases in the cost of medical care. For these Texans there is deterioration in the access of many to needed health services and an increase in financial distress of those who must receive those services.

The report's purpose is to review and analyze access to nonprofit hospitals in Texas who are obligated by law to provide charity care.

- What are the provisions of the Law?
- How effective has it been in its purpose of requiring non profit hospitals to mitigate the problems of lack of access to needed health care services by those who are unable to receive help from the governmental health care assistance programs or from private insurance programs?
- What changes would be desirable in order to improve the effectiveness of the Law?

WHAT DOES THE TEXAS CHARITY CARE LAW PROVIDE? (Section II)

Hospitals in Texas have sought and obtained nonprofit status on the grounds that their facilities and services were designed to be used for charitable purposes and, therefore, saved public resources that would otherwise have to be spent for charity care. Courts made a determination that hospitals were entitled to tax exemptions if they could show that they served numerous charity care patients and/or expended significant resources for charity care. But up to 1993, no factually objective standard was in use to determine whether hospitals did or did not meet minimum criteria for providing charity care.

In 1993 Texas led the nation in establishing objective charity care and community benefits obligations that nonprofit hospitals were to fulfill as tax-exempt entities. The rationale of the law was that a minimum test should be established to determine if nonprofit hospitals were providing help to those in need in return for the considerable tax benefits they receive.

Section II of this report reviews in detail the provisions of the 1993 Charity Care Law and subsequent amendments to provide the necessary legal background for an understanding of the strengths and weaknesses of the Charity Care law and how it has been implemented. To highlight some of the key provisions:

- Three alternative formulas for determining whether a nonprofit hospital has met the minimum requirements for providing access to care of those without adequate resources. The formulas are based roughly on the tax benefits these hospitals receive...
- Reporting requirements on charity care and community benefits by hospitals to the Texas Department of State Health Services (“TDSHS”) so TDSHS can make the necessary calculations on compliance with minimum standards...
- Guidelines, planning and notice requirements to be done by the hospitals to make eligible patients and communities aware of charity care policies...
- Data dissemination and reporting requirements by TDSHD to the public, the Attorney General and the Comptroller...
- Exemptions and exclusions from the law’s requirements for certain non profit hospitals...

ANALYSES OF AGGREGATE AND INDIVIDUAL HOSPITAL ANNUAL REPORTS RESULT IN CONCERNS ABOUT THE ADEQUACY AND AVAILABILITY OF THE DATA AND THE PRESENT REQUIREMENTS OF THE LAW (Section III and IV)

A review was done of both aggregate TDSHS reports and individual non profit hospitals’ reports on charity care and community benefits provided by non profit hospitals in Texas in the year 2006. TDSHS reported only one hospital not in compliance with the minimum requirements of the law.

However, our review of the reports resulted in numerous concerns about the adequacy and the availability of the data and about whether the present requirements of the law actually result in transparency of hospital operations relating to its charity care obligations or in the desired improvement in access of those in need to hospital medical services.

To highlight some of the concerns raised by our analysis of the reports:

- At least one of the formulas for determining whether a hospital has met the minimum requirements for providing charity care is so broad as to be of little value in a meaningful evaluation.
- The 1995 change in the law eliminating Medicare cost report data and allowing hospitals to use a less precise cost measurement has resulted in wide variations in reported patient operating expenses for essentially the same health care services among the non profit hospitals.
- The inclusion of bad debt in patient operating expenses is inappropriate for the purpose of calculating a fair estimate of charity care expense. Bad debt and charity care are very different expense categories and the calculation as presently done by hospitals for TDSHS reports result in highly questionable results and is contrary to federal Internal Revenue Service reporting requirements of charity care.
- The treatment of discounted rates in the calculation of hospitals' unreimbursed costs of providing charity care is not addressed by TDSHS but needs to be.
- The exemption of disproportionate share hospitals from the requirements of the Charity Care Law needs reexamination.
- Some data needs to be more transparent and more easily accessible to the public.

REVIEW OF ANNUAL REPORTS OF TEXAS NON PROFIT HOSPITALS REGARDING COMMUNITY BENEFITS DISCLOSES GAPS AND AREAS OF CONFUSION NEEDING CLARIFICATION (Section V)

“Community Benefits” is a phrase used in the Texas Charity Care Law. It provides a broader measure in determining whether a non profit hospital is meeting its obligation to serve the needy in consideration of its tax exemption. Two of the three formulas for calculating whether a hospital has met its minimum legal obligation allow consideration of community benefits. “Community Benefits” encompasses such benefits as education, research, subsidized health services and government-sponsored program services as well as donations made by the hospital to the community.

Hospitals are required to report annually to TDSHS regarding their community benefits. A review of these reports for 2006 suggested gaps and areas of confusion and concern:

- It is unclear from review of the reports whether some costs included as community benefits are being double counted by also being included as unreimbursed costs in the reports detailing charity care and government-sponsored indigent health care (“gsh care”)

- An “Other Services” subcategory under the “Unreimbursed Costs of Subsidized Health Services” category in the hospitals’ worksheets creates ambiguity and confusion, because the amounts in this subcategory are large and they are sometimes the only reported costs in the entire category.
- Costs reported in the hospitals’ reports included bad debt expense which raises the same concerns as already detailed in the Summary of Sections III and IV.
- Although requested to do so by TDSHS, many of the hospitals did not file annual reports on community benefit plans.

REVIEW OF REPORTED CHARITY CARE POLICIES SHOWED A WIDE VARIATION IN POLICIES (Section VI)

Texas law requires non profit hospitals to maintain charity care policies that provide eligibility criteria for those needing care but not having the resources to pay. These include income levels and means testing indexed to the federal poverty guidelines for qualifying patients. The law established two categories of charity care:

- Financially Indigent, i.e., those whose income could not exceed 200% of federal poverty guidelines;
- Medically Indigent, i.e., those whose hospital or medical bills after third party payers exceeded a certain percentage of the patient’s annual gross income and were unable to pay the remaining bill.

While the 2006 reports showed that most hospitals used the 200% ceiling for defining financially indigent, there was wide variation in the definition of medically indigent. Furthermore, the variation in the reporting of discounts and payment policies caused concern. For example, one hospital reported a 10% discount policy. Such a policy meant that needy patients were being required to pay more than the services cost, since posted prices at Texas hospitals (profit and non profit) are generally much higher than cost. To require a needy patient to pay 90% of the posted price is clearly not charity care at all and raises serious questions about discriminatory price practices (since third party payers are given much higher discounts).

A related concern addressed in the report is the adequacy of efforts to inform those in need of the availability of charity care in their community. While a 2001 requirement that TDSHS publish a Manual summarizing the charity care policies in each hospital has now been fulfilled in January 2009, there is much ground for concern that those in need of help are not being informed of the charity care programs in their local non profit hospitals.

At least one hospital, in its report of health care services covered by its charity care policy, has excluded “elective” procedures. Such exclusion is too broad, since medically necessary procedures include “elective” procedures in many cases.

REGULATORY OVERSIGHT IS DEFICIENT OR LACKING IN THE PROVISIONS OF THE LAW AND IN THE PROCEDURES EMPLOYED TO MONITOR AND ENFORCE THE LAW (Section VII)

- TDSHS views itself as collector of data required to be submitted by Texas non profit hospitals, with little or no responsibility either to evaluate the adequacy, completeness or accuracy of the data or to require follow up or clarification of data submitted.
- Form transparency and accessibility is lacking in several critical respects.
- Too much leeway is provided under the present law and regulations in determining what costs may be included by hospitals in calculating their charity care obligations. Expenses not necessary to providing health care services to low income Texans may be included and often are included as patient operating expenses.
- The Texas Charity Care Law fails to provide adequate accountability in compliance and enforcement of its provisions. The agencies involved need clearer provisions providing for their authority to monitor, evaluate and enforce legal accountability by non profit hospitals.

RECOMMENDATIONS (Section VIII)

Recommendation One. Nonprofit hospital reporting under the Texas Charity Care Law should be more transparent.

Recommendation Two. Consumer access to information about nonprofit hospital charity care should be improved.

Recommendation Three. There should be greater assurance that nonprofit hospitals include only medically necessary costs related to charity care in determining their unreimbursed costs of providing charity care.

Recommendation Four. Hospitals should be required to practice fair billing and collection practices to the uninsured and underinsured.

Recommendation Five. The method to calculate a nonprofit hospital’s charity care obligations known as the reasonableness standard should be eliminated.

Recommendation Six. To prove up its charity care obligations using the tax exempt benefits method, nonprofit hospitals should be required to include federal income tax benefits as part of its tax benefits.

Recommendation Seven. The Texas Charity Care Law should be amended to include a consumer complaint process and a public education program.

Recommendation Eight. The Texas Charity Care Law should be amended to provide the A.G. authority to investigate under the law.

Recommendation Nine. Insurers should be required to make claims processing more efficient and hospitals should be encouraged to make the creation and maintenance of its medical records more efficient.

Recommendation Ten. The Texas Legislature should create incentives and regulatory structures that will make health insurance more available and affordable to Texans.

Recommendation Eleven. The Texas Charity Care Law should be clarified to ensure that a nonprofit hospital's community benefit activities and projects are in response to community needs and be consistent with local governmental and public health planning; further, that the projects or activities should not be for marketing purposes and that public input is provided in the hospital's community benefits plan.

Recommendation Twelve. The Texas Charity Care Law should be amended to eliminate the statutory presumption that nonprofit hospitals designated as disproportionately share hospitals ("dsh") have fulfilled their charity care obligations.

Section I

Introduction

Nonprofit hospitals in Texas receive millions of dollars in tax exempt benefits. They pay no state taxes which include property taxes, franchise taxes, sales taxes, and hospital district taxes. Yet, they receive all the governmental benefits Texans receive and pay for through their taxes. The Texas Constitution provided for those tax exempt benefits to nonprofit hospitals in exchange for their taking up what otherwise would be a governmental burden, namely providing charity health care. Public concern about whether nonprofit hospitals were providing health care services to the indigent consistent with their tax exempt benefits led to the passage of the Texas Charity Care Law¹ in 1992. That law established objective standards nonprofit hospitals must meet to qualify for their tax exempt benefits. The Texas Department of State Health Services (“TDSHS”) administers this law along with the Office of the Attorney General. TDSHS establishes nonprofit hospitals’ reporting requirements. The agency also prepares and files annual reports to the attorney general that set out the level of charity care each nonprofit hospital provided in the most recent fiscal year. There have been changes in the Texas Charity Care Law since its original passage. The legislative history as well as the current statutory requirements is discussed in Section II of this report.

The purpose of this report is to review the effectiveness of the Texas Charity Care Law as implemented by TDSHS and the Attorney General (“A.G.”) in meeting the needs of low income Texans, particularly those without insurance, called the “uninsured,” and those without adequate insurance, called the “underinsured.” This report is timely. Access to nonemergency health care often turns on whether health insurance is available to cover the principal costs of that care. The U.S. Census reports that almost one out of four Texans are uninsured. The vast majority of these Texans work full or part-time, typically for a small business employer. According to a 2007 report² 60% of the underinsured earned less than \$40,000 per year in 2005. In 2004 the cost of insurance for

¹ Tex. Health & Safety Code, Sections 311.04-311.048 (Vernon 2001 & Supp. 2007-2008)

² Texas Health Institute (2007), *A Vision for Change: Policy Solutions for Increasing Health Coverage in Texas*, p.2, p.9.

a family of four represented a little more than 25% of that income.³ As the costs of health care have risen, businesses have and continue to cut back on the level of health insurance provided their employees. These employees, particularly low income employees, find themselves without adequate means to pick up the remaining share of hospital health care costs. As a consequence, the uninsured and underinsured go to work sick and wait until they are much sicker to seek health care. Ms. Diane Rowland, Executive Vice President of the Kaiser Commission on Medicaid and the Uninsured estimated in 2008 testimony before Congress that in 2006 America lost between \$102 billion and \$204 billion in productivity due to the lack of insurance. This is a conservative number for it does not include the underinsured, whose numbers have been growing. Lack of insurance or inadequate insurance coverage often leads to medical debt. Medical debt is the primary factor in personal bankruptcies.

To review the effectiveness of the Texas Charity Care Law, Texas Legal Services Center (“TLSC”) first reviewed the annual reports filed by TDSHS with the Office of the Attorney General (AG) for fiscal year 2006, the most recently completed reports available at the beginning of TLSC’s review. The reports revealed that almost all nonprofit hospitals met their charity care obligations under one of three available statutory methods to calculate their charity care costs. The least used measure was a reasonableness standard that allowed nonprofit hospitals to rely upon vague guidelines (which did not quantify any minimum levels of costs the hospitals were required to provide) to prove up their charity care obligations. The second least relied-upon method utilized by the nonprofit hospitals to prove up their charity care status was the tax exempt benefits standards whereby a nonprofit hospital would calculate its tax exempt benefits, then show its calculated unreimbursed charity care costs equaled or exceeded those benefits. The most relied upon method to show a nonprofit hospital met its charity care obligations was showing its calculated unreimbursed costs of charity care equaled or exceeded a certain percentage of its net patient revenue. This review can be found at Section III of this report.

