



**American Hospital
Association**

September 6, 2007

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The Honorable Charles Grassley
Ranking Minority Member
Senate Finance Committee
Washington, DC 20510

Dear Senator Grassley:

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other providers of medical care, and our 37,000 individual members, the American Hospital Association (AHA) is responding to your request for comments on the discussion draft on tax-exempt hospitals, released as a minority staff document (minority draft).

The real issue here is the lack of health insurance coverage for 47 million Americans. In our May 1, 2006 letter to you, we described in some detail how hospitals across the nation do their very best to compensate in the absence of a national policy to address this crisis. In 2005, hospitals provided more than \$28.8 billion in uncompensated care (based on the hospitals' costs) to their communities, and uncounted billions in value through services, programs and other activities to promote and protect their communities' health and well-being. The AHA continues to support and promote hospitals' efforts, including development of a plan to address this national health insurance crisis and to improve health and health care for all.

Unfortunately, the proposals in the minority draft do not address the problems of the uninsured. Instead, the draft singles out hospitals for unfair criticism and recommends punitive measures that are unwarranted. We are particularly troubled that the paper suggests abolishing the current community benefit standard for tax exemption and replacing it with a percentage test related only to charity care. We oppose any change to the community benefit standard.

In our testimony before the Finance Committee on September 13, 2006, we described why the courts and the Congress in the 1960s ultimately rejected use of a percentage test as outdated and why the community benefit standard is the correct standard to apply. We cited the 1960 decision in *City of Richmond v. Richmond Memorial Hospital*, in which the Virginia Supreme Court explained why a percentage test should be rejected:

“A tax exemption cannot depend on any such vague and illusory concept as the percentage of free service rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on the subject. Thus there would be no certainty or uniformity in the application of the section involved.”



The wisdom of that decades-old decision remains fully intact today.

We cannot support legislating any of the proposals in the minority staff draft. By all indications, the hospital field is already addressing the concerns cited in the paper, or those concerns are under study. Therefore, legislation is either premature or unnecessary. The AHA addressed many of the concerns in the minority draft in our May 1, 2006 letter to you, which is attached for your convenience. We will, however, address a number of the draft's new proposals in some depth.

SPECIAL RULES FOR TAX-EXEMPT HOSPITALS

The minority draft proposes legislation to set a minimum eligibility threshold for charity care policies of no less than 100 percent of the federal poverty level, and to prescribe what charity policies must say and where they must be posted. The hospital field has already responded to these concerns.

The policy on billing, collections and tax-exempt status adopted by the AHA Board of Trustees on April 29, 2006, and attached to the May 1, 2006 letter to you, calls upon hospitals to, among other things:

- provide services at no cost to patients below 100 percent of the federal poverty level and financial assistance to patients between 100-200 percent of the federal poverty level; and
- make information about a hospital's financial assistance policy easily available to the public.

Hospitals routinely provide assistance to low-income patients that exceed AHA guidelines or those in the minority draft proposal. To the extent that the concern reflected in the minority draft is for transparency, that goal will be accomplished by the Internal Revenue Service (IRS) through issuance of Schedule H to proposed revised IRS Form 990. The schedule will require hospitals to provide specific information about their financial assistance policies and how patients are informed about them.

A §501(C)(3) HOSPITAL MUST PROVIDE QUANTITATIVE AMOUNTS OF CHARITY CARE ANNUALLY

The minority draft proposes that hospitals, except critical access hospitals, dedicate a minimum of 5 percent of their annual operating expenses or revenues to charity care and further prescribes how the value of charity care would be calculated, when care could be classified as charity, and when a patient would be deemed "medically indigent."

As noted above, decades ago the courts and Congress rejected setting a percentage of charity care as a condition for hospitals' gaining or maintaining tax-exempt status. The rejection was not based on unfulfilled hope that the Medicare and Medicaid programs

would fully address concerns about the uninsured, but rather the changing nature of hospitals themselves. As the United State Supreme Court found:

“[T]he concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the ‘delivery’ of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and because of increasing costs, physician specialization, shortage of general practitioners, and other factors is often compelled to turn, whenever a medical problem of import presents itself.” Abbott Laboratories v. Portland Retail Druggists Ass’n, 425 U.S. 1, 11 (1976).

