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VIA ELECTRONIC MAIL

Senator Max Baucus, Chairman  
Senator Chuck Grassley, Ranking Member  
United States Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

Re: Comments on: *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*

Dear Senators Baucus and Grassley:

We are writing to offer our comments on the Senate Finance Committee's discussion of policy options to finance health care reform. We applaud your continued leadership in moving the discussion of health reform forward and appreciate the opportunity to provide our thoughts based on our experience working with consumer groups in 43 states to improve access to quality health care for all.

Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership required 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.

Our general stance with respect to financing is that health reform is an urgent national priority and that a financing package needs to be developed to support the necessary policy changes, rather than backing into a policy agenda based on the financing. We therefore encourage the committee not to preemptively take options off the table and to pursue a package of revenue increases and savings measures that is adequate to the task at hand.

We are not experts on federal tax policy. However in our work on health care reform we have acquired significant experience in two areas that are addressed in the financing paper—hospital community benefits and prescription drug policy. We will therefore focus our comments on these two topics.

## *Modifying the Requirements for Tax-Exempt Hospitals*

Since its establishment in 1997, Community Catalyst has worked with community organizations and other system stakeholders to promote hospital charity care and community benefit standards across the United States. These standards can be found in several resources and publications developed by Community Catalyst, including the [Patient Financial Assistance Act](#) and the [Health Care Institution Responsibility Model Act](#).

Community Catalyst's [2008 survey of the charity care laws and regulations](#) in each of the 50 states found that they vary dramatically from place to place, resulting in a system that is a confusing patchwork of voluntary hospital efforts and unspecific laws. This research, as well as our experience working with consumer advocates in many states on these issues, points to a pressing need for a national set of standards to ensure transparency, accountability and fairness. In addition, a recent [Community Catalyst national poll](#) found overwhelming public support for government oversight of charity care.

We believe that hospitals, in exchange for billions of dollars in annual tax exemptions, should play an essential role in their local health delivery systems by working with community members to support and create programs that target the health needs of underserved and vulnerable populations. This way, they can not only provide access to needed health care services for those that cannot afford them, but also have a broader impact on the overall health of their communities. Many tax-exempt hospitals achieve this through fair billing and collection policies, and by dedicating resources to provide important community health programs. In the absence of a clear community benefits standard, however, we have found that too many others fail to carry their fair share.

We were pleased, then, to see proposals in the financing policy options paper that would ensure transparency, accountability and fairness while helping to also strengthen the partnership between our nation's tax-exempt hospitals and the communities they serve. While we fully support firm and meaningful standards, we suggest several refinements of those proposals below.

### Requirements

#### *Community Benefits*

We urge the Committee to pursue proposals to inject firmer meaning into the existing IRS community benefits standard. For instance, in order to avoid intermediate sanctions, hospitals should be required to establish policies and procedures that meet the following principles:

- Establish **community benefits as a priority** within the hospital leadership and planning processes
  - Establish and maintain a **Board-level standing committee on community benefits** to oversee and evaluate the results of the hospital's community benefit programs and activities, with regular reporting by the committee to the full Board

- Designate a **community benefits manager** to implement the hospital's community benefits programs and activities
- Establish and regularly update an **annual community benefit plan** and budget as an integral part of the hospital's overall operating plan and budget
- **Regularly involve the community** – including representatives of the targeted underserved populations – in the hospital's community benefits planning activities
- Conduct a **community needs assessment** to determine the health care needs of low-income, indigent, and otherwise medically vulnerable community members
- Implement a **community benefits plan** that seeks to address the health care needs identified through the community needs assessment

### *Charity Care, Billing and Collections*

The need for charity care – currently an essential component of hospitals' community benefits obligation—will decrease should Congress enact national health reform. Nevertheless, there will remain a segment of uninsured and underinsured patients that will continue to rely on charity care as a safety net. We recommend that hospitals be required to:

- Screen patients for **eligibility for public programs**
- Establish a **meaningful charity policy** that includes free and reduced cost programs
  - **Charity care** available to patients with incomes up to 300% FPL
  - **Reduced cost care** available to patients with incomes between 300% and 500% FPL.
  - **Medical hardship assistance** care available to patients whose medical expenses exceed 10% of his or her net family income.
  - Eligibility for charity care is determined using a **uniform, fair and transparent application process**
- **Publicize widely** their charity and reduced cost programs particularly among vulnerable populations
  - **All patients are notified** in person and on any bill about the availability of charity care
  - The **hospital widely publicizes its charity care programs** through appropriate signage, websites, newspapers and through social services agencies
  - Notice of the hospital's charity care programs appears in **languages appropriate to the hospital's community**
  - Hospital **staff members are regularly trained** on the hospital's charity care programs
- **Limit what they charge uninsured and underinsured patients** to the rate paid by Medicare

- **Refrain from garnishing wages, placing liens on homes and charging interest on outstanding patient debts**

### *Minimum Annual Level*

We believe that tax-exempt hospitals have a duty to help address the health care needs of the communities they serve. Any national minimum standard should include all community benefits, and not simply charity care.

### Reporting/Transparency

We strongly support proposals that improve reporting and transparency of operations. Schedule H of IRS Form 990 is a strong basis from which to start. In order to promote greater transparency, however, we recommend an additional change to Schedule H. Currently, Schedule H mandates that hospital systems report on an employer identification number (EIN), rather than facility-by-facility, basis. Thus, it captures only what is generally true of the system's policies and practices. This prevents the public from getting an accurate picture of how hospitals in their particular communities are performing. It is not unusual for health care systems to control hospitals in urban, suburban, and rural areas, with different patient mixes and different levels of commitment to charity care and community benefits. Therefore, we urge the Committee to consider requiring hospital systems that control more than one exempt hospital to submit a separate Schedule H for each hospital in the system.

### Excise taxes/Intermediate sanctions

We support the concept of imposing intermediate sanctions on hospitals that fail to meet community benefits requirements that reflect the principles described above. Tax-exempt hospitals should play an essential role in their local health delivery systems by working with community members to support and create programs that target the health needs of underserved and vulnerable populations. In this way, they can both provide access to needed health care services for those that cannot afford them and have a broader impact on the overall health of their communities.

### No Preemption

Any modified federal community standard for tax-exempt hospitals should not preempt potentially stronger state charity care or community benefit laws.

### ***Lowering the cost of prescription drugs***

#### Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts

Community Catalyst supports the increase in the flat Medicaid drug rebate for brand name drugs from 15.1% to 23.1% and an increase in the basic Medicaid rebate for non-innovator, multi-source drugs from 11 to 13% and urges that these changes be included in the final package.

### Extend to and Collect Rebates on Behalf of Managed Care Organizations (MCOs)

Community Catalyst supports the Committee's option to extend and collect the Medicaid drug rebate on behalf of Medicaid managed care organizations and urges its inclusion in the final package. The inability of states to collect rebates on behalf of drugs prescribed to enrollees in Medicaid health plans hampers the ability of health plans to manage the Medicaid pharmacy benefit. The data that health plans receive from pharmacies regarding enrollees' drug utilization allows health plans to monitor patient compliance with treatment regimens, identify incidents of over-prescribing and drug abuse, and reduce harmful drug interactions.

Without this change, states may continue to have financial incentives to carve out prescription drug management away from the health plans. Indeed, those incentives may increase if the drug rebates are increased. Equalizing the drug rebate will not only save \$11 billion federal dollars over the next ten years<sup>1</sup>, it will also preserve systems that allow health plans to protect their enrollees.

### Application of Rebates to New Formulations of Existing Drugs.

Community Catalyst supports the option to consider modifications ("line-extensions") of existing drugs as if they were the original product for purposes of calculating the additional rebate.

Under the current system, modifications to existing drugs, such as new dosages or formulations, are considered new products for purposes of reporting AMPs to CMS, which is an incentive to drug makers to avoid incurring additional rebate obligations by making slight alterations to existing products.

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We thank you again for the opportunity to provide comments on this important set of proposals. We look forward to working with the committee as it continues its work.

Sincerely,

Robert Restuccia  
Executive Director

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<sup>1</sup> The Congressional Budget Office scored this policy in December 2008