³ *Id.*

TLSC then reviewed the individual reports called annual statements of community benefits and the individual reports on community benefits filed by a selection of nonprofit hospitals who reported close to the statutory minimum charity care guidelines. The more detailed review focused on how the calculations were made by the nonprofit hospitals in deriving their unreimbursed charity care costs including unreimbursed costs of providing Government Sponsored Indigent Healthcare (“GSIH”) like Medicaid. This review also focused on how the nonprofit hospitals reported their provisions of community benefits which included not only charity care, but other subsidized health care services needed by the community served by the hospital such as emergency room services. The individual nonprofit hospital reports revealed ambiguous reporting guidelines that resulted in confusing and potentially inconsistent calculations and reporting. For instance, the reporting of unreimbursed costs of subsidized health services as community benefits by a nonprofit hospital could also be included in the hospital’s unreimbursed costs of charity care. TDSHS guidelines that basically mirrored the statutory standards provided nonprofit hospitals large discretion regarding the data inputs into their charity care and community benefits calculations. The lack of detailed guidelines in the annual statements prevents TDSHS and the public from determining whether many nonprofit hospitals are meeting their charity care obligations.

Unlike the nonprofit hospitals’ reporting of their charity and community benefits costs as well as their charity care policies and their current community benefits programs on TDSHS forms, TDSHS did not provide forms for a nonprofit hospital reporting its community benefits. As a consequence, the reporting of community benefits by the nonprofit hospitals was varied and did not always follow the statutory requirements. It is probable that not all nonprofit hospitals filed this required report because TDSHS was unable to find and provide some of the reports requested by TLSC. TLSC’s review of the individual nonprofit hospital reports can be found at Section IV of this report.

TLSC also reviewed available individual nonprofit hospital reports on community benefits plans. This review is found in Section V. Section VI discusses TLSC’s review of the charity care policies reported by a selection of nonprofit hospitals. Generally the

charity care policies provided for the maximum ceiling of eligibility for financially indigent applicants. Two concerns arose from TLSC's review. First, the reviewed charity care policies noted price discounts as part of their charity care policy. None of the discounts were discounts from the costs the nonprofit hospitals would incur in providing the health care services. The discount was from the hospitals' list prices which in many cases were way above the costs the nonprofit hospital would incur to provide their health care services and were significantly above the discounted prices the hospitals provide insurance companies for similar health care service. Unless the discounted price provided by a nonprofit hospital is less than the discounted price provided an insurer, the discounted price would seem not to be charity care. Yet the individual charity care policy could be as low as 10%, leaving the low income patient with charges that amply recovered a nonprofit hospital's costs in providing health care given to that patient.

A second concern in nonprofit hospital charity care policies, was the exclusion of certain nonprofit hospital health care services from their charity care programs. From a public policy perspective, a hospital exclusion of cosmetic surgery from its charity care program seemed appropriate. But some charity care policies excluded certain "elective surgeries" from the nonprofit hospital's charity care program. Elective surgery is a broad term that may include implantation of a heart pacemaker or chemotherapy. Without clear guidelines, a nonprofit hospital could exclude all but emergency health care services which they are mandated to provide regardless of income if these services are within their delivery of services. Section VI raises several regulatory concerns involving the current implementation of the Texas Charity Care Law.

Several recommendations arose from TLSC's review of the TDSHS reports to the A.G. and the individual reports filed by the nonprofit hospitals with TDSHS. Some of TLSC's recommendations such as the need to have health insurance available to more Texans affect not only nonprofit hospitals but other hospitals and healthcare providers as well. But each recommendation is intended to result in nonprofit hospitals being able to serve more uninsured and underinsured patients under their charity care obligations. Section VIII sets out TLSC's recommendations.

Section II

Legal Background

(A) Law Before the Passage of Texas Charity Care Law

According to state law, the duty of nonprofit hospitals to provide charity care stems from their tax-exempt statuses permitted under the Texas Constitution.⁴ Article VIII Section 2(a) of the Texas Constitution requires that “all be taxed equally,” but allows for certain exemptions that could be established by the Texas Legislature.. One of these exemptions from taxation concerns “institutions engaged primarily in public charitable functions, . . .” Id. The current legislative provision related to this exemption is set out in section 11.18 of the Texas Tax Code.)⁵⁶

Previous to 1993, Texas was without any factually objective standards to determine whether a nonprofit hospital was engaging primarily in public charity functions. Tax exempt determinations were made on an individual tax authority by tax authority basis bounded only by broad judicial interpretations of the underlying Texas Constitutional and statutory authority. Determining whether a nonprofit hospital was exempt from taxation was a fact determination in which the hospital had to prove its property was used for charitable purposes based on an evaluation of its total operations.⁷ Courts found nonprofit hospitals qualified for tax exemptions based on hospitals’ charity care expenditures⁸ or the number of charity care patients served by the hospitals.⁹ Courts declined to establish any minimum levels of charity care.¹⁰ Instead, a nonprofit hospital needed to establish that based on its total operations it had assumed “to a material extent,

⁴ TEX. CONST. Art. VIII, Section 2(a) Vernon, Supp 2007-2008.

⁵ TEX. TAX CODE ANN. Section 11.18 (Vernon 2008).

⁶ This report only discusses a nonprofit hospital’s duty to provide charity care under Texas tax-exemption laws. Nonprofit hospitals have other duties to perform to qualify for tax-exemption. For general explanation of these other duties see, Grover Hart, “Ad Valorem Taxes and Non-Profit Health-Care Facilities,” 39 Tex. B. J. 864 (1976).

⁷ *City of McAllen v. The Ev. Lutheran Good Samaritan Society*, 530 S.W.2d 806 (Tex. 1975)

⁸ *Lamb County Appraisal District V. South Plains Hospital-Clinic, Inc.*, 688 S.W.2d 896,902 (Tex. App.—Amarillo 1985, wit ref’d n.r.e.)

⁹ *City of McAllen*, 530 S.W.2d at 809

¹⁰ *Id.* at 810

that which otherwise might become the obligation or duty of the community or the State.”¹¹ But, nonprofit hospitals were required to provide some charity care. Texas courts have denied tax exempt status to hospitals who could only show isolated instances of charity care,¹² or who could not prove that their properties were not used for private gain.¹³ To qualify for a tax exemption, nonprofit hospitals had to provide charity care unconditionally. Billed patients who do not pay were not considered charity care patients.¹⁴

(B) Legislative History of Texas Charity Care Law

In 1993 the Texas Legislature passed S.B. 427¹⁵ authored by Senator Rodney Ellis which became effective September 1, 1993. S.B. 427 led the nation in establishing objective charity care and community benefits obligations that nonprofits were to fulfill as tax-exempt entities.¹⁶ S.B. 427 established:

1. A statutory definition of “unreimbursed costs” that required costs to be calculated by applying cost to charge ratios derived from the hospital’s Medicare cost report to billed charges¹⁷, and required the costs to be offset with revenues the hospital received for the services rendered;

¹¹ *Id.*

¹² *Aransas Hospital, Inc. v. Aransas Pass Independent School Distric*, 521 S.W.2d 685, 691 (Tex. App.—Corpus Christi 1975, writ ref’d n.r.e.)

¹³ *Raymondville Memorial Hospital v. State*, 253 S.W.2d 1012, 1013 & 1014 (Tex. Civ. App.—San Antonio 1952, writ ref’d n.r.e.)

¹⁴ *Aransas Hospital*, 521 S.W.2d at 689

¹⁵ *Act of May 26, 1993*, 73rd Leg., R.S., Ch. 360 (codified at Tex. Health & Safety Code Sections 311.031, 311.033, 311.037, 311.041, 311.042, 311.043, 311.044, 311.045, 311.046, 311.047, 311.048; Tex. Tax Code Sections 11.18(1)(A)(B)(C)(D)(E) & (F), (18); Tex. Tax Code Section 151.310 (a)(1)(e); Tex. Tax Code Section 171.063 (a)(1), (4).

¹⁶ For background on S.B. 427, see Ann Kitchen & Catherine Fant, “Tax Exemption and Public Accountability”, 1 Tex. F. on C.L. & C.R. 8 (1993)

¹⁷ “Billed charges” are not normally what insurance companies or the federal government pay for health care services provided insureds and governmental benefit recipients. Discounts are provided to these entities. S.B. 427 recognizes this practice by creating a definition “contractual allowances” as “the difference between revenue at established rates (billed charges) and amounts realizable from third-party payers under contractual agreements with the hospital.” S.B. 427, Sec. 1 (codified at Tex. Health & Safety Code Section 311.031).

2. A requirement that charity care and community benefit amounts be reported annually to the Texas Department of State Health Services (“TDSHS”)¹⁸ at the unreimbursed costs incurred by the hospital;
3. An obligation by the hospital to establish written charity care guidelines that were to be provided to each person seeking care and to conspicuously post the notice of the hospital’s charity guidelines within the hospital;
4. A duty to annually provide additional financial and utilization data to TDSHS;
5. A requirement that the hospital do community benefits planning within the geographic and patient categories the hospital serves, annually report its plan to the Bureau of State Health Data & Policy, a division within TDSHS, and to notify the public about its community benefits plan through conspicuous posting within the hospital;
6. Objective and alternative criteria the hospital must meet to qualify for tax-exempt status set out in the Texas Health & Safety Code as well as in the respective state taxing statutes; and
7. Penalties for hospital non-compliance of these obligations to be assessed by TDSHS.

Under S.B. 427, nonprofit hospitals were to choose one of three methods to establish their tax-exempt status. Nonprofit hospitals were to provide either:

1. A level of charity care and government-sponsored indigent health care (“GSIH care”)¹⁹ reasonable in relation to community needs as determined through the hospital’s community benefits planning, available hospital resources and the hospital’s tax-exempt benefits;²⁰ (S.B. 427 clarified that the criteria the hospital

¹⁸ At the time S.B. 427 was passed TDSHSS was known as the Texas Department of Health.

¹⁹ GSIH is defined under S.B. 427 as “the unreimbursed cost to a hospital of providing health care services to recipients of Medicaid and other federal, state, or local indigent health care programs, eligibility for which is based on financial need.”

²⁰ Tax-exempt benefits are defined under S.B. 427 as, “consistent with standard accounting principles: the dollar amount of federal, state and local taxes foregone by the hospital and its nonprofit supporting entities including income, franchise, ad valorem and sales taxes; the dollar amount of contributions received by a nonprofit hospital and its nonprofit supporting entities; and the value of tax-exempt bond financing received by a nonprofit hospital and its nonprofit supporting entities.”

- is to rely upon in determining the reasonableness of its charity care obligation represent guidelines, not determinative factors);
2. A level of charity care and GSIH care provided in an amount equal to at least 100 per cent of the hospital's tax benefits exclusive of federal income tax; or
 3. A phase-in formula for community benefits as well as charity care, which after January 1, 1996 was to be community benefits in an amount equal to at least five per cent of the hospital's net patient revenues, four per cent of which is to be incurred for charity and GSIH care.²¹

S.B. 427 exempted from the charity care standards nonprofit hospitals located in a county with a population under 100,000 which has a hospital district, located in a county with a population under 50,000 designated as a Health Professionals Shortage Area, or which for the provision of their health care services received no third-party payments, including governmental payments and provided health care services without regard to a patient's color, creed, religion, gender, or inability to pay. The bill also statutorily presumed nonprofit hospitals designated as disproportionate share hospitals under the state Medicaid program fulfilled their statutory charity care obligations.

Since its enactment S.B. 427 has been re-visited by the Legislature in almost all subsequent legislative sessions. This report will only touch on the major changes to the charity care law that have occurred since its original passage.

In 1995 S.B. 1190²² was passed allowing a hospital system as defined in the bill to be a system of nonprofit hospitals within 125 linear miles of their corporate parent to satisfy the community benefits obligations of its member nonprofit hospitals on a consolidated basis. S.B. 1190 also changed the formula for deriving a nonprofit hospital's unreimbursed costs. Instead of using the hospital's Medicare cost reports to

²¹ S.B. 427 referred to "net patient revenue" as an accounting term relied upon by hospitals. Under hospital accounting standards, "net patient revenue" is that revenue derived from gross patient revenues calculated on the hospital's billed charges less the discounts provided payers by the hospital from its billed charges.

²² *Act of May 29, 1995, 74th Leg., R.S., Ch. 781, Section 1* (codified at Tex. Health & Safety Code Sections 311.042, 311.045; Tex. Tax Code Sections 11.18 (1) (18), 151(a), (e), and 171.063(a) (1), (4).

create the cost to charge ratio, a nonprofit hospital was to use its expenses derived in accordance with generally accepted accounting principles (“GAAP”). The effect of this change was to increase expenses, creating larger ratios and therefore larger unreimbursed costs attributed to charity and GSIH care. S.B. 1190 also extended the automatic qualifier for tax exempt status involving nonprofit hospitals designated as disproportionate share hospitals under the state Medicaid program. S.B. 427 had established that the designation of the hospital had to have occurred within the previous two fiscal years. S.B. 1190 extended that time period to include the current year as well.

H.B. 2384²³ passed in 1997 amended nonprofit hospital community benefit planning requirements to include hospital consideration of consulting and seeking input from a list of interest groups including public health entities, professional health care associations, private business and consumers.

In 2001 H.B. 2419²⁴ was passed clarifying that unreimbursed costs incurred by treating an indigent under a contract with the county could be counted as part of the hospital’s charity and GSIH care obligations. H.B. 2419 also required nonprofit hospitals to publish notice of its charity care program and policies in local newspapers. Lastly, H.B. 2419 required TDSHS to annually publish a manual listing each nonprofit hospital in Texas with a brief summary of the hospital’s charity care policies and its current community benefits plan.