As hospitals assumed “a larger community character,” it became increasingly clear to the courts and, apparently, to Congress that a percentage test was outdated and needed to be replaced with a standard that reflected hospitals’ need to serve the entire community. The leading commentator on hospital tax-exempt status, Robert Bromberg, described it as the “humanitarian approach”:

“[I]n determining whether a nonprofit hospital is operated in furtherance of charitable purposes, the proper touchstone should be the more widely accepted humanitarian approach, which focuses on the hospital’s delivery of health care to the community, rather than the public burden approach, which refuses to look beyond the quantum of free or below-cost care provided to the poor.”

In keeping with the humanitarian approach, in 1969 the IRS replaced its outdated percentage test with the community benefit standard in Revenue Ruling 69-545. That ruling established a variety of factors as the pillars of the “community benefit” standard:

- operating an emergency room open to all regardless of ability to pay;
- having an independent board of trustees composed of representatives of the community;
- having an open medical staff policy with privileges available to all qualified physicians;
- providing care to all persons in the community able to pay either directly or through third-party payers; and
- utilizing surplus funds to improve the quality of patient care, expand facilities and advance medical training, education and research.

Among its virtues, the community benefit standard allows the community in which the hospital operates to determine the needs of its residents and the hospital to tailor its activities accordingly. That approach still works well for communities across the nation.

In addition to the concerns above, the practical result of the 5 percent requirement would be to reduce payments for tax-exempt hospitals. We know you join us in opposing hospital payment cuts; therefore, any action in this regard would need very careful consideration.

In addition to adopting an outdated percentage test, the minority draft proposes undervaluing charity care by limiting it to the Medicaid payment rate. As the Congressional Budget Office in its 2006 report to Congress on community benefit confirmed, Medicaid reimbursement rarely compensates hospitals for the actual cost of the care provided. Currently, Medicaid pays only 87 cents for each dollar of care delivered.

Also of concern is that the minority draft proposes to limit the determination of charity care to situations in which patients identify themselves before the first bill is issued. This proposal advances a position that is impractical and, consequently, has been rejected by the courts. For example, in *St. David's Health Care System, Inc. v. United States*, the District Court harshly criticized the IRS for trying to make just such an artificial distinction:

*"The government attempts to quibble about how St. David's differentiates between free care that is charity care and free care that is bad debt. **The Court thinks that is a silly and meaningless distinction** . . . When all who need emergency care are treated regardless of willingness or ability to pay, the function is charitable regardless of what accountants discover later. The government uses the alleged fact that St. David's attempt to collect payment from all patients before determining whether the care rendered was charity care or bad debt ... This implicitly attempts to require St. David's to determine before rendering care whether to expect payment from that particular patient, a luxury allowed only to the privileged to live in a bubble constructed by theories without the rude pinprick of practicality that so frequently bursts such bubbles. Not surprisingly, the IRS offers no method by which that determination can be made ... (emphasis supplied)."*

Although the case was vacated and remanded by the appeals court, that court also criticized the IRS' position on bad debt. We agree with the District Court's view on bad debt.

Finally, by defining the term "medically indigent" as "a patient who has insurance all year but has inadequate financial protection," the minority draft seemingly penalizes hospitals for the health insurance industry's failure to police itself so that policies sold are truthful and otherwise adequate to cover the purchaser's reasonable needs. This problem is so severe that, for example, on August 23, Massachusetts Attorney General Martha Coakley filed suit against several health insurance companies for misrepresenting their policies and failing to cover benefits and services required by the state. By requiring hospitals to compensate for gaps in health insurance coverage, the minority draft overlooks a real and growing problem in the health insurance sector and shifts to hospitals the responsibility to compensate for the failure of others.