As part of the tort reform legislation, H.B. 4²⁵, passed in 2003, the charity care law was amended to limit tort liability for a nonprofit hospital certified by TDSHS to have used at least 8 percent of its (or its hospital system’s) net patient revenue (“npr”) to provide charity care, 40 percent of which to be within the county where the hospital is

²³ *Act of June 2, 1997, 75th Leg., R.S., Ch. 1101, Section 1 (codified at Tex. Health & Safety Code Section 311.044).*

²⁴ *Acts 2001, 77th Leg., R.S., Ch. 654, Sections 1, 2, 3 (codified at Tex. Health & Safety Code, Sections 311.0456(d), (f), 311.0461).*

²⁵ *Act of June 2, 2003, 78th Leg., R.S., Ch.204 Section 22.02 (codified at Tex. Health & Safety Code Section 311.0456).*

located. This amendment was refined in 2005 by S.B. 1378.²⁶ That bill streamlined the certification process by allowing TDSHS to utilize the reports filed by the nonprofit hospital under Tex. Health & Safety Code Sections 311.033 and 311.045 to process a nonprofit hospital's request for certification for limited tort liability. Additional reports would be required only if necessary to supplement information derived from the reports already on file.

(C) Current Provisions of Texas Charity Care Law

(1) Nonprofit hospital responsibilities

Nonprofit hospitals are required on an annual basis under the Texas Charity Care Laws to:

1. Report financial and utilization data to the TDSHS [Tex. Health & Safety Code Section 311.033(Vernon 2001)];
2. Unless statutorily exempted from providing statute-levels of charity care, provide community benefits, including charity care and GSIH care in an unreimbursed cost amount determined under one of three methods:
 - a. A reasonableness standard;
 - b. A tax-exempt benefits standard; or
 - c. A percentage(s) of net patient revenues standard [Tex. Health & Safety Code Sections 311.043, 311.045(Vernon 2001 & Supp. 2007)];
3. Develop and implement a community benefit plan that includes:
 - a. A mission statement;
 - b. Goals and measureable objectives for providing community benefits;
 - c. Mechanisms to evaluate the plan's effectiveness;
 - d. A budget for the plan; and

²⁶ *Act of June 17, 2005, 79th Leg., R.S., Ch. 376, Section 1* (codified at Tex. Health & Safety Code Section 311.0456(d)).

- e. (discretionary directive) Input into the hospital's community benefits plan from governmental, public and private entities, including consumers, health care insurers and professional health-related organizations [Tex. Health & Safety Code Section 311.044(Vernon 2001)];
4. Report its community benefit plan to the Bureau of State Health Data and Policy Analysis at TDSHS and post notices of its community benefits plan in conspicuous locations within the hospital; [Tex. Health & Safety Code Section 311.0456 (Vernon Supp. 2007)]; and
5. Establish a written charity care policy and annually notify the public of the hospital's charity care policies through newspaper publication and by posting the notice in conspicuous locations within the hospital and through the hospital's admission applications.[Tex. Health & Safety Code Sections 311.031, 311.046 (Vernon 2001 & Supp. 2007)]

(2) Agency responsibilities

TDSHS is directed by the Texas Charity Care Law to:

1. Prepare and file an annual report with the Attorney General and the Comptroller identifying each nonprofit hospital or hospital system that did not comply with its charity care obligations [Tex. Health & Safety Code Section 311.0455 (Vernon 2001)];
2. Submit an annual report to the Attorney General that sets out each nonprofit hospital's or hospital system's (based on the hospital's previous fiscal year):
 - a. Amount of charity care provided;
 - b. Amount of GSIH care provided;
 - c. Amount of community benefits provided;
 - d. Amount of total, and 4 & 5 per cent net patient revenue;
 - e. Level of compliance with the charity care law expressed as a percentage below or above the statutory minimal level of charity and GSIH care;
 - f. Amount of tax-exempt benefits (for nonprofit hospitals that relied upon the tax exemption or reasonableness standards); and

- g. Amount of charity care expenses reported on the hospital's or hospital systems' financial statement.

[Tex. Health & Safety Code Section 311.0455 (Vernon 2001)];

3. Publically notify and make available to the public the annual report on community benefits TDSHS prepares for the Attorney General. [Tex. Health & Safety Code Section 311.0455 (Vernon 2001)];
4. Ensure nonprofits report their community benefits obligations to TDSHS and to penalize the hospitals where appropriate; [Tex. Health & Safety Code Section 311.047 (Vernon 2001)];
5. Annually publish a manual that lists each nonprofit hospital in the state with a brief summary of the charity care policies and community benefits that the nonprofit hospital provides [Tex. Health & Safety Code Section 311.046 (Vernon Supp. 2007)]; and
6. Annually publish a report regarding certain financial and utilization data provided TDSHS [Tex. Health & Safety Code Section 311.035 (Vernon 2001)].

(3) Agency Rules Implementing The Charity Care Law

TDSHS has promulgated rules to implement the Texas Charity Care Law.

By rule, TDSHS has established nonprofit hospitals' reporting requirements relating to their charity care obligations. Unless exempted under law, each nonprofit hospital is to complete an online survey form, the Annual Statement of Community Benefits Standard ("annual statement" or "report"), based on the hospital's most recently completed fiscal year that reports its charity care obligations, its charity care policy and its community benefits. See 25 Tex. Admin. Code Sections 13.15, 13.17 ("TDSHS Rule"). Each nonprofit hospital, unless exempted, must annually file a Community Benefits Plan that is "developed by the hospital (and) serves as a hospital's operational plan for serving the community's health care needs and sets out goals and objectives for providing community benefits that include charity care and GSIH care." TDSHS Rule 13.17. The rules also establish filing deadlines and formal procedures for supplementation of the nonprofit hospital's reported data and for assessment of penalties

for noncompliance by the nonprofit hospital. See TDSHS Rules 13.15, 13.17 and 13.18. TLSC has included in the appendix of this report copies of the TDSHS Annual Statement of community Benefits Standard and Charity Care Policy forms.

Section III

Analysis Based of Annual Reports Filed by TDSHS

(A) Overview

For its analysis TLSC requested the 2006 annual reports on charity care prepared by TDSHS. TLSC also obtained all annual reports on charity care prepared by TDSHS that were available online. The online data was available from 1999. No attempt was made to verify the data entered in the report. The TDSHS report breaks the data down by method chosen by the nonprofit hospital to report its unreimbursed costs of providing charity and GSIH care. Also, the report separately presents the data relating to nonprofit hospitals designated as Medicaid disproportionate share hospitals (“dsh”) which are statutorily presumed to have provided adequate charity care. The report additionally included for profit hospitals and public hospitals that are supported by taxes that are dsh. It also identified those nonprofit hospitals that did not meet the charity care standards. The following relevant²⁷ data is reported for each nonprofit hospital reporting under the reasonableness standard and each hospital reporting under the tax-exempt benefits standard:

1. The city and county where the hospital is located;
2. The number of licensed beds;
3. The hospital’s charity care costs;
4. The hospital’s unreimbursed cost of GSIH;
5. The hospital’s net patient revenue;
6. The hospital’s tax-exempt benefits; and

²⁷ The reports list other data but TLSC focused only upon the data relevant to analyzing nonprofit hospital’s charity care compliance.

7. The difference between the hospitals charity and GSIH care costs and its tax-exempt benefits.

For nonprofit hospitals reporting data under the charity care and community benefits standard and for hospitals designated as Medicaid disproportionate share hospitals, the relevant data reported included the same data as above except the tax-exemption benefits and the difference between the charity and GSIH care costs and the difference between the charity and GSIH care costs and the tax exempt benefits. The reported data for these nonprofit hospitals additionally included: the hospitals' community benefits costs; a calculation of the 4% and 5% of the nonprofit's net patient revenues; and separately stated the percentages of net present revenues for the hospital's costs for providing charity and GSIH care and for providing charity, GSIH and community benefits. A copy of the 2006 TDSHS report on charity care as well as a TDSHS report on certain financial data on nonprofit hospitals are included in the appendix.

(B) The Community Benefits Mix Method

The method selected by most nonprofit hospitals to report their charity care obligations was the charity care and community benefits mix standard, ("community benefits mix" or "5% npr"). Under this standard, nonprofit hospitals were to have provided charity and GSIH care in an amount equal to or greater than 5% of its net patient revenues ("npr"). However, the hospital may provide community benefits to account for not more than 1% of the 5% of its charity care obligations. The data reflects that all nonprofit hospitals reporting under this method met their charity care obligations. The majority of the nonprofit hospitals reported spending more than twice as much on community benefits as they did on charity and GSIH care. The variances ranged from a hospital reporting no costs of providing community benefits in addition to its costs for providing charity and GSIH care to a hospital reporting 4.5% npr in its provision of charity and GSIH care and 45.4% npr in its community benefits. (This amount also includes the amounts relating to the hospital's provision of charity and GSIH care.)

TLSC requested the annual statements of several individual nonprofit hospitals who reported under this method their costs in providing charity and GSIH care were no greater than 5.1%. In the next section, TLSC will discuss these individual reports.

(C) The Reasonableness Method

Only three nonprofit hospitals reported under the reasonableness standard. Of the three methods a nonprofit hospital may rely upon to report its charity care obligations, the reasonableness standard is the most subjective. After setting out the methodology in Tex. Health & Safety Code Section 311.045(b) (1) (A), the statute goes on in subsection (c) to state:

- (c) The providing of charity care and government-sponsored indigent health care in accordance with Subsection (b)(1)(A) shall be guided by the prudent business judgment of the hospital which will ultimately determine the appropriate level of charity care and government-sponsored indigent health care based on the community needs, the available resources of the hospital, the tax-exempt benefits received by the hospital, and other factors that may be unique to the hospital, such as the hospital's volume of Medicare and Medicaid patients. These criteria shall not be determinative factors, but shall be guidelines contributing to the hospital's decision, along with other factors which may be unique to the hospital. The standards set forth in Subsection (b)(1)(B) and (b)(1)(C) shall also not be considered determinative of the amount of charity care and government-sponsored indigent health care that will be considered reasonable under Subsection (b)(12)(A).

The broad language in the statute allowed a nonprofit hospital ample leeway to qualify for its tax exemption. Yet a review of all available on-line annual reports TDSHS has prepared since 1999 showed few nonprofit hospitals relying upon this methodology. The most numerous use of this method by nonprofit hospitals occurred in 2001 when seven nonprofit hospitals reported under this method, one of which would have qualified under

the charity care community benefits mix standard. One probable reason nonprofit hospitals did not rely upon this methodology is that nonprofit hospitals remain vulnerable to Texas taxing authorities challenging their tax-exempt status. This risk can be costly not only in legal fees incurred in contending with the tax authority's challenge to the hospital's tax exempt status, but also in the loss of the hospital's tax exemption benefits. One of the three nonprofit hospitals reporting in 2006 under this standard has been reporting under this standard—except in 2004 when it reported as part of a hospital system under the tax-exempt benefits standard—since 1999. Another of the three nonprofit hospitals who reported in 2006 under the reasonableness standard has been using this standard since 2001 except for 2004 when it reported as part of a hospital system under the tax exempt benefits standard. From 1999 to their 2006 reports the total dollar difference between the tax exemption benefits these two nonprofit hospitals received and the costs for the charity and GSIH care they provided was a negative \$3,435,857.00. In other words, since 1999 and up to 2006 these two nonprofit hospitals provided charity and GSIH care in amounts less than \$3,435,857.00 of the tax exemption benefits they received. In the next section TLSC will analyze the individual 2006 reports these two nonprofit hospitals filed with TDSHS.

(D) The Tax-Exempt Benefits Method

All nonprofit hospitals reporting their costs of providing charity and GSIH care relying upon the tax-exempt benefits standard met their charity care obligations. Several nonprofit hospitals reporting their charity care costs under this methodology did not identify any unreimbursed costs for providing GSIH care. GSIH care includes Medicaid patients. Individual 2006 annual reports for some of these nonprofit hospitals were reviewed and will be discussed in the next section. The tax exemption benefits reported by nonprofit hospitals do not include the hospital's benefits from receiving an exemption from federal income taxation. See Tex. Health & Safety Code Section 311.045(b) (1) (B). In addition, current charity care law does not appear to require the nonprofit hospital reporting under this standard to adjust its unreimbursed costs of providing charity and GSIH care to account for income tax benefits it receives from the federal government,

thereby allowing state obligations to subsidize federal obligations of providing charity care.

(E) No Method Reported & A.G. Enforcement

Only one nonprofit hospital was identified by TDSHS in its 2006 annual report to the Attorney General (“A.G.”) as failing to comply with Texas’s charity care law. While unable to discuss ongoing investigations, the Attorney General’s office²⁸ briefly stated its policy. The A. G. reviews the reports and decides whether to investigate nonprofit hospitals not meeting the charity care law. If the A.G. investigates, an audit of the nonprofit hospital’s books and other financial records will be performed by an outside auditor obtained by the A.G. The A.G. has investigated hospital compliance in the past. TLSC requested copies of any written procedures the A.G. relied upon for its investigations involving nonprofit hospital compliance with the Texas Charity Care Law. The A.G. contended any written procedures it had were confidential and also stated its audits and investigations that did not result in litigation or settlement were confidential. TLSC received from the A.G. copies of two settlement agreements involving nonprofit hospital compliance with the Texas Charity Care Law whereby additional commitments of providing charity care were reached. One of the settlements related to a nonprofit hospital’s sale of its assets to a for-profit entity and another involved a university’s acquisition of a nonprofit hospital.

²⁸ October 07, 2008 telephone interview with Attorney General’s office.

Section IV

Analysis of Individual Annual Reports

(A) Overview

Nonprofit hospitals reported their 2006 charity care obligations to TDSHS using an online form entitled “Annual Statement of community Benefits Standard—2006; Texas Nonprofit Hospitals Part I and Part II.” Part I reported the hospital’s amount of unreimbursed costs of providing charity and GSIH care and community benefits, and government programs other than GSIH such as Medicare and CHAMPUS, and, if applicable, the estimated value of the hospital’s tax exempt benefits.

Part II reported the hospital’s charity care policy and community benefits. The nonprofit hospitals additionally are required to file the hospital’s report on its community benefits plan. TDSHS has not created a form for this report.

(B) Annual Statements of Nonprofit Hospitals Using the 5% npr Standard

TLSC requested annual statements and the community benefit plans for several hospitals reporting under the charity care community benefits mix standard whose unreimbursed costs of providing charity and GSIH care were reported at 5.1% or less of the hospital’s net patient revenue. This resulted in review of the reports of approximately 18 of the 75 nonprofit hospitals reporting under this method. Review of the individual online forms completed by the nonprofit hospitals found three areas of concern relevant to a nonprofit hospital’s calculation of its unreimbursed cost of providing charity and GSIH care and community benefits:

1. The replacement of Medicare cost report data as a base to calculate a nonprofit hospital’s cost to charge ratio with the GAAP expense data;

2. The inclusion of bad debt in the nonprofit hospital's total patient operating expenses that were used to calculate the hospital's cost to charge ratio; and
3. The treatment of discounted rates in the calculation of a nonprofit hospital's unreimbursed costs of providing charity and GSIH care.

For 2006 nonprofit hospitals utilized a worksheet—Worksheet 1—to the 2006 annual statement, part I—to calculate their unreimbursed costs of charity care. This calculation relied upon the use of a proxy cost per patient billed charge involving revenue and expense data for all the hospital's patients instead of a summing up of the nonprofit hospital's actual costs of treating just its charity care patients. The calculation is multi-stepped. Initially, a nonprofit hospital calculated its cost to charge ratio by dividing its patient-related GAAP expenses, including bad debt expenses, by its gross patient revenues (billed charges--“list prices”-- without any reduction for discounts, called contractual allowances under the Charity Care Law) involving all patients served by the hospital. That cost to charge ratio, a percentage, was then multiplied by the billed charges the nonprofit hospital attributed to its provision of charity care to determine a nonprofit hospital's unadjusted costs of providing charity care. This cost was then adjusted by deducting revenues received by the hospital for these health care services from patients and/or third party payers. The adjusted amount represented the nonprofit hospital's unreimbursed costs of charity care. The 2006 annual statements also contained a worksheet 3 that went through these same steps to derive a nonprofit hospital's unreimbursed costs incurred in providing GSIH. While these amounts did not necessarily reflect the actual costs that any nonprofit hospital incurred in providing charity care and GSIH, the use of a cost to charge ratio and the use of total billed charges as proxies should have provided reasonable results if underlying assumptions and reporting were internally consistent among the nonprofit hospitals.

(1) Medicare Cost Reports

As Section II of this report discussed, Texas Charity Care Law originally required nonprofit hospitals to rely upon their Medicare cost reports to calculate its cost to charge ratio used to derive its costs of providing charity and GSIH care. The law was changed in 1997 to require hospitals to use their GAAP expenses. An attempt was made in 2001²⁹ to return the basis of calculating the cost to charge ratio back to the Medicare cost report. Industry witnesses testifying at a hearing on H.B. No. 975 before the House Committee on Public Health³⁰ explained that the difference between the Medicare cost report and GAAP expense bases were that certain expenses, such as patient transportation, reported under GAAP were not included in the Medicare cost report. Consumer witnesses countered at the hearing that expenses such as the expenses a hospital incurs for its gift shop were included in GAAP expenses.³¹ The current form limits the GAAP expenses to “Total Patient Care Operating Expenses.”³² Even though nonprofit hospitals were required to calculate their costs of providing charity and GSIH care using GAAP expenses, the 2006 annual statements required the hospitals to also calculate a cost to charge ratio using their Medicare cost reports.

A review of the selected nonprofit hospital annual reports shows a great degree of variability from hospital to hospital involving the differences between a nonprofit hospital’s cost to charge ratio calculated with GAAP expenses (“GAAP ratio”) versus its cost to charge ratio calculated with its Medicare cost report (“Medicare cost ratio”). The differences ranged from the Medicare cost ratio being 20 points greater (1.07 vs. .8599) than the GAAP ratio to the GAAP ratio being 11 points greater (.64 vs. .53) than the Medicare cost ratio. This huge difference can partly be accounted for by the nature of some nonprofit hospitals areas of specialization such as mental health treatment and rehabilitation hospitals. Removing these types of nonprofit hospitals from the selection still results in variability among the hospitals ranging from a Medicare cost ratio three

²⁹ H.B. No. 975, 77th Leg., R.S.

³⁰ Transcript, Public Hearing on H.B. 2419 & 975 before the House Committee on Public Health, 77th Leg., R.S. March 28, 2001 (Tapes 3 & 4)/

³¹ *Id.*

³² See p. 3 of sample form included in appendix.

points greater (.59509 vs. .5627) than the GAAP ratio to a GAAP ratio 11 points greater (.64 vs. .53) than the Medicare cost ratio. Interestingly, the selected nonprofit hospitals designated as Medicaid disproportionate share hospitals had in general the least differences (no more than 4 points) between their GAAP ratios and Medicare cost ratios. An inference arose from this observation that the cost of providing health care to indigents were less on average than the costs of treating patients with commercial or governmental third-party payers and that their costs of treating indigents closely resembled the costs calculated using the Medicare cost ratio.³³ The nonprofit hospitals that reported their charity care obligations under the 5% of net patient revenues method had the greatest degree of variability ranging from an 11 point difference to a .5 point difference. The majority of differences between the GAAP and Medicare cost ratios for these hospitals were 4-5%. And for a hospital system within this selection of nonprofit hospitals, the variation among its members was from almost 11 points to 7 points. The great variations from one nonprofit hospital to another relating to the differences between the GAAP and Medicare cost ratios could be the result of the broad discretion nonprofit hospitals have in determining what constitutes a patient operating expense under GAAP.

The variability in GAAP vs. Medicare cost ratios can be highlighted by computing the charity care costs for the selected hospitals relying upon the 5% npr only by using the Medicare cost ratio. When the computations are done, eight out of the thirteen³⁴ selected nonprofit hospitals would have met the charity care law- required provision of charity care under the charity care community benefits mix standard.³⁵ The shortfall in charity care caused by substituting the GAAP expense ratio with the Medicare cost ratio for these eight nonprofit hospitals was \$13,849,424^{36 37}

³³ An observation was made in the 2007 Financial Analysis of general acute care hospitals in Pennsylvania that Medicare patients are more costly to treat than patients whose hospital care is financed by commercial insurers or by medical assistance. See Pennsylvania Health Care Cost Containment Council, *Financial Analysis 2007, Volume 1-General Acute Care Hospitals* (June 2008) at p.12. This observation tends to reinforce TLSC's observation noted above.

³⁴ There actually were eighteen hospitals in the selection but seven hospitals were consolidated for data reporting under two hospital systems.

³⁵ See Table of Annual Reports Using Medicare cost ratio in appendix.

³⁶ *Id.*

³⁷ The calculations were performed by relying upon the Medicare cost ratio that included the cost but not the profit portion of bad debt expenses excluding the profit portion of bad debt.

(2) Bad Debt Expense

The 2006 annual statement allowed nonprofit hospitals to include as part of their “total patient operating expenses” bad debt expenses.³⁸ The annual statement also derived an adjusted bad debt expense amount on its worksheet 1-A which utilized the Medicare Cost Report basis to calculate a hospital’s cost to charge ratio.³⁹

In response to a question by TLSC on how bad debt was to be reported by hospitals, TDSHS stated that nonprofit hospitals could include 100% of their bad debt expenses in their GAAP-based total patient care operating expenses to calculate their cost to charge ratios.⁴⁰ The A. G.’s office confirmed this fact.⁴¹ Inclusion of bad debt expenses in the calculation of the cost to charge ratio used to derive the cost of providing charity care causes some of the calculated costs of charity care to constitute bad debt expense which seems contrary to Texas’ charity care law. The charity care law defines charity care as the unreimbursed costs to a hospital of providing, directly or indirectly, through financial support, health care to an individual accepted for care with no obligation to pay for the services rendered.⁴² This is consistent with Texas court cases.⁴³

The reasonableness of including bad debt expense in the computation of a nonprofit hospital’s unreimbursed costs of charity care should be considered in relation to the purpose of the calculation. As mentioned in the overview of this section, the use of a cost to charge ratio is a proxy to calculate a nonprofit hospital’s costs of providing charity care. The current ratio represents an average cost per patient billed dollar of treating all the nonprofit hospital’s patients, both those determined by the hospital to qualify for

³⁸ 2006 annual statement form, p. 3, footnote 3.

³⁹ See 2006 annual statement form, p. 4.

⁴⁰ TDSHSS email response to TLSC (July 29, 2008).

⁴¹ TLSC telephone interview with A.G. (February 17, 2009).

⁴² Tex. Health & Safety Code, Section 311.031(2), (7), (10).

⁴³ See Section II above.

charity care and those who were considered paying patients, in whole or in part. In the previous subsection, TLSC raised the concern that the absence of any guidelines of what constitutes patient's expenses to include in a nonprofit hospital's calculation of its cost to charge ratio creates a regulatory environment that invites inconsistent reporting of patient operating expenses among nonprofit hospitals. Inclusion of bad debt expenses in the computation of a nonprofit hospital's charity care costs raises additional concerns. The first concern goes back to the purpose of the cost to charge ratio. And that is to reflect the cost the nonprofit hospital incurs in providing charity care. It would seem therefore, that hospital costs not related to charity care should be excluded. Bad debt expense does not relate to charity health care for which the nonprofit hospital does not expect to be reimbursed, but to health care the hospital provided to patients for which it expects to be reimbursed.⁴⁴ The second concern is that inclusion of bad debt expense as a patient expense causes the cost incurred by the hospital in treating patients who do not pay the hospital's charges billed them to be counted twice: first in the actual costs of goods and services provided by the hospital relating to that health care, and second, in the unpaid charges the hospital billed reflecting the costs of those same goods and services. Third, under the discretion provided by TDSHS, nonprofit hospitals may include not only the portion of the billed charges relating to the reimbursement of the nonprofit hospital's actual costs for its goods and services used to provide charity care, but also include the portion of the billed charges that relate to profit factored into the billing which may be

⁴⁴ A policy guideline published by the North Carolina Hospital Association relating to the reporting of hospital community benefits reported that roughly 50% of bad debt is often unproven charity care. In Texas this percentage should be substantially less because the Texas Charity Care Law requires nonprofit hospitals to maintain, advertise, and timely implement a charity care policy that would identify patients qualifying for charity care. Even under North Carolina Hospital Association's estimate at least 50% of a nonprofit hospital's bad debt expense is totally unconnected to indigent patients. And the hospital association notes that the State of North Carolina in 2005 recommended that bad debt should not be reported as a community benefit. Also, the hospital association recommended that bad debt not be included in patient operating expenses in calculating a hospital's cost of charity care noting that its recommendation was consistent with the Catholic Health Association's guidelines. The allowance of bad debt as a patient expense fosters a lax implementation of a nonprofit hospital's charity care policy. The North Carolina Hospital Association noted, "[e]very hospital and community would benefit by finding faster, cost effective ways to identify charity care cases earlier, rather than classifying them as bad debts." *See North Carolina Hospital Association Recommended Guidelines for Reporting Hospital Community Benefits* at pp. 2,4,15, 17-20, and 29. (October 31, 2008).

quite high⁴⁵ and seem to be contrary to the concept of charity care by a nonprofit hospital. These three concerns point to a conclusion that it may not be appropriate to include bad debt expense in a nonprofit hospital's calculation of its charity care obligations.

Recent revisions to IRS Form 990, the federal tax return nonprofit hospitals exempted from federal income tax are required to file, show nonprofit hospitals are to report their costs incurred in providing charity care. In calculating their costs of providing charity care, nonprofit hospitals are not allowed by the federal government to include bad debt expense as a charity cost "under any circumstance."⁴⁶

TLSC recalculated the selected nonprofit hospitals' unreimbursed cost of charity care to exclude bad debt expense in whole or in part. TLSC has assumed that each selected hospitals included 100% of its bad debt expense in its patient operating expense. If only the "profit" portion of bad debt is excluded from the total patient operating expenses for the thirteen⁴⁷ selected nonprofit hospitals, seven of these hospitals would have met the 4% of net patient revenue requirement to meet the charity care law under the charity and GSIH care/community benefits mix standard. For these six nonprofit hospitals that did not, absent the "profit" portion of the bad debt expense, the shortfall for 2006 would have been \$6,244,326.^{48, 47}

⁴⁵ The cost to charge ratios in the selected nonprofit hospitals reviewed by TLSC were found to be as low as .192 or 19.2%.