SPECIAL RULES FOR HOSPITAL JOINT VENTURES BETWEEN A FOR-PROFIT ENTITY AND A §501(C)(3) HOSPITAL

Despite the minority draft's stated concern about such ventures, there is nothing in the document to suggest why these should cause concern. Joint ventures in the health care sector are already pervasively regulated under the Stark and antikickback laws as well as by the IRS, *e.g.*, Rev. Rulings 88-15 and 2004-51. The minority draft never makes clear what gaps, if any, are left in

that encompassing regulatory scheme that would warrant additional legislation. No legislation should be enacted until those gaps are clearly identified and potential issues documented.

We appreciate your leadership and work with us since 2003 to address the problems created by physician-owned limited-service hospitals. Without your efforts, the current situation would likely be even worse. We believe that many of the concerns reflected in the minority draft are an outgrowth of the problems created by these hospitals that siphon off resources community hospitals must have in order to provide the entire range of services and benefits their communities need. We look forward to working with you to fully resolve this important issue by year's end.

GOVERNANCE

The minority draft also recommends percentage thresholds for hospital boards. Specifically, it would require tax-exempt hospitals to have a board controlled by "members who represent the broad interests of the public," and would limit to 25 percent the share of persons on the board who are employed by the hospital or who may benefit financially from the hospital. Physician and management participation would also be limited to 25 percent. Again, it is not clear what concern the minority draft is attempting to address. The community benefit standard requires that tax-exempt hospitals have an independent board of trustees composed of representatives of the community. The standard appears similar to that in the minority draft, albeit appropriately less prescriptive. Moreover, since the recently released IRS Hospital Compliance Project Interim Report found that the professional backgrounds of hospital board members are arrayed among a variety of backgrounds, with medicine and health appropriately representing slightly more than 25 percent of total board membership, it is difficult to determine why the minority draft promotes legislation to achieve this goal.

SANCTIONS FOR FAILURE TO MEET REQUIREMENTS

The minority draft calls for an array of sanctions for hospitals' failure to meet an arbitrary 5 percent charity care percentage. In addition to downgrading hospitals to §501(c)(4) status, the minority draft calls for an excise tax or fine "in an amount at least equal to twice the hospital's shortfall" below 5 percent, revocation of exempt status and possible revocation of Medicare provider status. These sanctions, which grow increasingly severe, are not warranted.

Although the minority draft is not entirely clear on this point, it appears that hospitals that fail to meet an arbitrary 5 percent charity care threshold would be downgraded to (c)(4) status and, therefore, would be unable to receive tax-deductible contributions or to obtain tax-exempt financing. In addition, a hospital that fell short of this arbitrary requirement would be fined, at a minimum, twice the amount of the purported shortfall. While the minority draft "suggests" the IRS determine the need for this sanction by looking at a hospital's performance over a three-year period, the IRS would not be required to do so.

Finally, the minority draft would presumably provide the IRS with authority to revoke tax-exempt status for failure to comply with any of its new proposals, and would couple revocation

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with a request that the Department of Health and Human Services consider revocation of a hospital's Medicare provider status.

All of the sanctions are objectionable. A hospital could fail to meet an arbitrary 5 percent charity care threshold for any number of legitimate reasons, including financial hardship, community priorities and the like. Yet, imposition of an IRS fine would invite private lawsuits and other disruptions that would add to the hospital's hardship or otherwise disrupt community-approved priorities. And, loss of exempt status and Medicare provider status would be cataclysmic, leading to the loss of services for Medicare beneficiaries and the community. Medicare accounts for approximately 40 percent of care provided by hospitals. These sanctions and the disruptions they could cause are simply not warranted as punishment for failing to meet an arbitrary charity care threshold.

We attach the AHA's May 1, 2006 letter to you, with additional attachments. The letter addresses a number of similar concerns raised in the minority draft. We would be glad to provide you with more information or discuss any of the proposals further, at your convenience. If you wish to do so, please contact Tom Nickels, our senior vice president of federal relations, at tnickels@aha.org or (202) 626-2314.

Sincerely,

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Rick Pollack
Executive Vice President

Courtesy Copy:
Senator Max Baucus

Attachments:

May 1, 2006 letter to Senator Chuck Grassley, with attachments:

AHA Hospital Billing and Collection Practices

Guide to AHA Governance and Policy Development - AHA Members Only

AHA Comments to Internal Revenue Service on draft Schedule H