⁴⁶ See instructions, Form 990, Schedule H, p.4. See also p. 16 of these instructions that state the reporting nonprofit hospital is to exclude its bad debt expense from its total operating expenses in calculating its ratio of patient care costs to charges. A copy of Schedule H and the Schedule H instructions are included in this report's appendix.

⁴⁷ See footnote no. 34.

⁴⁸ See Table of Annual Reports provided in the Appendix that recalculate charity care costs by deducting the "profit" portion of bad debt from the selected nonprofit hospital's patient operating expenses.

⁴⁹ If all bad debt had been excluded from the selected nonprofit hospitals' patient operating expenses the 2006 short fall in charity care obligations for these six hospitals would have been \$10,177,169. Lastly even assuming the hospitals only include the cost portion of their bad debt in their patient operating exclusions, exclusion of that amount leaves a short fall of \$1,627,554.

(3) Discounted Rate

Under Texas' charity care law financially indigent "means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system."⁵⁰

The 2006 TDSHS annual statements do not directly address how a nonprofit hospital is to regard its discounted rates for purposes of reporting its charity care obligations or in its charity care policy. This issue will be addressed in more detail in Section VI below.

(C) Annual Statements of Nonprofit hospitals Using The Reasonableness Standard.

The annual statements for all nonprofit hospitals reporting their charity care obligations under the reasonableness standard failed to provide charity and GSIH care equal to or greater than the tax benefits they received. TLSC has previously discussed two of the nonprofit hospitals in section III above. TLSC does want to add that it received a copy of a settlement agreement between one of these two nonprofit hospitals and the A.G. whereby the hospital agreed to provide additional charity care. The third nonprofit hospital appeared to have a reporting irregularity. The hospital reported \$1,744,341 in billed charges related to health care services provided to Medicaid recipients yet it reported that it had received no Medicaid payments.

(D) Annual Statements of Nonprofit Hospitals Using Tax-Exempt Benefits Standard

TLSC requested annual statements for nonprofit hospitals who relied upon the tax-exempt benefits standard to calculate their charity care obligations and that were identified on the TDSHS annual report to the A.G. as having "0" unreimbursed costs of

⁵⁰ Texas Health & Safety Code Section 311.031(7)(Vernon 2001).

GSIH care. This criterion resulted in six out of a total of twelve nonprofit hospitals selected. A review of the six annual statements found all nonprofit hospitals but one reported providing no GSIH on their Worksheet 3. The one nonprofit that did report providing GSIH reported receiving payments in excess of its costs incurred in providing GSIH.

Three of the selected nonprofit hospitals appeared to be hospitals within a hospital or hospital campus complex. These hospitals reported no ad valorem taxes. Their web pages listed the hospitals located either within another hospital or within a complex of a hospital. All three were long-term care facilities. TLSC did not research whether these facilities were structured in relation to the hospitals within which they were located in a way to minimize the level of charity care required under the statute. These hospitals provided no GSIH care and their reported charity costs were from 1.98% to 3.12% of their npr. Whether there is a symbiotic relationship between these three nonprofit hospitals and the corresponding hospitals within which they are located for charity care purposes does not seem probable but does merit further investigation.

(E) Nonprofit Hospitals Designated as Disproportionately Share Hospitals (“dsh”)

Under the Texas Charity Care Law, nonprofit hospitals designated as dsh are presumed to have fulfilled their charity care obligations.⁵¹ Although nonprofit hospitals must annually request to be designated a dsh hospital⁵², the charity care law provides an assumption that a nonprofit hospital has met its charity care obligations if it has been in either of its two previous fiscal years or in its current fiscal year designated a dsh—a three year period of essentially an exemption from minimal charity care cost obligations. A hospital designated as a dsh is provided extra funding from Medicaid funds.⁵³ The public policy behind a dsh designation is that the dsh-designated hospital is providing a

⁵¹ Tex. Health & Safety Code, Section 311.045(b)(3) (Vernon Supp. 2007 – 2008).

⁵² Attorney General Summit on Charitable Hospitals, *what is the True “Costs” of Health Care?*, Question and Answer Session (January 12, 2009).

⁵³ See Jean Hearne, CRS Report for Congress, *Medicaid Disproportionate Share Payments*(January 10, 2005).

proportionately greater amount than other hospitals of charity care not just to Medicaid recipients but to the uninsured as well.⁵⁴

A nonprofit hospital designated as a dsh should be providing at the very least the minimum level of charity care required by law. A review of the 2006 TDSHS annual charity care report to the A.G. showed that six of the fifty-seven or 10.5% of the nonprofit hospitals that identified themselves as dsh in their annual statements reported “0” unreimbursed costs for their GSIH. TLSC requested copies of these six annual statements and found that all six nonprofit hospitals had received payments in excess of their estimated costs of GSIH with the revenues in excess of cost ranging from \$99,770 to \$4,154,821.⁵⁵ The 2006 annual statement directed nonprofit hospitals whose offsetting revenue of providing GSIH care to report a zero, not a negative number.⁵⁶ None of the payments the nonprofit hospital received in excess of its GSIH costs were used to offset the hospital’s charity care costs. This TDSHS directive causes charity care costs to be overstated by the nonprofit hospital because the TDSHS procedure to calculate the nonprofit hospital’s charity and GSIH care does not consider the excess payments the nonprofit hospital received.

Of the six selected nonprofit hospitals designated a dsh, two reported charity care costs less than the minimum 4% net patient revenues required under the charity care law. When the revenues received by these nonprofit hospitals in excess of the costs they incurred in providing GSIH were used to offset their costs of providing charity care, an additional nonprofit dsh fell below the statutory minimum level of charity care.

One of the selected nonprofit dsh reported on its website that it provided charity care to patients that receive non-elective health care services. This restriction of health care services available for charity care patients may mean that the only health care services available to charity care patients is the hospital’s emergency health care services. If this is the case, the hospital’s charity care policies do not increase access for the

⁵⁴ *Id.*

⁵⁵ To calculate the excess revenues TLSC subtracted the total payments the nonprofit hospitals reported from their calculated costs of GSIH on Worksheet 3, 2006 annual statement, Part I.

⁵⁶ Annual Statement of Community Benefits Standard—2006 Texas Nonprofit Hospitals, Part I, Worksheet 3, footnote No.1, p. 6.

uninsured to this hospital because all hospitals are required under both federal⁵⁷ and state⁵⁸ law to provide emergency health care services regardless of ability to pay. The hospital's policy does allow the uninsured to be treated without being charged and therefore without the creation of a medical debt. TLSC also visited this nonprofit hospital on January 11, 2009 and found no signs posted notifying the public of its charity care obligations as required by the Texas Charity Care Law.⁵⁹

TLSC also reviewed the charity care costs reported on the TDSHS report to the A.G. from 1999 to the 2006 report relating to dsh hospitals that were identified in the 2006 TDSHS report as having provided 6% npr in charity and GSIH or less. For these hospitals there were twenty-seven out of a possible eighty-eight instances were one of the nonprofit hospitals reported incurring costs of providing charity and GSIH care that were less than 4% npr. This is a conservative number because some of the selected nonprofit hospitals did not report under dsh and may have been under a different name. Also TLSC did not review each TDSHS annual report to see whether nonprofit dsh other than those selected incurred costs in providing charity and GSIH costs that were less than 4% npr. TLSC limited its review to those nonprofit dsh identified in the 2006 TDSHS annual report as incurring costs in providing charity and GSIH costs equal to or less than 6% NPR.

Section V

Community Benefits

(A) Overview

For 2006, the Texas Charity Care Law addressed community benefits in four ways. The law:

⁵⁷ 42 U.S.C.A § 1395 dd

⁵⁸ Tex. Health & Safety Code, Section 311.022(b) (Vernon 2001).

⁵⁹ Tex. Health & Safety Code, Section 311.046(d) (Vernon Supp. 2007-2008).

1. defined the term (Tex. Health & Safety Code Section 311.042(2));
2. required a certain level of community benefits be provided by nonprofit hospitals (Tex. Health & Safety Code Section 311.045);
3. required nonprofit hospitals to develop a community benefits plan (Tex. Health & Safety Code Section 311.044); and
4. required nonprofit hospitals to file an annual report of their community benefits with TDSHS (Tex. Health & Safety Code Section 311.0455).

Under the Texas Charity Care Law community benefits refers to the unreimbursed costs incurred by nonprofit hospitals in providing charity and GSIH care, donations, education, government-sponsored program services, research and subsidized health services,⁶⁰ but does not include any costs incurred by the hospitals in the payment of any taxes or other governmental assessments. Under the charity care law's requirement, nonprofit hospitals were required to develop a community benefit plan. The community benefits under the charity care law were limited to those unreimbursed costs incurred to serve the health care needs of the patient categories it serves that are located within the county the hospital is located and extending to other geographic areas where the hospital provides health care services. Accountability criteria such as measurable objectives and a budget for the plan were required to be included in a nonprofit hospital's community benefits plan. A nonprofit hospital is to include in its community benefits report to TDSHS its mission statement, a disclosure of the health care needs considered by the hospital in developing its community benefits plan, a disclosure of the amount and types of community benefits actually provided, a statement of its total operating expenses computed under GAAP for the hospital's most recent audited fiscal year, and a worksheet calculating its costs to charge ratio.

Both parts of TDSHS's 2006 annual statement required nonprofit hospitals to report their community benefits activities.

⁶⁰ Subsidized health services as the term implies health care services provided below cost. The type of health services that generally considered subsidized health services are emergency and trauma care.

(B) Annual Statements, Part I

In Part I, nonprofit hospitals reported their unreimbursed costs of providing subsidized health services, research-related activities and education-related activities.⁶¹ In this same section, nonprofit hospitals were to report donations made by the hospital.⁶² Ambiguity exists as to whether certain of the unreimbursed costs of providing community benefits such as subsidized health services had not already been reported as unreimbursed costs incurred by the hospitals in providing their charity and GSIH care. By providing an “Other Services” subcategory under the “Unreimbursed Costs of Subsidized Health Services” category in Worksheet 4-A without a requirement to identify what the “other services” were, the 2006 annual statement created another ambiguity. Some of the selected annual statements reviewed reported the most unreimbursed costs as “other services”, often to the point of being the only type of unreimbursed costs reported as community benefits under that category. Part I of the 2006 TDSHS annual statement also required nonprofit hospitals to report their unreimbursed costs of providing Medicare, CHAMPUS and other government-sponsored health care. These unreimbursed costs may, in part, also be double counted as unreimbursed costs incurred to provide charity and GSIH care. TLSC believes this is probably unlikely; however, these unreimbursed costs may, in part, be double counted as unreimbursed costs incurred by the nonprofit hospital in providing “subsidized health services.” Lastly, because the same cost to charge ratio was used to identify the costs of providing government-sponsored health care as for charity care, the costs reported included bad debt expense.

(C) Annual Statements, Part II

Part II Section II of the TDSHS Annual statement required nonprofit hospitals to report their community benefits projects or activities. Specifically, nonprofit hospitals were instructed to “[p]rovide information on name, brief description (3 lines), target population or purpose (3lines) for each of the community benefit activities

⁶¹ 2006 TDSHSS Annual Statement, Part I, Worksheet 4-A.

⁶² *Id.*

CURRENTLY being undertaken by your hospital (example: diabetes awareness).”⁶³ Section II is responsive to the Legislative directive to TDSHS to “annually publish a manual that lists each nonprofit hospital in this state with a brief summary of the charity care policies and community benefits that the nonprofit hospital provides.”⁶⁴ Of the selected annual statements reviewed by TLSC, almost all of the nonprofit hospitals had reported on currently planned or occurring community benefits projects or activities. Only one of the selected nonprofit hospitals reported past as opposed to current community benefit activities. Whether the nonprofit hospitals reported all their currently active or planned community benefit plans is unknown. Nonprofit hospitals are not required to file their community benefit plan with TDSHS.

(D) Annual Reports on Community Benefit Plans

TLSC also reviewed the annual reports on community benefits plans filed by the nonprofit hospitals. Not all nonprofit hospitals filed these reports. Of the thirteen selected nonprofit hospitals, TDSHS only found three of the hospital’s Community Benefits Plans.⁶⁵ It is possible that nonprofit hospitals were confused about the need to file this report because they were already required to report some information on community benefits on their annual statements. Also, unlike the other required nonprofit hospital reports, TDSHS did not provide a form to guide nonprofit hospitals in preparing and filing this report. It is also possible that the annual reports, because they were not filed online with TDSHS, are not easily accessed by TDSHS staff. While the available reports reviewed by TLSC set out the nonprofit hospitals mission statements, the reports varied as to the other statutorily-required elements. None of the reports set out the nonprofit hospital’s total operating expenses. Two of the reports did not discuss the health care needs considered by the nonprofit hospital in developing its community benefit plans.⁶⁶

⁶³ 2006 TDSHSS Community Statement, Part II, P.6.

⁶⁴ Tex. Health & Safety Code, Section 311.0461 (Vernnon Supp 2007 -2008)

⁶⁵ TDSHSS email response to TLSC dated July 2, 2008.

⁶⁶ One report provided a copy of a TDSHSS report on selected health facts of the various counties in which the hospital system provided health care services.

Section VI

Charity Care Policies

(A) Overview

For 2006 Texas charity care law required nonprofit hospitals to maintain charity care policies that provided eligibility criteria including income levels and means testing indexed to the federal poverty guidelines for qualifying patients for charity care. The two categories of charity care established by this law were: (1) financially indigent patients whose income could not exceed 200% of federal poverty guidelines;⁶⁷ and (2) medically indigent patients whose hospital or medical bills after third-party payers exceeded a certain percentage of the patient's or his/her responsible party's annual gross income and were unable to pay the remaining bill.⁶⁸

Part II of TDSHS's 2006 annual statement required nonprofit hospitals to report their charity care policies. The form required the hospitals to provide annotations for four items: 1. a statement of the hospital's charity care mission statement; 2. the hospital's definition of charity care as provided by them; 3. if the hospital had a charity care policy for the medically indigent, its definition of the term medically indigent; and 4. if the hospital utilized an asset test to determine charity care eligibility, a summary of its asset test's methodology. For the most part, the nonprofit hospitals reported its charity care policy using a check-off system of reporting with a couple of fill-in-the blank sections. Every question to be answered by the hospital with a checked answer(s), the question included an "others" answer in which the hospital was to provide a description or explanation. A nonprofit hospital was to attach to the statement its application for charity care form if in use by the hospital. See copy of TDSHS annual statement, Part II form, included in appendix.

⁶⁷ Nonprofit hospitals cannot have income eligibility criteria of less than 21% of federal poverty guidelines. See Tex. Health & Safety Code, Sections 311.031(11), 61.023, and 61.006.

⁶⁸ Tex. Health & Safety Code Section 311.031(13).

(B) Income Eligibility

None of the selected nonprofit hospitals have income eligibility criteria below 100% federal poverty guidelines. Most criteria were set at the ceiling established under the Texas charity care law. The selected hospitals were more varied in their eligibility guidelines for patients to establish medical indigence. One nonprofit hospital provided a vague “exceed a specified percentage of the patient’s annual gross income.” Another stated its medical indigents were patients whose “hospital private pay balance exceed(ed) 75% of annual gross income.” Still another referred to its medical indigents as patients whose hospital bill was twice the patient’s annual income.

(C) Charity Care Discounts

Almost all of the selected nonprofit hospitals offered bill discounts. The level of discounts was not provided in any of the annual statements. TDSHS provided only a check-off spot under question no. 6: “How much of the bill will your hospital cover under the charity care policy?”⁶⁹ A nonprofit hospital could either answer that it had a specified amount/percentage based on the patient’s financial situation or that it had a minimum or maximum dollar or percentage established by the hospital.⁷⁰ The annual statement did not require the nonprofit hospital to list its discounts. Of the selected nonprofit hospitals, only three included specific discounted amounts in its charity care policy attached to its annual statement. One nonprofit system’s charity care policies for its member hospitals required indigent patients at 200% federal poverty guidelines (“fpg”) to pay 24 monthly payments of \$20.00 with the remaining balance to be written off as charity care. The system’s charity care policy still provided for a write-off of charity care after 24 months of payments for patients at higher income levels but increased the 24 monthly payment amounts as the patient’s income increased: at 250% fpg the monthly payment was \$40.00; at 300%, fpg, the monthly amount was \$50.00; and at over 300% fpg, the monthly payment was \$60.00.

⁶⁹ TDSHS Annual Statement, Part II, p. 5

⁷⁰ *Id.*

For the nonprofit hospitals that reported its discounts, the discounts ranged from 75% (patient pays 25% of the account balance) for patients at 200-225% of federal poverty guidelines to 10% for patients at 376-400% federal poverty guidelines. A concern TLSC had for one 2006 discount policy reported as part of the nonprofit hospitals charity care policies was that a 10% discount policy would leave the remaining bill to be paid by the patient substantial enough to recover the costs the hospital incurred in providing the patient health care. The question that arose from this observation was whether the “10% discount” patient was considered charity care and reported on the hospital’s annual statements as a charity care patient. TLSC was not able to find any instruction in the annual statements or obtain any direction from TDSHS. Yet, reporting the costs of providing health care to the “10% discount” patient would seem counter to the Texas charity care law. Under that law, charity care is defined as “the unreimbursed costs to a hospital of . . . financially supporting health care services . . . to a person classified by the hospital as ‘financially indigent’ or medically indigent’ . . .”⁷¹ There would be no unreimbursed costs to the hospital for providing health care to a patient who pays 90% of his/her bill. As such, the billed charges to this patient should not be reported as charity care by the hospital in its annual statement. Yet, this discount was considered part of the nonprofit hospital’s charity care program. One can readily assume that the hospital reported its costs in providing health care to the “10% discount” patient in its annual statement as charity care. The 2006 worksheet used to calculate a nonprofit hospital’s unreimbursed costs of its provision of charity care was unclear as to how to capture the unreimbursed costs incurred by the hospital in providing health care to the discount patient, especially if that patient fails or refuses to pay any or all of his/her charges billed from the hospital, thereby creating a bad debt.

Another public policy concern arising out of the classification of a discounted bill as charity care is the billing and collection practices of hospitals. As a recent cover story in time magazine stated, “A paradox of medical costs is that people who can least afford them—the uninsured—end up being charged the most.”⁷²

⁷¹ Tex. Health & Safety Code, Section 311.031(2) (Vernon 2001).

⁷² Karen Tumulty, *The Health Care Crisis Hits Home*, Time (March 16, 2009)

In Texas, hospital billed charges to the uninsured and underinsured are often two to four times and sometimes six times greater than the hospital billed charges to insurance companies and governmental payors for essentially the same health care services.⁷³ These billing practices result in large medical debts often causing bankruptcies for the uninsured and underinsured. A large billing disparity between the uninsured and insurance companies by hospitals without economic justification is counter to legal concepts of fair business dealings. The resulting bankruptcies harm all the uninsured's and underinsured's creditors negatively impacting the economy.

Hospital billing practices, therefore, raise the question of when and whether a discounted price is charity care at all. It may be that the discounted price was more reflective of a fair price for the value of health care services provided than the inflated price from which the discount was taken. Discounts should be provided in relation to a nonprofit hospitals cost-to-charge ratio in order for us to be comfortable that the discounts are truly charity care. But current reporting requirements do not address this problem.

(D) Services Provided Under Charity Care Programs

Most of the nonprofit hospitals reported that all their health care services were covered under their charity care policies. Some nonprofit hospitals reported health care exclusions such as elective cosmetic surgery, vasectomy reversal, bariatric bypass surgery and professional services. Two nonprofit hospitals excluded non-medically necessary health care services from coverage under their charity care policies. And one nonprofit hospital excluded elective medical services from coverage under its charity care policies.⁷⁴ The exclusion of elective procedures from a nonprofit hospital's charity care

⁷³ *Id.*, See also, Yamil Berard, *Aggressive Price Hikes at JPS Hurt Many*, Ft. Worth Star-Telegram (April 29, 2008) and Barbara Martinez, *Cash Before Chemo: Hospitals Get Tough*, Wall Street Journal (April 28, 2008).

⁷⁴ Another selected nonprofit hospital posted on its website that it provided charity care for patients that have received non-elective care.

program raised concerns. The Encyclopedia of Surgery⁷⁵ lists as elective surgery such procedures as hysterectomies, angioplasties, implantation of pacemakers and orthopedic surgical procedures such as hip replacements. These procedures that may be excluded under the nonprofit hospital's charity care policies as elective procedures would seem medically necessary to maintain a reasonable quality of life.

(E) Charity Care Manual

As mentioned in Section II, HB 2419 passed in 2001 required the TDSHS to annually publish a manual listing each Texas nonprofit hospital's charity care policy and community benefits plan. No such manual had been published up to January 2009. TLSC brought this matter to the attention of Representative Coleman the author of HB2419 Representative Coleman's work with TDSHS led to the first publication of the charity care manual on the TDSHS website in January 2009.

Section VII Regulatory Oversight

(A) Lack of Form Transparency

Adequate regulatory oversight of the Texas Charity Care Law is not evident from the information TLSC has reviewed. TDSHS does not apparently view itself as an arbiter of nonprofit hospital's reporting of their charity care obligations. TDSHS's position is that it is only required to collect the data.⁷⁶ The instructions provided by TDSHS generally recite the statutory standards. For instance, when TLSC sought guidance on how nonprofit hospitals were to consider discounted rates in the calculation of their charity care costs, TDSHS deferred to the nonprofit hospital's charity care policies/guidelines.⁷⁷ This is despite the concern TLSC expressed to TDSHS and raised

⁷⁵ *Encyclopedia of Surgery: A Guide for Patients and Caregivers*, <http://www.surgeryencyclopedia.com/Ce-Fi/Elective-Surgery.html>

⁷⁶ TDSHS email to TLSC, November 12, 2008.

⁷⁷ *Id.*

in Section VI above that some nonprofit hospital patient discounts revealed in the individual annual hospital statements were so low that the patient-responsible portion amply covered the hospital's costs, thereby leaving no unreimbursed costs for the hospital to incur.

The TDSHS forms used by nonprofit hospitals to report their charity care obligations lack transparency raising issues such as whether nonprofit hospitals duplicated their charity care costs by reporting the costs again as community benefit costs. The subsidized health care services portion of the TDSHS form reporting a nonprofit hospital's community benefits allow hospitals to report expenditures under "other services" without any requirement to list any of these "other services". This vague reporting of "other services" prevents any type of determination whether any of the health care services underlying the reported costs were provided in response to community needs as required by the Texas Charity Care Law.⁷⁸

There is no guidance provided nonprofit hospitals by TDSHS on the hospitals' reports on community benefit plans required under the Texas Charity Care Law.⁷⁹ A review of available reports on community benefit plans found some missing statutorily-required elements.

Another important aspect of form transparency concerns the ability of the public to readily access the nonprofit hospital's annual statements. Currently nonprofit hospitals' annual statements, part I,(that report on the costs nonprofit hospitals incurred in providing charity and GSIH care in the previous fiscal year) cannot be downloaded off the TDSHS website. These annual statements can only be obtained through a public information request.⁸⁰ This can be a time consuming and costly process. Costs may be assessed by TDSHS for consumer requests for copies of the annual statements⁸¹ and there

⁷⁸ See Tex. Health & Safety Code, Section 311.031(15)(Vernon 2001).

⁷⁹ Tex. Health & Safety Code, Section 311.046(Vernon Supp. 2007-2008)

⁸⁰ Texas Public Information Act, Tex. Govt. Code Ch. 552 (Vernon2004 Supp2007-2008)("PIA")

⁸¹ PIA, Section 552.261. The PIA provides for a waiver or reduction of fees if the waiver or reduction is in the public interest and if providing the information primarily benefits the general public. See PIA, Section 552.267.

is up to a ten business day time lag between the agency's receipt of the request and its provision of the information.⁸² While state law sets a maximum time within which the agency is to provide the requested information, agencies do not always timely respond. TLSC made several requests for annual statements to TDSHS. In at least two of the requests, TDSHS took more than six weeks to respond after continued requests for the information. The time delays and costs involved in having to request the information from the agency hinder public access to the annual statements that have valuable information for philanthropists, community leaders and community advocates concerned about access to health care provided by nonprofit hospitals.

Since the annual statements are filed online, TDSHS could readily post them on its website as in the case of its website current posting of the nonprofit hospitals' part II, annual statements that report nonprofit hospitals' charity care policies. A TDSHS posting of the part I annual statements would in all likelihood reduce overall agency expenses related to public requests for this information.

Website postings should be conspicuous. The current TDSHS posting of nonprofit hospitals' charity care policies is not readily apparent to a user. The home page of the TDSHS website does not refer to the agency's charity care manual. This is in sharp contrast to the home page of the A.G.'s website that provides a clearly identifiable portal that sends the user to its posting of Texas charity care organizations.

(B) The Unreasonableness of Current Cost Calculation

Transparency is also lost in the broad latitude nonprofit hospitals have under current law in determining what costs they may include in calculating its charity care obligations. This latitude extends to the current statutory directive that a nonprofit hospital must rely upon GAAP to calculate its charity care costs. It also extends to the allowance of all expenses identified by GAAP as patient operating expense in a nonprofit hospital's calculation of charity care costs regardless whether some of these expenses

⁸² PIA, Section 552.221.

underlie health care services the hospital has excluded from its charity care program. The broad discretion hides from clear view and analysis the medically necessary costs a nonprofit actually incurs in providing charity and GSIH care.

Under GAAP nonprofit hospitals are provided wide leeway in determining what constitutes a patient operating expense. Expenses not necessary to providing health care services to low income Texans may be included as patient operating expenses. One nonprofit hospital's website listed spa services such as massages and facials as services available to their patients. That same nonprofit hospital provided concierge services which included arranging catering for birthday parties, and the hospital also provided valet parking. Another nonprofit hospital's website listed premium patient services for patients from other countries that included luxury accommodations, concierge services and room services. The hospital also listed on its website that it provided valet parking services. Still another hospital's website listed spa services and valet parking as part of its delivery of services.

The question arising from these website observations is not whether the nonprofit hospital can or should provide the above-mentioned services to some patients, but whether those services are necessary to provide health care services to low income Texans. From a public policy perspective, the question is whether these are the type of health care services whose costs should be reimbursed by the state of Texas and by Texans through the taxes they remit the state if provided to low income patients by a hospital. TLSC doubts these types of costs a hospital may incur would even be considered medically necessary costs reimbursable from insurers and other third-party payers. Nevertheless, GAAP's parameters of expense classification are broad enough for nonprofit hospitals to include these expenses as patient operating expenses that apparently may be included in the calculation of a nonprofit hospital's charity care obligation.

Another public policy question is whether costs incurred for health care services a nonprofit hospital excludes from its charity care program should be considered a part of

that hospital's charity care costs. As mentioned in Section VI above, some of the selected nonprofit hospitals' annual statements filed with TDSHS reported that the health care services it provided its charity care patients were restricted. Some nonprofit hospitals reported excluding cosmetic surgery, others excluding non-medically necessary health care services, and others excluding elective health care procedures. Yet, the current reporting requirements do not prohibit a nonprofit hospital from including in its calculation of its charity care costs the costs related to health care services that have been excluded in its charity care program.

Still another public policy question is whether it is fair to compare the charity care costs of a nonprofit hospital who does not provide spa, valet, or concierge services ("hospital a") with a nonprofit hospital that does provide these services but excludes them from its charity care program ("hospital b"). Even though both hospitals may have reported incurring charity care costs equal to 4% of their net patient revenues, it is more likely that "hospital a" reported more costs as a percentage of its net patient revenues that actually were incurred in treating indigent patients than "hospital b." Nevertheless, under current reporting requirements, hospitals "a" and "b" equally satisfied the Texas Charity Care Law requirements.

The wide disparity from nonprofit hospital to nonprofit hospital concerning the differences between a hospitals' GAAP and Medicare cost ratios discussed in Section IV above underscores the lack of uniform reporting standards for what constitutes a patient operating expense related to a nonprofit hospital's provision of health care services to its low income patients.

(C) Lack of Accountability

While the Texas Charity Care Law imposes several obligations upon nonprofit hospitals, the law fails in establishing clear guidelines for accountability involving nonprofit compliance with these obligations. The only penalties for nonprofit hospital

noncompliance with the Texas Charity Care Law set out in that law is for failure “to make a report of the community benefits plan .”⁸³

The Charity Care Law does not designate or even reference –except for the penalties noted above--whether the A.G. or TDSHS is to enforce the law. The law does not state any consumer rights in enforcement and the law does not set out a consumer complaint process. Apparently, the A.G. believes it is the agency to handle consumer complaints concerning violations of the Texas Charity Care Law.⁸⁴ Be it that it may, TLSC is not aware of any public education campaigns informing the public of nonprofit hospitals’ obligations under the Texas Charity Care Law and of the public’s right to file a complaint with the A.G. involving violations of the law.

It would seem that the authority the A.G. has to investigate violations of the Texas Charity Care Law is not directly provided for under the law, but under the A.G.’s general authority to investigate corporations set out at Texas Miscellaneous Corporation Law Act.⁸⁵ Unfortunately, investigations under this statutory authority are considered confidential and cannot be made public unless litigation ensues.⁸⁶ This confidentiality leaves not only the complainant but the public as well without access to any audit reports or such other information or reports arising from an investigation that did not lead to litigation. This veil of secrecy seems incongruent with the public nature of nonprofit hospitals. Under Texas laws, nonprofit organizations are required to make their “records, books and reports available to the public for inspection and copying.”⁸⁷ Since investigation under the Texas Charity Care Law would principally concern audits of a nonprofit hospital’s books and records that are open for public inspection, any audits or findings derived from A.G. inspections of the hospital’s business records should be

⁸³ Tex. Health & Safety Code, Section 311.047 (Vernon 2001).

⁸⁴ TLSC interview with A.G. (February 2009). Specifically, when TLSC asked the A.G. where a consumer would file a complaint concerning a nonprofit hospital’s violation of its duty under the Charity Care Law to post signs notifying the public of its charity care obligations, the A.G. responded that the complaint could be made with the A.G.

⁸⁵ Texas Miscellaneous Corporation Laws Act, Vernon’s Civil Statutes, Article 1302-5.01-5.10 (Vernon 2003).

⁸⁶ *Id.* Article 13.02-5.04. *See also* A.G. letter to TLSC (December 5, 2008).

⁸⁷ Tex. Business Organizations Code, Section 22.353 (Vernon pamphlet 2008).

public. However, without providing the A.G. the statutory duty or authority to make the investigation public, the public will not be able to access this information. This creates a significant informational barrier for public policy and charitable giving purposes.

Even when statutory authority is clear as in the case of TDSHS's authority to assess a penalty for hospital non-filing of reports, there seems to be a failure by TDSHS to hold nonprofit hospitals accountable. Section V above noted that a material number of the nonprofit hospitals selected by TLSC for individual report analyses failed to file a report of community benefits plans. Early in TLSC's analysis, TDSHS was not able to find part II annual statements that set out a nonprofit hospital's charity care policies for at least one nonprofit hospital requested by TLSC. TDSHS is required to annually publish a manual listing each nonprofit hospital's charity care policies and community benefits. TDSHS gathers this information on the annual statement, part II page 6 which requests the nonprofit hospital to list its community benefits projects or activities. For its charity care manual TDSHS simply posted these annual statements. Several of the nonprofit hospitals failed to make any notation under the form question asking the hospital to list its community benefits projects/activities. Other nonprofit hospitals made a reference to an enclosed list, but no list was attached to the nonprofit's annual statement. The TDSHS manual is incomplete. TLSC is not aware of any amendments or adjustments to the manual since its original posting in January 2009.

Section VIII

Recommendations

TLSC has several recommendations arising from its analysis of nonprofit hospitals' provision of health care services to the uninsured and underinsured. Several of the recommendations would require legislation to be implemented. Other recommendations would require state agency action to implement. The rest of the recommendations could be implemented by nonprofit hospital policy changes. Some of the recommendations apply to for profit and public hospitals as well as nonprofit

hospitals. Each recommendation is intended to increase access to nonprofit hospitals by the uninsured and the underinsured.

Recommendation One. Nonprofit hospital reporting under the Texas Charity Care Law should be more transparent.

Section VII discussed the transparency problems with TDSHS forms. The primary transparency concern involves the potential double counting of expenses: once in the calculation of a nonprofit hospital's charity care costs and second in the calculation of the hospital's community benefits costs. The TDSHS form on its face does not provide assurances that double counting does not occur. Double counting of expenses would result in an over reporting of charity care costs. IRS has published a nonprofit hospital reporting form—IRS Form 990, Schedule H—with detailed instructions for tax-exempt reporting purposes. The various worksheets accompanying the form provide Texas with an excellent model for ensuring that costs are not doubly counted. The IRS Form and worksheets create a more transparent reporting of a nonprofit hospital's charity care costs. TDSHS forms should be amended to incorporate a procedure similar to that developed by IRS in its worksheets to adjust the hospitals operating expenses to avoid the double counting of expenses.⁸⁸

There is very little TDSHS form transparency provided for the nonprofit hospital's reporting of its unreimbursed costs incurred in providing community benefits. No calculation is shown in the form to see how the hospital calculated its unreimbursed costs incurred in providing community benefits. Nor are there any TDSHS form instructions setting out how the calculations are to be made. The TDSHS form also does not require nonprofit hospitals to identify what "other services" were provided that were subsidized. The TDSHS form's lack of transparency is in contrast to the IRS Form 990, Schedule H including instructions. The IRS form and worksheets establish transparent calculations and clear instructions on what can and cannot be considered a community benefit. TDSHS reporting forms should be reformed to create nonprofit hospital

⁸⁸ See IRS Form 990, Schedule H, Instructions, Worksheet 2.

reporting of its community benefits in a manner similar to the IRS Form, Schedule H with instructions.

There is no transparency for nonprofit hospitals reporting of their community benefits plans. TDSHS has created no form to guide nonprofit hospitals. Once again, the IRS Form 990, Schedule H with instructions has provided an example of how, with instructions and well-designed forms community benefits plans can be transparently reported.

The IRS Form 990, Schedule H with instructions cannot be simply substituted for current TDSHS forms. The Texas Charity Care Law methods of proving up a nonprofit hospital's charity care obligations are not entirely consistent with the IRS forms. But, TDSHS should consider emulating to the extent not inconsistent with state law the IRS Form 990, Schedule H with instructions for purposes of nonprofit hospital reporting of its charity care obligations. The result would be a more transparent reporting process for nonprofit hospitals that would provide more meaningful information on charity health care for public policy purposes.

Recommendation Two. Consumer access to information about nonprofit hospital charity care should be improved.

TLSC recommends that TDSHS post on its website each nonprofit hospital's annual statements, part I that report its unreimbursed costs of providing community benefits. TDSHS already posts each nonprofit hospital's annual statement, part II that reports the hospital's charity care policies. Since nonprofit hospitals are required to file these statements online, there should be little incremental costs to the agency to post them on its website. And this extra cost would probably be offset by the savings accrued to the agency due to fewer open records requests. TLSC's experience in obtaining the hospital annual statements has been one that is time-consuming for both TLSC and for the agency. The annual statements should also be archived online, be publically available

through the TDSHS website, and be indexed by hospital and year. TDSHS should also provide for a portal to these annual statements on the homepage of its website.

TDSHS does not provide any public information describing a nonprofit hospital's charity care obligations. The A.G.'s website provides a webpage with a quick description of nonprofit hospitals' obligations to provide charity care but fails to inform the public that nonprofit hospitals must report their costs it incurred in providing charity care to the TDSHS. Moreover, the A.G.'s posting of these charity care obligations is not readily assessable. Even though the A.G.'s homepage of its website has a portal for "charity search", assessing that portal does not send you to a web page that addresses nonprofit hospital charity care obligations. Nor does the webpage assessed through the "charity search" portal on the A.G.'s homepage send the user or refer the user to the A.G. webpage that discusses nonprofit hospital's charity care obligations. TLSC was able to access this information only through a word search. The A.G. should place a portal on the homepage of its website that would send a user to the A.G.'s web page that addresses nonprofit hospitals' charity care obligations.

Recommendation Three. There should be greater assurance that nonprofit hospitals include only medically necessary costs related to charity care in determining their unreimbursed costs of providing charity care.

This recommendation has two parts. One addresses the need to use a more accurate base for calculating a cost to charge ratio than GAAP to derive a nonprofit hospital's unreimbursed costs in providing charity care. The other recommendation relates to the exclusion of bad debt from a nonprofit hospital's cost to charge ratio that is used to calculate that hospital's unreimbursed costs.

- A. Medicare cost ratio should be reinstated with adjustments as a more accurate method to capture a nonprofit hospital's unreimbursed costs in providing charity care.

The use of GAAP to calculate a nonprofit hospital's charity care costs is prescribed by the statute. GAAP permits the inclusion of expenses that really do not relate to the hospital's provision of charity care. Either the costs relate to services the hospital does not provide its charity care patients or involves expenses that relate to services that are not medically necessary to treat low income patients. This results in a nonprofit hospital's charity care costs becoming overstated and prevents any comparative analysis of the nonprofit hospitals for public policy purposes.

TLSC recommends that the Medicare cost ratio be reinstated in the calculation of a nonprofit hospital's cost-to-charge ratio. The Medicare cost ratio with its standardized cost reporting more closely reflects a nonprofit hospital's actual costs in treating its charity care patients. TLSC is sensitive to nonprofit hospital concerns that some expenses such as patient travel are reasonable expenses in providing charity health care services may be excluded from the calculation of the Medicare cost ratio. To address this concern, TLSC recommends that TDSHS have the authority to adjust the Medicare cost ratio to include additional expenses the agency finds in a rulemaking to be reasonable and necessary to provide charity care health services.

- B. Bad debt should not be included directly or indirectly in the calculation of a nonprofit hospital's unreimbursed cost of charity care. Alternately, only the actual cost of bad debt that is attributable to patients eligible under the nonprofit hospital's charity care policy should be allowed.

Bad debt expense has never been considered charity care under Texas law. But because bad debt expense may be included in a nonprofit hospital's patient operating expense to calculate its charity care costs, bad debt is incorporated into the hospital's charity care costs. Bad debt does not represent the actual costs a nonprofit hospital incurs in treating a charity care patient. It basically represents charges a hospital bills to people the nonprofit hospital did not qualify as charity care patients to both reimburse the hospital for the costs it incurred in providing health care services and to obtain revenues over costs for profit purposes. GAAP seemingly allows both the "cost" portion and the

“profit” portion of bad debt expenses to be included in a nonprofit hospital’s calculation of its charity care costs.

TLSC recommends that bad debt not be included either directly or indirectly in a nonprofit hospital’s patient operating expenses for purposes of its calculation of its charity care costs. This recommendation is consistent with federal income tax reporting requirements of a nonprofit hospital’s charity care costs and it is consistent with Texas case law that found bad debt is not to be considered charity care. Alternatively TLSC recommends that only the “cost” portion of bad debt expense that can be attributed to patients who would qualify under a nonprofit hospital’s charity care policy be included in a nonprofit hospital’s calculation of its charity care costs. While the IRS does not allow a nonprofit hospital to include any bad debt expense in the calculation of its charity care costs, IRS does allow a hospital to separately report its bad debt expense: (1) that relates to its actual costs of providing the underlying health care services, excluding any portion attributable to profit; and (2) that is attributable to patients eligible for the hospital’s charity care program. Because the federal government already requires nonprofit hospitals to adjust their bad debt expenses consistent with TLSC’s alternate bad debt expense recommendation, nonprofit hospitals would not incur any additional expenses should TLSC’s alternate recommendation be adopted.

Both the A.G. and TDSHS interpret the Texas Charity Care Law to allow a nonprofit hospital to include both the “cost” portion and the “profit” portion of bad expense in its calculations of the hospital’s charity care costs. Because of this interpretation, TLSC recommends that the Texas Legislature amend the Texas Charity Care Law to require the total exclusion of bad debt (or alternatively exclude both the “profit” portion of bad debt and the bad debt attributable to patients not eligible for the hospital’s charity care program) from a nonprofit hospital’s patient operating expenses for purposes of calculating the hospital’s charity care costs.

Recommendation Four. Hospitals should be required to practice fair billing and collection practices to the uninsured and underinsured.

Information reviewed by TLSC found hospitals charging the uninsured and underinsured significantly more than insurers and governmental payers for essentially the same health care services provided. The inequitable pricing treatment the uninsured and underinsured receive from hospitals is most likely the result of the uninsured's and underinsured's unfavorable bargaining position with the hospital.⁸⁹ Hospital inequitable pricing policies for the uninsured and underinsured have been addressed by legislation in several states. States by legislation limited the amount that would be charged low income (California & New York) and moderate income (Illinois) uninsured consumers. In Missouri a class action lawsuit based on contract principles involving fairness and good faith bargaining was settled successfully for all uninsured patients of a Missouri hospital system.⁹⁰ The hospital agreed to provide discounts to all its uninsured patients. Attorney Generals in Minnesota and Wisconsin successfully obtained price discounts for uninsured patients from hospitals operating in their respective states.

In addition to hospital inequitable pricing policies for the uninsured and underinsured, some hospital's collection practices require the uninsured or underinsured to pay the full amount of the estimated charges for the health care services before treatment will be provided. Other hospitals require the uninsured or underinsured to pay the full amount within an extremely shortened timeframe—even if the medical debt equals a substantial portion of the uninsured's or underinsured's annual income. Hospital inequitable pricing policies and collection practices cause many uninsured and underinsured to have large levels of medical debt that often lead to bankruptcy. Medical debt now causes a bankruptcy in America every thirty seconds.⁹¹

⁸⁹ See testimony of Professor Gunderson before the House Energy of Oversight Investigation. (June 24, 2004) Professor Gunderson, a professor at John Hopkins explained that many times the underinsured or uninsured have no choice as to which hospital he or she must go. Many times his or her choices are limited by their physician's hospital admitting privileges. The uninsured or underinsured may have been in an accident and was transferred to the hospital. Because the uninsured tend to have fewer resources, they wait until they are ill before they seek medical care making them more vulnerable because it is an emergency.

⁹⁰ See *Quinn, et. Al. v. BJC Health System*, Second Amended Class Action Petition, Cause No. 1052-00821A, Division No. 17 (St. Louis Circuit Court Missouri, June 2205). See also, settlement summary posted at Plaintiff attorney's website: www.grgpc.com/PDF/707301.pdf.

⁹¹ President Obama, Address to Congress (February 24, 2009).

TLSC recommends that steps be taken to prohibit hospitals from charging the uninsured and underinsured inequitable prices and requiring unreasonable payment terms. TLSC would encourage the Texas Legislature to enact a statute requiring all hospitals—for profit, nonprofit and public hospitals—to set a price for their uninsured and underinsured patients within a reasonable range of the rates they charge insurers or governmental payers. In addition, TLSC would encourage the Texas Legislature to enact a statute that would require all hospitals to set up payment plans for low and moderate income consumers at payment levels that would not exceed 15% or 20% of the patient’s annual income, not including federal taxes either withheld or paid.

TLSC believes legislation would need to apply to all hospitals and not just nonprofit hospitals. TLSC’s recommendation furthers the public policy of fair business dealings that applies equally to all hospitals. In addition, nonprofit hospitals should not be placed at a market disadvantage to other hospitals on pricing issues.

Recommendation Five. The method to calculate a nonprofit hospital’s charity care obligations known as the reasonableness standard should be deleted.

Very few nonprofit hospitals have reported their charity care obligations under this method. The standard is not an objective one and leaves nonprofit hospitals exposed to litigation. It also is not administratively easy to administer because agency review under this method would require a review of the nonprofit hospital’s whole business operations. This is contrasted to agency review of the other two methods that can be done by reviewing the annual statements.⁹² One nonprofit hospital who reported under this methodology was questioned as to whether it had met its charity care obligations resulting in the hospital agreeing to provide more charity care. The standard is too vague. The Texas Legislature should delete this method as a means for a nonprofit hospital to prove up its charity care obligations.

⁹² This is not to mean that audits would not be performed to ensure the accuracy of the reporting. But desk audits can be performed for these nonprofit hospitals for the most part.

Recommendation Six. To prove up its charity care obligations using the tax exempt benefits method, nonprofit hospitals should be required to include federal income tax benefits as part of its tax benefits.

Even though the Texas Charity Care Law defines tax-exempt benefits to include federal income tax benefits⁹³ the law excludes federal income tax benefits from the amount of tax-exempt benefits the nonprofit hospital must meet to prove up its charity care obligations.⁹⁴ The exclusion of federal tax exempt benefits is not consistent with the Charity Care Law's definition of tax exemption benefits. The law also does not require the nonprofit hospital reporting under this method to adjust its charity care costs to delete charity care costs attributable to its federal income tax benefits. Failing to either include federal income tax benefits in a nonprofit hospitals tax exempt benefits or exclude the hospital's charity care costs related to its federal income tax benefits results in state subsidization of a nonprofit hospital's federal income tax exemption.

TLSC recommends that the Texas Legislature amend the Texas Charity Care Law to delete the federal income tax benefit exclusion from the tax-exempt benefit method to prove up its charity care obligations. The alternative would be to require the nonprofit hospital to adjust its charity care costs to exclude charitable costs attributable to its federal income tax benefit which would be more administratively costly to implement.

Recommendation Seven. The Texas Charity Care Law should be amended to include a consumer complaint process and a public education program.

From a consumer perspective the Texas Charity Care Law is confusing. It is not clear from the statute what agency is required to enforce the law, what rights do consumers have under the law, who can file a complaint, and where can a complaint be filed. Consumers should be able to complain because they are harmed when the

⁹³ Tex. Health & Safety Code, Section 311.042(12)(A) (Vernon 2001).

⁹⁴ Tex. Health & Safety Code, Section 311.045(b) (1) (B) (Vernon Supp 2007-2008).

nonprofit hospital violates the Charity Care Law. The A.G. should be the agency clearly identified in the statute as the agency where complaints may be made for violations of the Charity Care Law. The A.G. should be required to keep the complainant apprised of his/her complaint. The A.G. should be required to carry out a public education campaign that educates consumers about the Texas Charity Care Law and about the complaint process. The Charity Care Law should be amended by the Legislature to include an investigation and enforcement provision.

Recommendation Eight. The Texas Charity Care Law should be amended to provide the A.G. authority to investigate under the law.

Although the A.G. has authority to investigate nonprofit hospitals under its authority provided for in the miscellaneous corporation Laws, that authority makes investigations not ending in litigation confidential. Investigations into whether a nonprofit hospital has violated the Texas Charity Care Law do not need to be kept confidential. Business records of nonprofit corporations are open for public inspection and copying. The Texas Charity Care Law should be amended to authorize the A.G. to investigate upon consumer complaint or its own initiative nonprofit hospital compliance with the law. The A.G. should be required to keep the consumer regularly informed of the progress of his/her complaint. Once finished, the investigations should be made public. The A.G. should be required to annually report to the public a summary of its activities involving its enforcement of the Texas Charity Care Law.

Recommendation Nine. Insurers should be required to make claims processing more efficient and hospitals should be encouraged to make the creation and maintenance of its medical records more efficient.

One of the biggest administrative costs a hospital incurs is processing its claims with insurers. The legislature should direct the Texas Department of Insurance to increase the efficiency of claims processing. The legislature should also direct TDSHS to work with hospitals to establish electronic medical records. The legislature should take

all steps to maximize any opportunity to receive federal funding to help fund the transition from written to electronic medical records.

Recommendation Ten. The Texas Legislature should create incentives and regulatory structures that will make health insurance more available and affordable to Texans.

Texas has the largest percentage of uninsured in the nation. Affordable insurance products would decrease the percentage of uninsured thereby increasing the uninsured's access to health care. The legislature should charge the Texas Department of Insurance ("TDI") with the task of working with the insurance industry, health care providers, governmental entities and the public to create affordable insurance products. The legislature should also direct that TDI establish a customer assistance program within the department that includes a computer program that will allow consumers to input health care requirements and receive suggested health care plans with pricing options.

Recommendation Eleven. The Texas Charity Care Law should be clarified to ensure that a nonprofit hospital's community benefit activities and projects are in response to community needs and are consistent with local governmental and public health planning and not for marketing purposes. Further the law should be amended to ensure that public input is provided in the hospital's community benefits plan.

The language in the Texas Charity Care Law is a little vague. It does not clearly state that community benefit activities and projects cannot be for marketing purposes. And the definition of community benefits does not clearly state that the projects or activities are to be in response to community needs. Reading the statute as a whole TLSC believes that the legislature intended that community benefit projects and activities be in response to community needs and not for marketing purposes. Clarifying that intent would provide clearer guidelines to nonprofit hospitals and the agencies administering the law.

A TLSC interview with the Texas Primary Care Office of TDSHS found that the office was not aware of any nonprofit hospitals contacting the office concerning its

community benefit planning. The office was not aware that the nonprofit hospitals' reports on community benefits plans were required to be filed in TDSHS. The Texas primary care program with TDSHS is tasked with helping low income Texans gain access to primary health care. The office is to do long-term and short-term planning to implement that task. While nonprofit hospitals are to consider consulting with local governmental and public health agencies, they are not required to do so let alone ensure that their goals and objectives in their community benefit plans are consistent with local governmental and public health planning. Requiring nonprofit hospitals to establish goals consistent with these public entities' health care plans will promote the uninsured's and underinsured's access to health care.

The Charity Care Law should also be amended to require nonprofit hospitals to advertise and hold a public hearing to allow the public the opportunity to provide input into the hospital's community benefit plan.

Recommendation Twelve. The Texas Charity Care Law should be amended to delete the statutory presumption that nonprofit hospitals designated as disproportionately share hospitals ("dsh") have fulfilled their charity care obligations.

The purposes of designating a hospital a dsh is to provide additional funds to hospitals who have taken on a disproportionately large amount of Medicaid recipients and uninsured as patients. Logically these so-designated hospitals should meet the minimum levels of charity care required under the Texas Charity Care Law. TLSC's review found that the great majority of the nonprofit dsh did. However, there were instances where the hospitals did not meet the minimum level of the required charity care. In addition, a nonprofit hospital need only have the designation of a dsh once over a three year period and be considered to have met the minimum levels of charity care required under the law for all three laws. There is no administrative reason to provide a three year exemption because hospitals are required to annually apply to be designated a dsh.

The current statutory presumption does not seem necessary. A nonprofit dsh is not avoiding any administrative costs by this designation. The hospital is required to file

the annual statements. The statutory presumption does seem to allow a few nonprofit hospitals to avoid incurring the statutory minimum level of charity care costs. Deleting this presumption would therefore cause few of the dsh hospitals to increase the number of uninsured and underinsured they serve.

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Community Catalyst is a national non-profit advocacy organization dedicated to making quality, affordable health care accessible to everyone. Since 1997, Community Catalyst has worked to build consumer and community leadership to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society. The organization is based in Boston, Massachusetts. *For more information, visit www.communitycatalyst.org*

The Hospital Accountability Project supports efforts to change hospital practices by reforming state and local policy. HAP is a 15-state project funded by the settlement of a class action lawsuit against the Tenet Healthcare Corporation, a national for-profit hospital company. The suit alleged illegal billing and collection tactics against the uninsured and underinsured.

As part of the settlement, the court awarded Community Catalyst funds to provide grants in Alabama, Arkansas, California, Florida, Georgia, Indiana, Massachusetts, Mississippi, Nebraska, Nevada, North Carolina, Pennsylvania, South Carolina, Tennessee, and Texas to attack the problems that gave rise to the original litigation.

In Texas, HAP funding was awarded to a coalition comprised of ACORN (Association of Community Organizations for Reform Now), TexPIRG Education Fund, Texas Impact, and Texas Legal Services Center (TLSC).

ACORN is the nation's largest community organization of low- and moderate-income families with over 30,000 members in eleven cities across Texas. ACORN brings ordinary people together to work on key community-based issues such as affordable housing and access to health care.

TexPIRG Education Fund is a nonprofit organization that works to protect consumers and promote good government. They investigate problems, craft solutions, educate the public, and offer Texans meaningful opportunities for civic participation.

Texas Impact is a 35-year old statewide interfaith network that was established by the state's bishops and other religious leaders to bring forward a voice of religious social concern in the state public policy debate. Health care is a core social concern for many faith traditions including nearly all branches of the Abrahamic traditions.

TLSC is a Legal Services program that provides state support to advocates of low-income people and individual support to low income people in need of legal services. Since 1989, TLSC has operated a hotline legal service to help low-income people with problems accessing or paying for health care.